American Hospital Association

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Cynthia Mann, J.D.
Deputy Administrator
Centers for Medicare & Medicaid Services
Director
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail Stop: S2-26-12
Baltimore, MD 21244

RE: Center for Medicaid and CHIP Services Revisions to Medicaid Managed Care Regulations

Dear Ms. Mann:

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 provide you with our initial thoughts regarding revisions to the federal Medicaid managed care regulations.

Managed care provides significant opportunities to improve care coordination for the populations served by the Medicaid program. An Oct. 23 Avalere report estimated that the number of Medicaid and Children's Health Insurance Program (CHIP) enrollees in managed care will increase from 67 percent in 2013 to 76 percent in 2016. This rapid growth calls for a review of how Medicaid managed care functions in the changing health care delivery landscape.

Hospitals' involvement with Medicaid managed care ranges from participating in a health plan's provider network or providing out-of-network services, to establishing their own comprehensive risk-based plan. **The AHA urges review and revision of the Medicaid managed care regulations in five areas:**

1) **transparency in the establishment of capitation rates;**
2) **adequacy of provider networks and out-of-network provider services;**
3) **greater consistency in quality measures;**
4) **elimination of potential barriers to coordination across settings, particularly for behavioral health; and**
5) **examination of the direct pay prohibition and the implications for Medicaid supplemental payments.**

TRANSPARENCY IN CAPITATION RATES AND ADEQUACY OF PROVIDER PAYMENTS

Actuarially Sound Capitation Rates for Managed Care Organizations (MCOs)

The AHA recommends that the Centers for Medicare & Medicaid Services (CMS) require greater transparency in how states set MCO capitation rates. Transparency means public disclosure of the assumptions and supporting analysis used in establishing MCO capitation rates. CMS also should require that states evaluate how their capitation rates affect provider access and provider network development.

States use a variety of rate-setting methods and adjustments. Some states risk-adjust their capitation rates to account for a sicker enrollee population; other states use risk corridors and stop-loss strategies to help plans manage unexpected enrollee care costs. The Government Accountability Office and key Members of Congress have raised concerns publicly about the lack of transparency in state capitation rate-setting methods. The Members of Congress further expressed concern about whether states are monitoring MCOs to ensure they are reimbursing providers appropriately for services so that enrollees have access to care.

Adequacy of MCO Payment to Providers

The AHA recommends that CMS require states to take additional steps to ensure that MCOs' payment rates to providers are adequate. One such measure could be the requirement that MCOs, like health plans offered in the new Health Insurance Marketplace, meet a minimum medical loss ratio (MLR). CMS also should require states to establish an oversight process that allows providers to raise concerns regarding MCO practices.

The use of a minimum MLR is a possible payment safeguard. The MLR measures how well an MCO is using its capitated payment to pay for clinical services and quality improvement versus MCO plan administrative costs. Medicare Advantage plans and health insurers selling qualified health plans in the new Health Insurance Marketplace are required to meet a minimum MLR. Most state regulators also set a minimum MLR for commercial health plans sold in their states. The Medicaid program, however, does not require MCOs to meet a MLR, but according to the Kaiser Family Foundation's recent survey of state Medicaid programs, 27 programs specify a minimum MLR for their MCOs.[i] The adoption of a minimum MLR would further align the Medicaid managed care program with broader insurance marketplace reforms.

PROVIDER NETWORK ADEQUACY AND OUT-OF-NETWORK PROVIDER SERVICES

The AHA believes it is important to ensure that MCO enrollees have access to a selection of high-quality providers in or near their communities, and that they benefit from care coordination and integrated care systems. Integrated care systems, by their nature, offer narrower networks of providers. However, those providers are highly integrated, coordinate

multiple aspects of care delivery in a defined geographic area and use a common electronic health record.

The issue of provider network adequacy is being raised in many contexts, such as the implementation of the qualified health plans that are sold in the new Health Insurance Marketplace and the Medicare Advantage program. The National Association of Insurance Commissioners (NAIC) also is actively reviewing its Model Act on network adequacy to better align its legislative and regulatory recommendations with the Affordable Care Act (ACA) and the changes in the broader health insurance marketplace.

