July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 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 (Federal Register Vol. 80, No. 104, June 1, 2015).

Dear Mr. Slavitt:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA), thank you for the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed Medicaid managed care rule revising the current managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP). AzHHA is a statewide association of hospitals, healthcare systems, and other healthcare organizations across Arizona. As you know, Arizona has a mature statewide Medicaid managed care system that has operated successfully under a Section 1115 waiver since 1983. Our members are active participants in Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). Our comments reflect input we have received directly from our membership and from our national affiliate, the American Hospital Association (AHA).

AzHHA generally agrees with the approach of the proposed rule. However, we believe that some sections would benefit from clarification, modification or revision before the final rule is adopted. We support alignment of the Medicaid, Medicare Advantage (MA), and private insurance processes to the extent that those changes provide realistic opportunities to enhance the quality and efficiency of services and improve the experience of beneficiaries and providers. It is equally important not to lose sight of the many differences between Medicaid and the other programs. These differences include the federal-state partnership nature of the program, the constraints of state budgets and budget cycles, and differences in eligibility procedures, enrollment cycles, and beneficiaries.

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

The proposed rule clarifies the concept of "actuarial soundness" and improves transparency and consistency in the development of actuarially sound capitation rates for Medicaid managed care plans by incorporating the practice standards of the American Academy of Actuaries. Under the proposed rule, capitation rates must be appropriate for the covered population and services, sufficient for the plan to meet the network adequacy and access standards, and adequate for the plan to meet the Medical Loss Ratio (MLR) requirements. Incentives and withholds tied to performance can be counted toward actuarial soundness only if it is reasonable to assume the performance goal can be attained. The proposed rule also includes detailed documentation requirements for the state capitation rate-setting process, including identification of trend factors and adjustments. **AzHHA supports these proposed changes, which will require states to meet greater transparency standards for the development of actuarially sound Medicaid capitation rates.** We believe the proposal as it relates to incentives and withholds (and the reasonableness of goals) will become increasingly important as states continue to incorporate value-based purchasing into their Medicaid programs.

CMS also proposes to increase its oversight of state capitation rate setting by establishing a new agency-level rate certification process. The proposal will require states to submit detailed documentation supporting the capitation rates for each managed care plan to CMS. This documentation and the managed care contracts must be provided to CMS no later than 90 days before the effective date of the managed care contract. **AzHHA supports this increased oversight; however, CMS should ensure that this process is realistic and does not impede timely implementation of rates.** In Arizona, and likely in most other states, the state budget year and managed care contract year are "hard" deadlines. It is essential to program continuity that rates be approved and implemented on a timely basis. Failure to meet state deadlines could inject considerable uncertainty into state Medicaid programs and adversely affect the availability of services to beneficiaries. We urge the agency to carefully consider its own resources to confirm that it can provide timely and thorough review of the managed care contracts and certification of rates within the 90-day timeframe it has proposed in the rule.

CMS has specifically asked for comments on how to incorporate concerns regarding plan provider payment rates and the sufficiency of the rates to maintain an adequate network into its rate certification process. The agency also requested comments on the methods, measures, and data sources that states and actuaries should use to assess whether capitation rates are adequate to support the provider reimbursement levels necessary to meet network adequacy and timely access standards. AzHHA appreciates CMS seeking comments on these important issues and welcomes the opportunity to provide input.

There is no question that Arizona's state budgetary pressures over the past several years have factored heavily into how capitation payments to health plans have been calculated. Cuts and freezes to fee-for-service provider rates have been incorporated into the capitation rates as they occur. Because contracts between hospitals and health plans in Arizona are typically based on the fee-for-service rates, health plan payments to hospitals have reflected all rate reductions. The cumulative impact of the reduction on hospitals between 2008 and 2015 is **$911 million**—a **38 percent** payment reduction.

While "actuarial soundness" is easier to define in theory than to evaluate in practice, it is hard to see a 38% reduction over 7 years as reasonable, appropriate or "sound." It is, frankly, simply a matter of politics and the state budgeting process.

But these processes have real life consequences. Eight Arizona hospitals filed for bankruptcy between 2013 and 2014 and 11 more have merged or entered into affiliation agreements with another system due to financial strain. Approximately one-quarter of Arizona hospitals reported a negative operating margin in 2014. As financial pressures build on hospitals and other providers, beneficiary access to comprehensive care is at greater risk. While it is true that hospitals do not leave communities or close as easily as some other provider types, the mere presence of a hospital in a community does not necessarily indicate there is good access to care. Several hospitals and other providers have reported that they were considering either eliminating services or no longer contracting with Medicaid managed care plans in response to recently proposed rate cuts by the State Legislature.

