

July 23, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: RIN 0938-AS25 Medicaid and Children's Health Insurance Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; (Vol. 80, No. 104, June 1, 2015)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule revising the managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP).

The proposed rule marks an important step in more closely aligning Medicaid and CHIP managed care with Medicare Advantage (MA) plans and private insurance, particularly qualified health plans (QHPs) sold in the Health Insurance Marketplaces. While it looks to standardize requirements for state capitation rate-setting, medical loss ratio (MLR) requirements and provider adequacy standards, the rule also would grant states a fair amount of flexibility in adapting their current programs to these proposed requirements.

In general, the AHA supports the direction of the proposed rule and applauds CMS's efforts to modernize these regulations. Indeed, a number of the proposed policy changes are in line with recommendations the AHA submitted to the agency in December 2014, including greater transparency in capitation rate-setting, MLR requirements, provider network adequacy standards and strategies for quality improvement. As CMS moves forward in implementing these policy changes, we urge the agency to continue to be mindful of the need to strike the appropriate balance between federal standards and state flexibility so that enrollees have timely access to quality health care services.



The AHA's comments on the proposed rule primarily focus on eight key areas:

- transparency and oversight requirements of states' capitation rate-setting process;
- uniform standard for MLR;
- special contracting provisions related to provider payment and delivery system reform;
- provider network adequacy standards;
- institutions for mental diseases (IMD) related capitation payments;
- quality improvement and measurement;
- beneficiary protections; and
- other contractual requirements and program integrity.

STANDARDS FOR ACTUARIAL SOUNDNESS, CAPITATION RATE DEVELOPMENT AND CERTIFICATION (SEC. 438.3-438.7)

The AHA supports CMS's proposals to require that states adhere to greater transparency standards in developing actuarially sound Medicaid capitation rates for managed care plans. Specifically, the rule proposes to strengthen current regulations by adopting the American Academy of Actuaries' practice standards for Medicaid managed care, which would lead to greater transparency and consistency in capitation rate development at the state level. In addition to requiring that states develop rates in accordance with the academy's generally accepted actuarial principles and practices, the proposed rule would require that the capitation rates set are appropriate for the population covered and the services furnished; adequate for the plan to meet the network adequacy and access standards; and sufficient for the plan to meet the MLR requirements. States would be required to document their rate-setting process, including the trend factors and adjustments used. The AHA believes these proposals will ensure greater standardization and transparency in the rate setting process.

In addition, the AHA supports CMS's commitment to a substantive review and assessment of the assumptions and methodologies states use in the development of actuarially sound rates through its new rate certification process. However, there are risks that certain revisions to the certification process, particularly the movement away from allowing a range of allowable rates, may have unintended consequences of diminishing states' ability to implement rate adjustments that support critical funding to providers. Specifically, CMS proposes to increase its oversight of state capitation rate setting by establishing a new agency-level rate certification process. The proposed process would require that states submit to the agency detailed documentation that supports the setting of the capitation rates for every managed care plan. In addition, the rule would require that states submit to CMS the managed care contracts and all the necessary information for the rate certification review no later than 90 days before the effective date of the managed care contract.

The AHA supports CMS's proposal to require that the agency more closely examines how states and their actuaries assess whether capitation rates are adequate to support provider reimbursement levels that will lead to network adequacy and timely patient access. While

the closer examination of the link between capitation rates and provider reimbursement levels is welcomed, the AHA, however, recommends that CMS require states, on a periodic basis, to study and report on how capitation rates and the subsequent plan reimbursement to providers affect patient access and provider network development. In addition, we caution the agency to carefully consider its own resource needs to ensure it can provide timely and thorough review of the managed care contracts and the capitation rates within the 90-day timeframe specified by the rule.

MLR: CALCULATION, REPORTING AND STATE OVERSIGHT (SEC. 438.8, 438.74)

The AHA supports CMS's proposed new uniform MLR standard for Medicaid and CHIP managed care plans set at a minimum of 85 percent. This proposal is in line with our December 2014 letter to the agency, which urged CMS to adopt an MLR standard to better align Medicaid managed care with the MA and private insurance markets. Because the MLR measures how much of a managed care plan's premium dollar is spent providing covered services compared to the total revenue it receives in capitation payments, it can serve as an important safeguard to help ensure actuarially sound rates and adequate provider payments.

