ACAP
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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

January 8, 2016

The Honorable Orrin G. Hatch
Chairman

The Honorable Ron Wyden
Ranking Member

Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Hatch and Ranking Member Wyden,

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to respond to your letter of November 13, 2015 regarding Medicaid reporting and data requirements.

ACAP is an association of 60 nonprofit and community-based Safety Net Health Plans. Our member plans, located in 24 states, provide coverage to more than 15 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans (QHPs). ACAP plans currently serve approximately one-third of Medicaid and CHIP enrollees who receive coverage through risk-based managed care, including approximately one-third of all enrollees in the Medicaid-Medicare demonstrations. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon the Medicaid and CHIP programs.

ACAP and our member health plans recognize the importance of data in continuing to improve our nation's health care system. Among other activities, ACAP supports the use of data and data transparency to improve quality and quality measurement, to increase access to care through telemedicine and other technologies, to allow a focus on population health, to develop value-based payment mechanisms, to ensure accountability, to reduce fraud, waste and abuse, and to measure churn in and out of the Medicaid program by still-eligible enrollees, a problem plaguing every state.

ACAP also realizes, however, that there are barriers to reliable data reporting and potential reforms that could improve the use of data by Medicaid programs, as well as by all health plans, including Safety Net Health Plans. This letter will focus on those issues and potential solutions.

Our responses to your questions follow.

1. *What data sources are lacking or should be employed more effectively, updated, or better coordinated to facilitate state operations, administrative functions, and inform state and federal decision-making? Are there specific reporting requirements in the Medicaid program that are duplicative, overlapping, or outdated that could be streamlined? If so, please be specific about which reporting requirements are duplicative, overlapping, or outdated, or could otherwise be streamlined?*

Alignment and Avoiding Duplication

ACAP has long been supportive of efforts to align and streamline data requirements for health plans within and across programs. We feel strongly that any data submission requirement should be achievable and meaningful.

As has been widely acknowledged, Medicaid health plans currently submit numerous reports in accordance with their state contracts, and also often report the same information to multiple sources for a variety of purposes. This summer the Centers for Medicare and Medicaid Services (CMS) issued an omnibus Medicaid managed care proposed regulation. In our review, we found the propensity for extensive overlap for plans undergoing various reviews, including, for example, accreditation surveys, annual program assessments, and existing External Quality Review requirements. In our response to CMS, we pressed the agency to take regulatory action to clearly and definitely eliminate and or otherwise reduce excessive overlap that is inherent to any new quality assurance requirements, and urged CMS to make public in the final rule a "map" of each requirement for each quality and program monitoring activity to ensure that plans are only required to be reviewed once for the same requirement or activity. We reiterate those thoughts in this letter.

- **Encounter Data.** ACAP and our member health plans recognize and support efforts to improve encounter data submissions. However, we see numerous challenges to ensuring that appropriate and accurate encounter data is available. To understand the current issues with the submission of encounter data, one may start at the very beginning, from inception of encounter data to acceptance into the federal MSIS system.

  The first issue involves the submission of encounter data from a provider to a Medicaid managed care plan. While contractually required to submit the data, providers who are paid on a capitated basis have no financial incentive on a day-to-day basis to submit data or to correct data that is rejected or denied due to a variety of issues. This has actually caused some plans to move away from capitation payments to FFS payments for their network providers. The movement to value-based payment (for example, bundled payments) that pays lump sums for a group of services, but is dependent on receiving comprehensive data, will continue to highlight this dilemma.

  Also, states and the federal government are moving to require the assignment of individual pricing values for each service rendered during an encounter. This is not appropriate when actual payments to providers are based on a capitation rate that, for an individual service to an individual member, may not reconcile.

It is important to note that, to the extent that capitation rates are risk adjusted, health plans are clearly incentivized to gather the most accurate and complete information available. To that end, efforts to improve encounter data submissions should be addressed as an effort to assist all stakeholders in the system to gather and report accurate data.

- **Deeming and Avoiding Duplication.** One specific item we proposed was a mandate in the final rule that plans that have been reviewed by Medicare or accredited by an approved entity should not be required to undergo External Quality Review for the mandatory and optional activities outlined in the regulation. Allowing Medicaid plans that have already undergone substantial review for other official purposes to avoid further review will promote the efficient use of resources and avoid overlapping requirements.

  The proposed rule also states that CMS, through a public notice and comment period in consultation with states and other stakeholders, may specify performance measures for collection. As we state later in this letter, ACAP is supportive of the development of standards measures that apply across all Medicaid delivery systems.