We recognize that CMS has limited leverage over state budget processes. But at a minimum it can improve the transparency around capitation rates and the rate setting process so that the impacts of rates can be fully evaluated by advocates, providers and the public generally. Specifically, greater transparency on how capitation rates impact rates paid to Medicaid providers and resulting beneficiary access to care is imperative. **AzHHA recommends that CMS require each state to contract with an independent third party to study and report on how capitation rates and subsequent health plan reimbursements to providers affect patient access to care and provider network development. These studies and reports should be done on a periodic basis at least once every three years.** These reports should be based on a broad definition of "access" and include an evaluation of the inpatient and outpatient Medicaid payments compared to full costs ratios for each hospital type in each county (critical access hospitals, short term hospitals, children's hospitals, long term care hospitals, rehabilitation hospitals, and psychiatric hospitals). CMS should require states to update this "Access to Care" report when significant changes to provider rates are planned or implemented, as applicable. The states also should be required to validate the data in the reports with the affected providers before the reports are finalized, and the reports should be made publicly available on a timely basis.

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

Existing federal regulations allow states some flexibility to experiment with risk sharing and incentive-based payment arrangements with Medicaid health plans through special contracting provisions. The proposed regulations build upon this framework to encourage state-health plan partnerships to achieve delivery system and payment reform and performance improvement. **AzHHA supports CMS's intentions in this area, but has some specific concerns with the proposed regulations.**

The general rule prohibits states from directing health plan expenditures to providers. The proposed rule has specific "special contracting provisions" as exceptions to the general rule that would allow states to require health plans to:

1. Implement value-based purchasing models,
2. Participate in a multi-payer delivery system reform or performance improvement initiative, and
3. Adopt a minimum provider fee schedule or raise provider rates in an effort to enhance access to quality services.

From a process perspective, states that pursue these delivery system payment arrangements through contracts with managed care plans must:

1. Make participation in the initiative available to all public and private providers under the contract using the same terms of performance,
2. Use a common set of performance measures across all payers and providers,
3. Not set the amount or frequency of the expenditures, and
4. Not require recoupment of any unspent funds allocated for these arrangements.

CMS has asked for comments on whether these three special contracting provisions are sufficient to support its efforts to improve population health at lower cost while allowing plans to fully utilize the payments it receives for high value delivery of care. We believe the exceptions will generally help achieve the triple aim of better care, better health and lower cost. We offer the following comments regarding the implementation of the exceptions.

We generally support the requirement that performance improvement initiatives under § 438.6(c)(1)(i) and (ii) be made available to all contracted providers providing the service related to the reform or improvement initiative. This includes making the initiative available all providers within the geographic area served by the health plan. Plans should not be allowed to "cherry pick" providers, which could exacerbate healthcare disparities between rural and urban areas or within pockets serving safety net communities.

If a state requires contracted health plans to participate in a performance improvement initiative, health plans should be required to document, and the state should be required to verify, their efforts to include all qualified providers. **Conversely, the rules should clarify that contracted providers cannot be required to participate in a performance improvement initiative as a condition of contracting with the health plan.** Not all providers will be equally positioned to accept the terms of a risk-based contract, and states and plans should not be permitted to exclude them for not participating in these contract arrangements. Similarly, health plans should not be permitted to simply pass on the risk resulting from a state withhold arrangement. Withhold arrangements imposed at the provider level should be based on quality and value criteria clearly within the provider control.

It is important to note that as states experiment further with Medicaid delivery system and payment reforms, they will seek greater flexibility to design payment arrangements that incentivize quality care and a movement toward population

health. Such arrangements, for example, may include contracting with accountable care organizations or creating supplemental payment programs for delivery system reform or quality improvement. **States must have the flexibility to design these programs and pay providers differently if they meet desired performance or other metrics. As noted above, AzHHA supports an approach that makes performance improvement initiatives available to all providers. Eligibility to receive incentive payments (or accept downside risk) should be based on whether the provider is willing to and does meet specified metrics.** The added flexibility also would allow for future payment innovations not yet envisioned by CMS or the states.

Under proposed § 438.6(c)(2)(ii)(D), a state is prohibited from recouping any unspent funds allocated for these special contracting arrangements. The preamble states that this approach "ensures that any additional payment is associated with a value relative to innovation and statewide reform goals." We support this intent. It is particularly important for providers that they not be exposed directly or indirectly to state recoupment because the state match for many new performance improvement initiatives originates with provider assessments or healthcare district taxes. **The final rule should make it clear that while the state may not recoup any unspent funds from the plans, it can direct them to be held and used for future performance improvement initiatives or subsequent year payments based on state assessment of plan or provider performance under the initiative.**

Finally, AzHHA urges CMS to require more transparency around performance improvement initiatives that are part of state contracts with health plans. Metrics should be clearly defined and broadly disseminated to affected providers, and there should be a common set of performance measures across all payers and providers so that CMS can evaluate the degree to which multi-payer efforts achieve the collaborative goals of improved health and lower cost. To achieve full transparency and public accountability, health plans should report on performance metrics including the providers that are participating in the initiatives, the incentives that are paid or penalties that are withheld, and outcomes, and this information should be publicly available on a timely basis.