The proposed rule follows the National Association of Insurance Commissioners (NAIC) standards for calculating the MLR. The numerator of the MLR would consist of three basic categories – incurred claims of the managed care entity; expenditures for activities that improve health care quality; and expenditures for program integrity requirements. The denominator of the MLR would be broadly defined as premium revenue less any expenditure for federal/state taxes and licensing or regulatory fees. In general, the proposed rule uses definitions for incurred claims and revenue that are outlined in federal regulations for private health insurance MLR calculations, although it also deems some unique Medicaid expenditures, such as health information technology (IT) and meaningful use, as appropriate quality expenditures. The list of unique Medicaid quality expenditures CMS provided in the rule, however, may be too restrictive. **CMS may wish to consider expanding this list to include, for example, enrollee transportation costs as quality improvement expenditures. Some hospital-based Medicaid managed care plans provide transportation for enrollees to facilitate access to timely services, thereby improving quality of care and health outcomes.**

More broadly, the AHA urges CMS and the states to provide greater guidance to managed care plans on the appropriate definitions of what constitutes health care or quality expenses versus administrative expenses. While the plans must report to the state the components of their MLR calculations, and the states must submit annual reports summarizing the MLR calculations for each type of managed care plan, these reporting requirements are not a substitute for clear guidance on MLR terms and definitions. The MLR should not be used to allow Medicaid managed care plans to classify what are truly administrative costs as health care or quality costs through the use of overly broad definitions of these categories. For example, plan utilization review is a claims processing activity and is correctly defined as an administrative expense and not as a quality expenditure according to CMS's instructions for MLR calculations that apply to commercial insurance. Including utilization review costs in the numerator of the

MLR calculation could artificially increase a plan's MLR, thereby conveying an inaccurate picture of how much of the premium dollar a plan is actually spending on health care services.

SPECIAL CONTRACT PROVISIONS RELATED TO PROVIDER PAYMENTS THAT SUPPORT STATE DELIVERY SYSTEM REFORM EFFORTS AND DIRECT PAY PROHIBITION (SEC. 438.6 (C))

The AHA, in general, supports CMS's proposed exceptions to the special contracting provisions. Specifically, states are prohibited from directing payment to providers in a managed care setting. However, CMS proposes three exceptions to this prohibition that would allow states to direct plans to participate in multi-payer delivery system reform and performance improvement initiatives, value-based purchasing models for provider reimbursement or integrated care delivery.

As CMS notes in the rule, states could use the special contracting exceptions to continue to pass through payments for primary care providers at the Medicare reimbursement rate or to promote incentive payments for the adoption of health IT in provider settings not currently eligible for incentive payments, such as post-acute care. In addition, states could use the special contracting exceptions to promote value-based purchasing models that recognize value or outcomes. To promote integrated care delivery, the proposed rule would specifically permit states to require that managed care plans adopt a minimum reimbursement standard or fee schedule, or increase provider payments through a uniform dollar or percentage increase to ensure timely access to high-quality care.

The AHA, however, recommends that CMS grant states greater flexibility in their use and design of special contracting provisions, which would help promote our shared goal of furthering delivery system reforms. The three proposed exceptions to the special contracting provisions are too limiting and fail to encompass all current and future provider payment innovations.

For example, CMS discusses that one objective of the exceptions to the special contracting provisions is to "...incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries under a managed care arrangement." However, the exceptions seem to limit states' ability to "incentivize and retain certain types of providers" by requiring, as stated in the preamble and the rule, that the state treat all providers of the service equally and not direct payments to specific providers. In other words, under the proposed rule, states may not be able to pay certain providers incentive payments for meeting certain quality metrics. This seems contrary to CMS's stated goal of tying payment to the quality of services delivered. **Therefore, the AHA recommends that CMS modify these exceptions to allow states to pay providers differently if they meet certain performance metrics.** This would allow states the flexibility to design payment arrangements through the special contracting exceptions that continue to support CMS's overall objective of quality care and a movement toward population health. The added flexibility also would allow for future payment innovations not yet envisioned by CMS or the states.