  However, to promote a quality improvement focus, we are also concerned about the need to ensure the alignment of measures and the avoidance of measurement fatigue for plans. In order to promote effective quality improvement, managed care entities can only reasonably be required to meet a select number of performance improvement projects in each performance period. Also, since local issues may be more compelling than a national priority as determined by CMS, states and their plan partners need to have the flexibility to determine and address the most compelling needs.

  When replying to CMS's request for comments, we asked that the proposal be modified so CMS can recommend, but not require, the inclusion of a specific performance improvement project. In addition, the regulations should be modified to clearly provide for deeming of a performance improvement project that was completed in order to meet the accreditation standards of a national approved accreditation entity. We also asked that in order to ensure quality improvement activities are focused on areas that will most benefit from a concerted effort, health plans in addition to states need to be able to seek an exemption from the CMS-designated performance improvement project if that plan can demonstrate that they are already meeting and exceeded set a set performance threshold. For example, we know that CMS is interested in early delivery before 39 weeks. However, Texas and the Texas managed care plans had already spent years addressing that issue and some plans have gotten the rate down to near zero. In this case trying to improve beyond what has already been done would be an inefficient use and diversion of resources.

- **Central Database for Critical Data.** We have recommended in the past that Medicaid programs should gather certain information in a common database, allowing all Medicaid plans contracting with a given provider to access that information. In particular, CMS has proposed a requirement for plans to include information in provider directories on the accessibility of providers' offices. ACAP does not oppose such a requirement, recognizing the importance of

this information to enrollees, but we do believe that it would be far more efficient and meaningful to either have CMS validate this information as part of the NPI assignment for the provider group or have the state validate this information as part of the screen and enroll process. This data could then be stored centrally and communicated or otherwise available to the MCOs to utilize in the provider directories. Having individual Medicaid plans collect such data would be inefficient and burdensome on plans and providers alike.

Gaps in Critical Data Collection

ACAP has identified two conspicuous examples of gaps of critical Medicaid data which could ensure the Medicaid program is working properly.

- **Quality Gap.** A significant gap exists in information about Medicaid quality in the fee-for-service and primary care case management delivery systems. Whereas managed care plans currently measure and report quality data in a variety of ways, managed care is just one of an increasing number of delivery systems serving Medicaid eligible individuals. ACAP feels strongly that it is inappropriate to focus on the quality of care provided only through managed care.

  In its draft omnibus Medicaid managed care regulation, CMS proposes a comprehensive quality strategy for Medicaid managed care plans called a Quality Rating System, similar to that required of Qualified Health Plan issuers in the health insurance Marketplaces. Currently, however, there exists no comparable system of quality measurement and reporting for Medicaid coverage provided through fee-for-service or primary care case management. This gap naturally also prevents comparisons between different delivery systems.

  As you indicate in your November letter, Federal and state governments will spend significant funds on Medicaid over the next decade. Unfortunately, with the current gap in reporting requirements, it is impossible to measure the quality of care that enrollees receive, for which significant financial outlays are made. Without a system to evaluate the quality of care provided to Medicaid and CHIP enrollees across all states and across all health care delivery systems, there can be no comprehensive efforts to improve the quality of care.

  In response to the rule, ACAP strongly urged CMS to modify its proposed Quality Rating System so that it applies to all delivery systems including fee-for-service and other emerging delivery systems to ensure a comprehensive approach to quality reporting.

  In addition, ACAP has long espoused a legislative fix building on existing adult and pediatric core set of quality measures that were developed to specifically measure the unique health care needs of people in Medicaid and CHIP. This proposal would require all states to submit Medicaid data on these measures by delivery system – including managed care, fee-for-service, and primary care case management – and would require HHS to submit an annual report to Congress allowing for comparisons to determine where Medicaid excels in delivering high-quality care to Medicaid enrollees, and where there is room for improvement. Furthermore, the

proposal would provide financial incentives through a capped funding pool to those states that demonstrate the highest levels of quality, as well as those states that show the greatest improvement in quality.

The following table demonstrates that the Quality Rating System proposed by CMS in the draft rule does not ensure that quality care is being measured and delivered in delivery systems other than managed care. As discussed previously, ACAP urges CMS to modify the proposal to hold all delivery systems equally responsible for the quality of care they provide to the individuals they serve.[1] We also encourage the Senate to consider ACAP's comprehensive Medicaid quality proposal; additional information is available here.