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

The proposed rule seeks to align network adequacy standards for Medicaid and CHIP with network standards for qualified health plans (QHPs) sold in Marketplaces and MA plans. States are required to develop time and distance standards for the following provider types: 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. **AzHHA supports CMS's proposal to require states to set minimum provider network adequacy standards for their Medicaid/CHIP managed care programs. And while we understand the intent to align standards with QHPs and MA, it is most important that the standards be workable on a local level and for the relevant population.**

CMS asked for comments on whether the agency should set (1) specific time/distance standards, (2) provider-to-enrollee ratios by provider type, or (3) ratios on a per county or other geographic basis. While there are benefits and drawbacks to each methodology, we are not convinced that a national standard will be beneficial. Standards that seem achievable (or optimal) in one geographic area or for certain provider types may not be possible (or sufficient) elsewhere. For example, current QHP network standards are based on access to essential community providers at the county level. While this may be an acceptable approach in states with small counties that are easily traversed, it is impractical in a state like Arizona, which has very large counties and geographic barriers affecting travel time. The AHCCCS Administration has developed minimum network requirements that take into account the state's geography and reflect the state's actual rural and urban geography. All states should have the flexibility to design standards that are suitable for the state.

While we are less hesitant about national time and/or distance standards than national ratios, these also may be problematic. Time/distance standards may make sense for access to ambulatory care, but are not necessarily appropriate to describe access to institutional providers, especially in a large rural area where only one hospital may serve the entire county. Moreover, patients with complex or chronic medical conditions may need more immediate and frequent access to care than is accommodated by a uniform time/distance standard. Finally, without the availability of or access to adequate transportation, it may not matter if the distance to a contracted provider is 10 miles or 30 miles. For example, there are large areas in many western states where the transportation "problem" cannot be effectively improved by imposing a standard, because there is simply no transportation readily available to anyone. Again, **AzHHA recommends that CMS allow states flexibility to establish their own minimum provider network adequacy standards. Access to care can be monitored through comparative metrics such as wait times and incorporated into the periodic "Access to Care" report we have recommended in our comments on capitation rate setting.**

CMS also asked for comments on whether there should be separate provider network adequacy standards for pediatric and adult behavioral health services. **AzHHA strongly supports establishing standards that distinguish between pediatric and adult behavioral health providers.** The behavioral health needs of adults and children are significantly different. Provider networks should be evaluated based on the needs of each of these populations.

QUALITY IMPROVEMENT AND MEASUREMENT (SEC. 438.310 AND 438.370)

The 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 states quality strategy and framework must include the state's 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 a core set of performance measures and define 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.

AzHHA strongly supports CMS incorporating the requirements of a quality strategy into the proposed rulemaking. However, as the AHA stated in its comments, the approach taken in the proposed rule has significant drawbacks. **We agree with the AHA that requiring that each state to develop *its own quality strategy, its own standards of service, and its own list of measures* "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."**

AzHHA supports the AHA recommendation that CMS direct Medicaid programs to review and adopt the set of 15 improvement areas identified in Institute of Medicine's (IOM) report that represent the core metrics to better health, ranging from life expectancy to care access. We agree that CMS should require states to select the measures appropriate for assessing the contributions that Medicaid health plans can make toward achieving better performance in each of the relevant IOM improvement areas. While it may be necessary for states to augment these improvement areas with others that are of particular concern for their citizens, **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 quality measurement and greater opportunities for collaboration to improve outcomes.**

Finally, AzHHA agrees that public transparency on quality performance is vitally important. **We support CMS's proposal to have states provide plan quality information which should help beneficiaries trying to identify the appropriate plan for themselves and their family members. However, as noted by the AHA, 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, including financial support.**

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

The proposed rule allows states to pay capitation payments to managed care plans for enrollees aged 21-64 receiving short term inpatient treatment in an IMD "in lieu of" other services covered in the state plan for up to 15 days. A**zHHA supports this expansion. However, we agree with the AHA that that CMS should seriously consider increasing this limit.**

Specifically, AzHHA recommends that CMS give states the option to increase the available days based on an assessment of the availability and accessibility of appropriate alternate equivalent services. The proportion of Medicaid and low income individuals with behavioral health issues is substantial. As the AHA points out, 13.6% of uninsured adults aged 18-64 have a substance abuse disorder; according to a July 20, 2015 GAO report, this proportion rises to 17% for when all behavioral health disorders are considered. For first-time substance abuse treatment, inpatient stays of 21-30 days are common. Moreover, adult behavioral

health services and providers are frequently in the shortest supply, particularly in sparsely populated rural areas. States should have the flexibility to ensure that behavioral health services are available to the Medicaid populations in the manner best suited to the available resources, within the statutory limitations.

