



American Hospital
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November 3, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

RE: Request for Information: Health Plan Innovation Model Concepts

Dear Ms. Tavenner:

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) request for information (RFI) on initiatives to test: plan design; care delivery; beneficiary and provider incentives; and network design. The AHA's comments will focus on Sections III and IV of the RFI pertaining to Medicare Advantage and Medicare Advantage Prescription Drug Plans and Medicaid Managed Care, respectively.

SECTION III: MEDICARE ADVANTAGE AND MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

Transforming health care delivery for those with multiple chronic conditions is essential to achieving the Triple Aim of improving the patient experience of care, improving population health and reducing per-capita health care costs. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services and key drivers of health care costs. These individuals are more likely to visit the doctor, use the emergency department, be hospitalized, receive post-acute care services, and manage multiple medications. In response, hospitals and health systems are engaging in numerous initiatives to become more integrated with other providers across the care continuum, more accountable for the quality and cost of the services they provide and more financially at-risk in caring for their populations. **The AHA is supportive of testing innovations in care delivery for Medicare's chronically ill population as well as testing innovations in Medicare Advantage that leverage these capabilities to bring better health and better care coordination to Medicare Advantage enrollees.**



Other Model Opportunities

The AHA encourages CMS to test innovations that would allow hospitals and health care systems to move toward value-based population care at various risk levels, short of full risk. These approaches could borrow from existing Medicare models, such as medical homes, accountable care organizations, bundled payment and chronic care management. This concept for innovation would allow hospitals and health care systems to be the focal point of organizing the essential elements of coordinated care for the chronically ill populations. Many hospitals and health care systems have the capacity to organize care delivery but do not serve a sufficiently sized population to assume full insurance risk without appropriate protections, such as risk corridors or reinsurance. The opportunity for hospitals and health care systems to assume varying levels of risk would allow these providers in communities with smaller populations to participate in meaningful care coordination.

Value-Based Insurance Design (VBID)

The AHA recommends, with certain restrictions, that CMS test innovations that would allow VBID for beneficiaries in the Medicare Advantage program with chronic illnesses. Participating Medicare Advantage plans could reduce the copays and coinsurance amounts for services provided by a sub-network of integrated health care providers who would seamlessly transition care across settings. The AHA strongly encourages CMS to establish guidelines for minimum thresholds of care integration and quality, so that participating plans cannot simply drive patient care to the lowest cost providers, thus undermining the intent of the test. **Since point-of-service costs have the greatest impact on provider choice under VBID, the AHA recommends that CMS focus VBID on copay and coinsurance reductions, as well as lower deductibles, while maintaining affordable Medicare Advantage premium levels.**

Commercial insurance has successfully implemented reduced cost sharing for preferred integrated providers that coordinate care resulting in greater control of chronic illness and healthier behaviors. These successful approaches should be tested for the Medicare Advantage program. Since Medicare Advantage is a capitated program, VBID further aligns the incentives of payers, providers and beneficiaries to achieve the benefits of the Triple Aim. Many hospitals and health systems already have the care integration capability, and VBID would complement their care delivery strategies.

SECTION IV: MEDICAID MANAGED CARE

Medicaid managed care provides significant opportunities to improve care coordination for the populations served by the Medicaid program. An Oct. 23 Avalere report estimates that Medicaid managed care will increase from 67 percent of total Medicaid and Children's Health Insurance Program enrollees in 2013 to 76 percent in 2016. This rapid growth calls for a thorough review of the regulatory barriers that interfere with care coordination across settings, particularly for behavioral health. **The AHA strongly recommends that CMS test innovations in Medicaid managed care that remove barriers to care innovation and integration for behavioral health.**

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Behavioral Health

The AHA recommends that CMS test innovative models that prohibit the carve out of behavioral health services from Medicaid managed care benefits. States currently have the option to carve out certain services, particularly behavioral health services, from Medicaid managed care benefits. Such carve-out arrangements create barriers to the integration of behavioral health and physical health care and inhibit the sharing of information across care settings. The inability of behavioral health and medical care providers to share information and coordinate care can have a significant impact on millions of patients. For the Medicaid disabled population, half are diagnosed with a mental illness.

The AHA also recommends that CMS continue to test delivery innovations through the Medicaid Emergency Psychiatric Demonstration project which looks at whether eliminating or restricting the scope of the Institutions for Mental Disease (IMD) exclusion can improve access to care and help reduce costs. The IMD exclusion prohibits federal Medicaid reimbursement for inpatient care provided to individuals between the ages of 21 and 64 in IMDs, such as private free-standing psychiatric hospitals with more than 16 beds. In recent years, state funding challenges have led to the closure of many state-operated behavioral health facilities and the decline in the number of inpatient psychiatric beds thereby limiting access to care for many who suffer from behavioral health and substance abuse disorders.

Promoting innovations in health care delivery will allow our society to test new ideas that will push us closer to achieving the Triple Aim. The AHA supports the efforts of CMS to continue to pursue innovations in care delivery. Thank you for your consideration of our comments. If you have any questions, please contact Jeff Goldman, vice president for coverage policy, at (202) 626-4639 or jgoldman@aha.org; or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development