American Hospital Association

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October 24, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS–9975–P; Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule (Vol. 76, No. 136), July 15, 2011

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the mitigation of health plan risk. The risk mitigation rule implements provisions of the *Patient Protection and Affordable Care Act* (ACA) designed to spread and manage risk and stabilize health plan premiums in states, especially during the period when many key ACA insurance reforms take effect and the new health insurance exchanges are being established.

The AHA supports the approaches used to mitigate risk for health plans due to significant changes in insurance rules, but is concerned about the lack of specificity and transparency requirements related to the various methodologies that will be issued annually by CMS or the states. The risk mitigation rule gives the states and federal government important tools to stabilize the insurance market, but the lack of specificity regarding the methodologies to be used and data collection requirements raises questions for hospitals, as does the lack of specific transparency required around the issuance of notices containing those methodologies, the data used to form or execute them, and their availability for public comment prior to adoption.

The proposed rule sets forth the standards for three elements, two of which are temporary and would apply to calendar years (CY) 2014-2016 and one of which would be permanent:

- A temporary state-based reinsurance program, funded by premiums paid by all health plans and third-party administrators (TPA), would be established to provide payments to plans to offset high-cost outlier individuals.
- A temporary federal risk corridor (+/- 3 percent) program would protect health plans against inaccurate rate setting given major market reforms.
- A permanent state-based risk adjustment program would protect against adverse selection by transferring funds from lowest risk plans to highest risk plans.

SPECIFIC ISSUES

Methodologies: **The AHA recommends that for each of the three risk mitigation programs, all notices (whether issued by the Department of Health and Human Services (HHS) or the state) regarding methodologies should be made public with a sufficient period of time allowed for review and comment**. Each of these risk mitigation approaches includes one or more complex methodologies. While described in general terms, the actual methodologies are not included in the proposed rule. The proposal indicates that the methodologies would be published in annual notices, but does not appear to require that the notices be published for public comment *prior to* finalization. For example, the proposed rule specifies that the reinsurance program would be funded by percent-of-premium contributions by plans and TPAs, but the methodology to be used in calculating the actual annual percentage premium will be included in an annual notice. In another case, states are allowed to use alternative methods with concurrence from HHS, as in the case of risk adjustment. The proposed rule also does not indicate whether states will be required to publish notices for public comment.

Pro Rata Payments by the Reinsurance Program: **The AHA recommends that plans be prohibited from passing on to providers the losses from *pro rata* reduced payments when the reinsurance program is inadequately funded**. The proposed rule requires that the state reinsurance program collect and make payments to eligible plans based on the plan's medical costs for high-cost enrollees. The state reinsurance entity would be prohibited from making payments in excess of contributions collected. In the case where payments are in excess of collections, a *pro rata* approach would be adopted to scale all payments back to the funds available. A *pro rata* approach could put pressure on plans to recoup losses from providers treating the high-cost cases.

Data Collection: **The AHA believes that states should be required to comply with current federal provider regulations when collecting encounter-level data and avoid deviating from standardization efforts to the maximum extent possible**. Accurate and reliable encounter-level data are critical to successful risk adjustment and, by definition, must be collected from providers by the plans for submission to the state and/or CMS. At the same time, the rules grant states wide latitude in deciding what data are collected, or reporting frequency. Yet, there is no consideration given regarding the impact on providers of collecting encounter-level data and the variety of applicable

federal provider requirements. The degree of latitude offered to states to modify data collection requirements flies in the face of other ACA provisions designed to reduce variations in data collection or handling, such as HIPPA transaction standards and operating rules, "meaningful use" requirements for electronic health records, recent changes to the uniform bill, movement to ICD-10 coding, or privacy standards. It is also important to consider the timing of any data collection requirements that deviate from those being implemented at the federal level. For example, requiring that encounter data be reported based on ICD-9 coding after implementation of ICD-10 coding would be extremely burdensome for providers.

Thank you for your consideration of our comments. If you have any questions, please feel free to contact me or Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President