BENFICARY PROTECTIONS: ENROLLMENT, AUTHORIZATIONS, APPEALS AND GRIEVANCES, AND CARE COORDINATION (Sec. 438.54, 438.208, 438.210, 438.228).

AzHHA agrees with the comments made by the AHA. We have the following additional comments:

Enrollment: We agree with CMS that beneficiaries are best served when they are provided the time and information to make an informed choice of managed care plan. However, AzHHA believes that the proposed rule does not give states that have significant experience in managed care enrollment enough flexibility to achieve (or demonstrate that they have already achieved) CMS' desired goal within the existing infrastructure. The proposed rule therefore could inject needless cost into the system for no great benefit.

Specifically, CMS has proposed that that each state must provide 14 calendar days of FFS (*e.g.* paid by the state agency) coverage before any "default" (passive) enrollment occurs. This approach has several downsides. First and most obviously, if the state agency is not currently paying claims upon initial enrollment, the agency must alter its claim system to do so. More importantly, for beneficiaries with serious illnesses or chronic conditions, the 14-day lag delays their entry into the managed care system; this is not conducive to the care and quality goals of these very regulations. Finally, for providers serving hospitalized or ill patients, care coordination and billing will be made more complex and more costly.

AzHHA believes these adverse effects can be eliminated and CMS's goals met by giving the states the flexibility to continue with "first day" enrollment if they require managed care plans to process claims in the same manner (and without regard to network requirements) as would the state as a FFS payer. With this flexibility, the goals of the proposed regulation could be met while minimizing additional costs and maximizing care availability.

Authorizations: The proposed rule clarifies and expands the standards for service authorizations, including reductions in services. **AzHHA supports these changes.** Not only do these changes provide greater protections for beneficiaries, they provide the beneficiaries with important information about their health care needs that will assist in their discussions with treating providers about treatment plans and alternatives. **However, AzHHA recommends further clarification. Although "reductions in service" fit within the definition of an adverse benefit determination under § 438.400, they are not expressly actions requiring the plan to notify the beneficiary under § 438.210.** Hospitals regularly experience Medicaid managed care plans ending authorizations in the middle of the stay, with no legal obligation to directly notify their member. There are similar occurrences with long courses of outpatient treatment. Plans should be required to directly notify members of these important changes to coverage in a timely manner, so that the beneficiary can take appropriate action.

Grievance and Appeals: The proposed rule makes various changes to the "grievance system". **AzHHA generally supports these changes**. We agree that providers should be allowed to file appeals and requests for state fair hearing when acting on behalf of beneficiaries without the requirement for a written consent. We are concerned, however, that the 120 day time period to request a state fair hearing in § 438.408(f) is excessively long, and inconsistent with most administrative appeal processes. CMS's comments explain that the lengthy time was selected to give the enrollee time to prepare their case or find assistance. However, we frequently find that the beneficiaries do not seek assistance until *after* a notice of hearing is issued and they are confronted with an actual hearing date. Moreover, it may be administratively difficult or costly for states, hearing agencies, or managed care plans to have cases pending with in such procedural "limbo" for so long. We believe the concerns of CMS and our concerns can be effectively resolved **by allowing states to establish a shorter time frame for the filing of a RSFH (30-60 days), but requiring that the hearing be noticed no sooner than 60 to 90 days before the scheduled hearing date.**

PROGRAM INTEGRITY (SEC. 438.608)

The AHA recommendation that states be required to give clear and consistent guidance to managed care plans on the methods they use to verify the delivery of services by providers. **AzHHA strongly supports that recommendation and further recommends that the states be required to (1) issue guidance related to all program integrity activities undertaken by plans, (2) require the plans to demonstrate the validity and accuracy of any planned program integrity project based on sampling or data mining to the state agency before it is implemented, and (3) coordinate program integrity activities by the plans on issues likely to be common.** AzHHA members have unfortunately experienced Medicaid managed care plans unilaterally starting a "Fraud & abuse project" based on faulty understanding of federal or state law and policies, or poor-to-nonexistent internal validation of "mined" information. Misguided or duplicative efforts by managed care plans create, and don't prevent, unnecessary cost and inefficiency in the system. It should be the obligation of the state Medicaid agency to ensure this does not happen.

Thank you for the opportunity to comment on the proposed Medicaid managed care rule. If you have any questions, please do not hesitate to contact me.

Sincerely,

Greg Vigdor
President and CEO