PROVIDER NETWORK ADEQUACY STANDARDS AND PROVIDER DIRECTORY (SEC. 438.68, 438.10(H))

The AHA supports CMS's proposal to require that states set minimum provider network adequacy standards for their managed care programs. We have long advocated that health plans in all markets – Medicaid, Medicare and private insurance – maintain provider networks sufficient in number and types of providers, including providers that specialize in mental and behavioral health and substance abuse services, to ensure that all services are accessible without unreasonable delay for both adults and children.

The proposed rule seeks to align the provider network adequacy standards for Medicaid and CHIP with network standards for QHPs sold in Marketplaces and MA plans. States would be required to develop time and distance standards for the following provider types covered under the managed care contract: primary care (adult and pediatric); OB/GYN; behavioral health; specialists (adult and pediatric); hospitals; pharmacy; pediatric dental; and any additional provider type determined by CMS. States with managed care contracts that also include coverage for long-term services and supports (LTSS) would be required to develop time, distance and other network adequacy standards for LTSS provider types.

The AHA, in general, supports the use of time and distance standards for provider networks, but encourages CMS to allow for the special circumstances and unique medical needs of children and adults with complex and chronic medical conditions. These complex patients may need more immediate and frequent access to certain specialty providers than is accommodated by a uniform time and distance standard. **The AHA is pleased that CMS recommends that provider network adequacy standards for behavioral health providers distinguish between adult and pediatric providers, which would better identify shortages and reduce reliance on out-of-network authorizations for care.** The behavioral health needs of adults and children are significantly different, and managed care plan provider networks should be evaluated based on the needs of each of these populations they are contracted to serve.

The proposed rule also includes various elements that states should include in their provider network adequacy standards, such as geographic location of providers, the health needs of the population, the numbers and types of health providers, whether providers are available to accept new patients, and the need for special accommodations such as disability and/or limited English proficiency. **The AHA supports including these elements in states' network adequacy standards and stresses the importance of ensuring that in-network providers are accepting new patients when assessing the adequacy of the network.** Too often health plans list providers as in-network but fail to ensure or inform the enrollee whether the provider is accepting new patients.

Accordingly, the AHA supports CMS's proposal to require states to ensure that managed care plans maintain and update provider directories and make the directories available in electronic or paper form. The maintenance and updating of provider directories is an important component of ensuring an adequate network. **The AHA believes that the obligation and**

responsibility for maintaining and updating the provider directories lies with the managed care plans. As such, managed care plans should be required, as a condition of their contract, to periodically update their directory by proactively reaching out to the providers in their network to confirm the currency of the information. Further, the AHA urges CMS to explore ways to standardize provider directory information. CMS should consider adopting the provider directory standard listed in the Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology's draft of the "2015 Interoperability Standards Advisory."

MEDICAID CAPITATION PAYMENTS FOR ENROLLEES SUBJECT TO THE INSTITUTIONS FOR MENTAL DISEASE (IMD) EXCLUSION (SEC. 438.3 (U))

The AHA supports CMS's recommendation to allow states to pay a capitation payment to managed care plans for enrollees aged 21 to 64 who are subject to the IMD exclusion, but urges the agency to consider expanding the 15-day limit on enrollees' stay. Specifically, CMS's proposed change would allow states to pay managed care plans for the care provided to adult enrollees who have a short-term stay of no more than 15 days in an IMD, as long as the facility is an inpatient psychiatric hospital or a sub-acute facility providing short-term crisis residential services. According to CMS, 7.1 percent of those aged 18–64 currently meet the criteria for a serious mental illness. Further, an estimated 13.6 percent of uninsured adults within the Medicaid expansion population have a substance use disorder. These data underscore the need to improve access to short-term inpatient psychiatric and substance abuse disorder treatment.

