ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

April 22, 2011

Ms. Cindy Mann, Director
Center for Medicaid, CHIP, Survey and Certification
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Mann:

I am writing on behalf of the Association for Community Affiliated Plans (ACAP) regarding Section 1202 of the Patient Protection and Affordable Care Act (ACA). ACAP represents 54 non-profit, safety net health plans in 26 states serving over 8 million individuals. ACAP and its members are committed to the goal of ensuring access to high-quality health care in a timely manner.

ACAP and its member plans believe that the temporary increase in reimbursement for certain primary care services will help to attract and retain primary care providers to the Medicaid program and to health plan networks in several states. We are committed to working with you to ensure the provisions are implemented in an efficient and effective manner within states' Medicaid managed care programs.

Our comments focus on the following three themes that we respectfully ask you to consider as you draft guidance:

- Provide direction to states and incorporate oversight mechanisms in actuarial soundness policies to ensure plan rates are appropriately adjusted to reflect the Section 1202 requirements.
- Ensure that Section 1202 does not impede development of initiatives to drive care coordination and quality improvement, including the delivery system and payment models included in the ACA.
- Minimize and streamline reporting and related administrative requirements for Medicaid managed care plans.

Key considerations for Medicaid managed care plan

1. ACAP urges CMS to incorporate policies and procedures to ensure the actuarial soundness of Medicaid health plan rates.

The statutory rulemaking and/or the actuarial soundness "Checklist" used by CMS staff to review states' proposed rates, should explicitly state that the rate setting methodology reflects the mandatory change in reimbursement rates and associated administrative costs. Further, the state methodology for making this change to the rates should be transparent to the participating health plans.

Transparency is essential to this process for a number of reasons. First, transparency will help ensure a comprehensive dialogue between plans and states about accuracy of the specific assumptions and

the scope of the assumptions to be applied. Further, while transparency is necessary to facilitate accurate, fair rate setting process for 2013 and 2014, this information also will be vital for determining the 2015 baseline and informing the development of plans' rates in 2015 and beyond.

In addition, we respectfully request that CMS' oversight and enforcement of actuarial soundness policies ensure that rate adjustment increases to plans to comply with Section 1202 do not result in an inappropriate decrease in other factors used in the rate setting methodology. Plans must have access to all of the information that is used to make the adjustment for this provision.

2. ***ACAP supports allowing states to implement the increase in the capitation rate to health plans at the aggregate actuarial level, unless they already establish rates at the individual plan level.***

In many states' rate setting process for Medicaid managed care plans, actuaries make a number of assumptions and adjustments that reflect factors such as provider rates and utilization levels. Based on those assumptions, actuaries calculate a plan's capitation rate. The assumptions and contractual requirements for plans may include requirements to "pass-through" higher reimbursement rates to certain types of providers or for specific services. These rates can be determined on a program/aggregate level (for example, plans would be paid a uniform capitation rate or receive a uniform increase) or alternatively states may determine rates on a plan-by-plan basis.

ACAP believes that states and plans should have flexibility in determining whether to apply the increase in the capitation rate at the aggregate actuarial level or the individual plan level. States vary in the type of rate setting methodologies used while plans vary in the rates paid to providers and specific proportion of providers who will be eligible for the rate increase. Specifically, ACAP is supportive of allowing this process to occur on an aggregate basis rather than requiring states to calculate increases for individual plans if this approach aligns with its overall rate setting approach.

Transparency is essential to this process given the number and scope of assumptions that will be applied to adjust plan rates to reflect Section 1202. Medicaid health plans must have access to the information that is being used to build the capitation rate otherwise they cannot have a reasonable discussion with the state about the rates.

3. Any requirement to <u>newly</u> cover specific primary care codes identified by Section 1202 should be accompanied by a corresponding adjustment in a plan's rates.

The statutory language identifies services by CPT code that Medicaid must reimburse at 100 percent of the Medicare rate. However, all of these codes are not necessarily included in a plan's contract with the state. ACAP asks that CMS clarify in its guidance to states that Section 1202 is *not* a de facto requirement that Medicaid managed care plans must cover these services. If a state does wish to amend the contract with plans, CMS guidance should direct states to make appropriate adjustment to the plan's rates in a timely and transparent fashion.

4. Capitation rates to plans must be adjusted to reflect the distribution of FQHCs.

As you know, in some states, a plan's payment to primary care providers delivering services in FQHCs are tied to the non-FQHC provider rates. However, Section 1202 does not apply to FQHCs

and it is unclear whether states will retain or delink these rates. Therefore, consistent with actuarial soundness requirements, ACAP respectfully requests that CMS clarify in its guidance that if a state requires Medicaid plans to increase payments to primary care providers practicing in FQHCs, the state should make a corresponding adjustment in the plan's capitation rate in a transparent and timely fashion.

5. CMS guidance should facilitate collaborative models of care.

ACAP and its members strongly support the various care coordination and quality improvement provisions promoted in the ACA, such as the health homes, accountable care organizations, and bundled payment initiatives. We are eager to partner with states, providers and patients to develop and implement these as well as patient-centered medical homes and other care coordination, delivery system and payment models.

We also note that many of these initiatives would pilot new incentive-based reimbursement structures, thereby potentially complicating implementation of Section 1202. Specifically, we are concerned that Section 1202 provisions have the potential to contradict such efforts which would not be based on a traditional fee-schedule or incentive or outcomes-based reimbursement schedule.

In fact, safety net health plans already employ a range of payment methodologies. For example, some sub-capitate network primary care providers while others reimburse network providers on a fee-for-service basis. Plans employ incentive-based payment strategies that seek to improve the quality and coordination of care. In some situations, plans have found it effective to use "withhold" strategies and many offer bonuses for providers that meet quality-related goals. Plans should be permitted to continue these strategies provided they ultimately do not reimburse providers below the specified mandatory levels.

It is critical for federal and state officials to engage in further dialogue about how to comply with Section 1202 so as not to impede progress on collaborative models of care and care models that may not based on straightforward CPT code utilization. By necessity, these may incorporate new or different reimbursement methodologies. ACAP and our safety net health plan members advocate that plans be allowed to demonstrate that they are using a reliable methodology for ensuring that the payment methodology reflects the higher payment rates.

6. Attestation by safety net health plans should be sufficient documentation for compliance with Section 1202.

CMS and states should assume that plans are passing the mandatory increase along to the subset of eligible primary care providers for appropriate services. Contractual language, addendums, manuals, or other regular operating agreements between the state and plan could be amended to reflect the new federal requirement and agreement of compliance per the provisions in Section 1202 and implementing federal regulations. Therefore ACAP recommends that attestation by health plans be sufficient proof of compliance.

ACAP and our member plans would welcome further discussion on the specific documentation and format for such attestation. States would still retain their existing right to review and audit a plans' claims consistent with program integrity and fraud, waste and abuse policies.

7. Federal guidance should protect the confidentiality of Medicaid health plan rates.

Currently some states require disclosure of plans' payment rates to providers. This practice is becoming more common as states establish data warehouses which may house claims, clinical, and other Medicaid and health care-related information. If rates are submitted directly to the state or to a central data warehouse, it is essential that plans' reimbursement methodologies and rates remain privileged information between the state and the plan.

Thank you for your consideration of the recommendations from safety net health plans. Please do not hesitate to contact me if we can be of further assistance to you.

Sincerely,

Margaret A. Murray
Chief Executive Officer