The AHA recommends that CMS consider the following emerging models regarding provider network standards:

1) **the essential community provider standards for Qualified Health Plans participating in the Federally-Facilitated Marketplace;**
2) **the time and distance standards for the Medicare Advantage Program; and**
3) **the NAIC's upcoming revisions to its state Model Act for provider network adequacy.**

Federal Medicaid regulations require that managed care enrollees have access to all services covered under their state Medicaid plan. MCOs must document that they offer a range of primary, preventive and specialty services and maintain a provider network sufficient in number, type and geographic distribution. While federal Medicaid regulations set minimum standards for provider networks, states and MCOs are allowed discretion in defining how MCO plans ensure networks are adequate. State oversight and monitoring of provider networks varies significantly. A 2012 report by the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Service noted that the requirements of provider networks vary across states, as does the enforcement of standards by states and health plans.[ii]

Federal rules require that MCOs cover out-of-network services if such services are not available in-network. Some of our hospital members serving specialty populations, such as children, have raised concerns that health plans are not including them in their provider networks but, at the same time, referring MCO enrollees to their facilities and paying the hospitals out-of-network rates. **The AHA recommends that CMS require MCOs to clearly articulate their out-of-network provider policies and cost-sharing policies for their enrollees (if appropriate).**

QUALITY MEASUREMENT

Federal Medicaid managed care regulations require states to meet standards for monitoring the quality of care provided through MCOs. States have a fair amount of leeway in establishing their quality criteria, but most managed care quality programs include:

- the use of external quality review organizations;

- data collection through the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- accreditation; and
- pay-for-performance.

States can choose the accrediting body, but most states use the National Committee for Quality Assurance and URAC (formerly known as the Utilization Review Accreditation Commission).

Our hospital members, however, have raised several issues with regard to quality measurement and reporting that deserve attention, such as:

- lack of consistent quality measurement;
- providers' burden of submitting encounter-level data to plans; and
- lack of transparency around pay-for-performance metrics.

The AHA supports the work of the National Quality Strategy (NQS) led by the Agency for Healthcare Research and Quality to align quality reporting and payment across care settings and programs. The AHA urges CMS to assess how the work of the NQS applies to the Medicaid managed care program. The alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and unnecessary duplication of effort among providers and help balance the allocation of limited resources between data collection and actual efforts to improve performance. The success of the NQS is contingent on the alignment of the various payment and public reporting programs using a consistent set of principles.

CARE COORDINATION AND BEHAVIORAL HEALTH

The AHA makes the following recommendations with regard to Medicaid managed care and behavioral health.

The AHA recommends that CMS eliminate the state option that allows behavioral health services to be carved out of Medicaid managed care benefits. Most states carve out behavioral health from managed care[iii]. Among the Medicaid disabled population, half are diagnosed with a mental illness, and care is not coordinated. Carve-out arrangements create barriers to the integration of behavioral and physical health care and inhibit the sharing of information across care settings.

The AHA urges CMS to continue to examine, through the Medicaid Emergency Psychiatric Demonstration project, 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.

The AHA recommends that CMS provide further guidance on how the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to MCOs. The MHPAEA requires group health plans that offer mental health or substance use disorder benefits to provide them at parity with their medical/surgical benefits – removing barriers to care and limitations on coverage affecting many patients. The ACA applied MHPAEA to the managed care-based Alternative Benefit Plans available under Medicaid expansion. The final rule for the implementation of the MHPAEA, however, did not provide guidance on how the parity law applies to Medicaid managed care.

DIRECT PAY PROHIBITION AND IMPLICATIONS FOR SUPPLEMENTAL PAYMENTS

The AHA recommends that CMS engage hospitals, as key stakeholders, in looking for ways to preserve critical supplemental payment programs, such as Medicaid Upper Payment Limits (UPL), as the program looks to transition to greater integrated health care delivery. Currently, states can make Medicaid supplemental payments to hospitals through the state's UPL program, which is fee-for-service (FFS) based. As more of the Medicaid population moves into managed care, the level of supplemental payments will decline. These UPL payments provide financial support for safety-net hospitals and help supplement Medicaid provider reimbursement that, in the aggregate, pays hospitals only 89 cents on average for every dollar spent treating Medicaid patients. Under current federal Medicaid regulations, states are prohibited from making supplemental payments *directly to hospitals* as Medicaid beneficiaries' services move away from the FFS setting to the managed care setting. This federal "direct pay prohibition" limits a state's ability to continue these important supplemental payments to hospitals as states turn to managed care payment arrangements.

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

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[i] Smith, V; Gifford, K; and Ellis, E. (October 2014) Medicaid in an Era if Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015, Kaiser Family Foundation

[ii] Howell, E; Palmer, A; and Adams, F. (July 2012) Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services Medicaid and CHIP Risk-Based Managed Care in 20 States Experiences over the Past Decade and Lessons for the Future, The Urban Institute, Washington, DC.

[iii] Bachrach, D; Anthony, S; and Detty, A. (August 2014) State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment, The Commonwealth Fund, New York, New York.