In addition, to further improve access to care for this vulnerable population, the AHA urges CMS to continue to examine, through the Medicaid Emergency Psychiatric Demonstration project, whether eliminating or restricting the scope of the IMD exclusion can improve access to care and help reduce costs. Finally, the AHA recommends that CMS eliminate the state option to allow behavioral health services to be carved out of Medicaid managed care benefits. Such carve-out arrangements create barriers to the integration of behavioral and physical health care and inhibit the sharing of information across care settings.

QUALITY IMPROVEMENT AND MEASUREMENT (SEC. 438.310 AND 438.370)

CMS's proposed rule would require states to establish a quality framework built upon the principles set forth in the HHS National Quality Strategy and the CMS Quality Strategy. In addition, each state must develop a quality strategy and framework that includes the state's defined standards for provider networks and availability of services; the state's goals, objectives and metrics for continuous quality improvement; the state's annual and external independent review process; the state's use of intermediate sanctions; and the state's assessment of performance and quality outcomes. CMS would require each state to determine core set of performance measures and its own performance improvement activities, and require that each state have a public comment period to gather input on what those measures and projects should be.

The AHA agrees fully with CMS that it is important and useful to receive public input on which topics should be pursued in large scale improvement activities and which measures should be used to track improvement. CMS's proposal would require each state to develop its own quality strategy, its own standards of service and its own list of measures and to solicit public comment independently. This recommendation however, has significant drawbacks. It will inevitably add burden, increase the number of measures and disparate activities and diminish the likelihood these efforts would have the desired effect of improving outcomes.

As noted in the Institute of Medicine's recent *Vital Signs* report, the greatest opportunity for improvement in health and health care will come through a coordinated strategy that focuses on a modest number of topics and a relatively small set of core measures for assessing progress. Currently, hospitals, health plans, and other health and health care organizations are responding to a dizzying array of mandates and requests for data and involvement in quality improvement activities. Responding to the disparate data requests is resource intensive and, more importantly, leads to confusion and frustration when disparate ways of measuring performance provide disparate information on how well an organization is performing.

The overabundance of measures also decreases the ability of health care and public officials to identify the most important opportunities for improvement, which health plans and managed care organizations have the capacity to generate the best outcomes, and whether particular types of managed care organizations (MCOs) have particular challenges in achieving critical performance goals. **Therefore, the AHA urges CMS to direct Medicaid programs to review and adopt the set of 15 improvement areas identified in IOM's report that represent the core metrics to better health, and range from life expectancy to care access. CMS should require that states select the measures appropriate for assessing the contributions that Medicaid managed care entities can make toward achieving better performance in each of the relevant IOM improvement areas.**

In our recommendation, we recognize that not all of the topics may be appropriate to the work of MCOs and that some states may judge that it is necessary to augment the set of topics with one or two of their own that are of particular concern for their citizens, but **we believe that having a single common set of topics and related measures from which to choose will lead to a more unified approach to measurement and greater opportunities for collaborative improvement work.**

Further, the proposed rule would require states to establish a Medicaid and CHIP managed care quality rating system that would include performance information on all health plans, including information on clinical quality, member experience, and plan efficiency, affordability and management. States would be required to post on their website plan quality ratings. In addition, plans serving only enrollees that are dually eligible for Medicare and Medicaid could use the MA five-star rating system.

The AHA agrees that public transparency on quality performance is important. We support CMS's proposal to have all states provide this information, which should be helpful to those trying to find a plan for themselves and their family members. However, there is a science behind constructing effective websites or other mechanisms for communicating such information. CMS should support states in complying with this requirement through technical assistance and resources. One such resource is the Agency for Healthcare Research and Quality's website, <https://cahps.ahrq.gov/consumer-reporting/talkingquality>, which contains current research on effective communication and provides examples of effective data displays.

BENEFICIARY PROTECTIONS: MARKETING, AUTHORIZATIONS, APPEALS AND GRIEVANCES, AND CARE COORDINATION (SEC. 438.54, 438.104, 438.210, 438.230)

Marketing. **The AHA supports CMS's proposal to allow issuers that offer both Medicaid and Marketplace QHPs to market their QHP plan product to Medicaid enrollees in the event the enrollee loses his or her Medicaid eligibility.** This proposed change would allow greater access to coverage for a low-income population that may lose Medicaid coverage due to a change in income, but would be eligible to purchase subsidized coverage through the Marketplace.

Authorizations and Beneficiary Protections. **The AHA supports CMS's proposed changes to adopt new standards for plans regarding coverage authorizations if there is a change in plan coverage; new expedited timeframes for authorization requests, including drug authorizations; a new requirement that states cover drugs excluded from the managed care contract; and the inclusion of early and periodic screening and diagnosis treatment (EPSDT) in the definition of medically necessary services.** These changes would provide greater protections for beneficiaries by helping ensure they are able to access needed care in a timely manner. Specifically, plans would be required to provide coverage authorization requests if they propose to reduce or eliminate treatment. Plans also would be required to adhere to Medicaid's long-standing requirements that treatments are to be reasonable in amount, duration and scope, and not arbitrarily discriminate, based on conditions, such as chronic conditions or the need for LTSS.

Appeals and Grievances. **The AHA supports CMS efforts to better align the appeals and grievance process for Medicaid managed care with MA and private insurance.** Specifically, the AHA supports the ability of providers to appeal a coverage decision on behalf of the enrollee without the written consent of the enrollee. Also, we support the proposed regulation that managed care plans provide to enrollees, free of charge and upon request, the basis for an adverse coverage decision. In addition, the AHA recommends that CMS require that states include in their assessment of a managed care plan's network adequacy an examination of any questionable patterns of coverage denials. Similarly, we recommend CMS consider requiring states to develop a mechanism for providers to raise problematic patterns of plan behavior regarding coverage and payment decisions.

Care Coordination. **The AHA supports CMS's proposals to strengthen care coordination standards imposed on states when a beneficiary moves into a new managed care plan or is in need of LTSS.** The proposed rule would require states to ensure that, if a plan contract is terminated or the enrollee is dis-enrolled, Medicaid services are provided without delay, including transition of care services if the enrollee would suffer serious harm or be at risk for hospitalization or institutionalization. Any care coordination or transition of care policy by the plan also would need to ensure that the enrollee has access to services consistent with the access he or she previously had; is able to retain his or her current provider for a period of time; and is referred to appropriate in-network providers of services.

In addition, the proposed rule would require that managed care plans coordinate benefits and claims for managed care enrollees who are dually eligible for Medicare and Medicaid. Plans would be required to sign a Coordination of Benefits agreement and participate in Medicare's automated crossover process if the state uses the automated crossover process for fee-for-service. **The AHA supports this proposal because it alleviates the administrative burden many hospitals face in having to submit separate bills to two entities for their dually eligible patients.**

OTHER CONTRACTUAL REQUIREMENTS AND PROGRAM INTEGRITY PROVISIONS (SEC. 438.600-438.610)

Subcontractual Relationships and Delegation. **The AHA supports CMS's proposal to require that states stipulate that managed care plans are to be held accountable for subcontractual relationships and delegation of service delivery because doing so would align these requirements with MA standards.** CMS, through the proposed rule, would further require that any plan that delegates activities or obligations under the contract to another individual or entity is ultimately responsible to ensure that the individual or entity complies with all applicable laws, regulations, subregulatory guidance and contract provisions.

Program Integrity. The proposed rule would require states to screen and enroll and periodically revalidate all network providers of plans, as well as primary care case managers that are not already enrolled with the state, according to current federal Medicaid program integrity standards. CMS also proposes that states require plans to provide for a method to verify, by sampling or other means, whether services that have been represented to have been delivered by network providers have actually been delivered. **The AHA recommends that CMS require states to provide clear and consistent guidance to managed care plans on the methods they can use to verify the delivery of services by network providers. The verification process and methods should be the same for all plans in the state to ensure providers are not facing an unnecessary administrative burden and inconsistent guidance from managed care plans.**

Andy Slavitt
July 23, 2015
Page 10 of 10

Thank you for your consideration of our comments. We look forward to working with CMS in implementing these important changes to the Medicaid and CHIP managed care programs. If you have any questions, please contact Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President