	FFS & PCCM	PCCM Entities	MCO
Quality Strategy	✓	✓	✓
Goals and objectives for continuous quality improvement – publicly available	✓	✓	✓
State specified quality metrics and performance targets	✓	✓	✓
Stakeholder input	✓	✓	✓
Effectiveness evaluation	✓	✓	✓
Provide for CMS comment and feedback	✓	✓	✓
How state will assess performance and quality outcomes achieved by PCCM entities		✓	
Performance Improvement Projects			✓
Network Adequacy Standards			✓
Annual External Quality Review including validation of the performance measures reported			✓
Use of intermediate sanctions			✓
Annual Review of the MCO quality assessment and program improvement program			✓

[1] While the Quality Strategy must now include State specified quality metrics and performance targets, there is no standardization of the measures to be used or how they will be calculated. Therefore, it will not lead to any meaningful comparisons. The standardized Quality Rating System, External Quality Review, Network Adequacy, Annual Quality Program review as well as other provisions such as Mental Health Parity requirements only applies to managed care.

	FFS & PCCM	PCCM Entities	MCO
Quality measure performance			✓
Outcome and trended results of performance improvement projects			✓
Results of MCOs efforts to support community integration for enrollees using LTSS			✓
Meet National Accreditation Standards			✓
Standardized Quality Rating System – Report on CMS identified measures			✓
Clinical quality management			✓
Member experience			✓
Plan efficiency, affordability and management			✓

- **Eligibility Churn Gap.** ACAP also sees a substantial gap in data related to another priority issue in the Medicaid program – eligibility churn, where enrollees are disenrolled and reenrolled in the program owing to paperwork issues or small and temporary changes in income, despite underlying eligibility remaining unchanged. An analysis conducted for ACAP by researchers at George Washington University finds that the average person enrolled in Medicaid receives benefits, on average, for just 9.7 months of the year due to churn. Other research shows that the cycle of enrollment and disenrollment leads to poorer health, results in higher-cost episodes of care, and diminishes efforts of providers and plans to measure quality. Furthermore, continuous coverage reduces the average monthly cost of care: an adult enrolled for all 12 months of the year in Medicaid incurred costs averaging $326 per month, less the half of the average monthly costs of $705 for someone enrolled only one month. [2]

  In past years, CMS has made Medicaid data, including enrollment and expenditures by type of person or service by state, via the MSIS Data Mart, a tool on the CMS web site. This tool allowed researchers and others to determine, for example, how many children or adults were enrolled in each state in a given month or year, as well as the cost of coverage for those populations. ACAP's research partners at the George Washington University relied heavily on this data source for our and additional analyses; the Data Mart was considered richer, faster and more useful than almost any other Medicaid data source. In 2015, this tool was removed from

[2] Leighton Ku, PhD, MPH, Erika Steinmetz, MBA, Tyler Bysshe, MPH, George Washington University. *Continuity of Medicaid Coverage in an Era of Transition*. November 2015. www.tinyurl.com/churn2015

the CMS web site, although CMS staff could still access the data and have been occasionally willing to share it. Recently our partners learned that CMS' contract has ended and CMS is unable to use the data or share it with the public, and that researchers are asked to seek out an unresponsive third party.

We understand that T-MSIS should ultimately resolve this issue, but until it does, we urge that these data be available. We recommend that the Senate ask CMS to continue to make this critical data source available.

2. *As payment methodologies continue to move towards incorporating pay for performance methodologies, the development and use of standard quality indicators will become more prevalent—such as with the Adult and Pediatric Quality Measures Programs. What quality indicators should be required reporting in Medicaid and what steps should be taken to move in this direction?*

ACAP Quality Proposal

In addition to ACAP's quality reporting and improvement proposal, ACAP has developed number of positions on how to strengthen and standardize quality reporting in the Medicaid program.

- **Core Sets of Measures.** In measuring and reporting quality across all Medicaid delivery systems, ACAP's quality proposal would require all states to report on the core set of quality measures for Medicaid-eligible adults, as described in §1139B of the Social Security Act, as well as on the initial child health care quality measures identified in §1139A of the Act.

  ACAP selected these existing measure sets because Congress called for them to assess the specific needs of people served by the Medicaid program, and because they were developed with the collaboration of health care quality leaders like the National Committee on Quality Assurance, the Agency for Health Quality and Research, the nation's governors, and other key stakeholders. ACAP supports the mandatory use of the measure sets by all states in a way that would allow for meaningful comparison across delivery systems in lieu of a proliferation of measures that only examines quality in some sectors.

- **Stratification.** Stratification by population is critical in any quality measurement and reporting system to ensure just and "like" comparisons. In responding to CMS's Quality Rating System proposal in the Medicaid managed care proposed rule, ACAP urged CMS to employ stratification based on populations served to ensure a fair and accurate evaluation of quality. For example, plans serving people with special needs should not be compared to plans serving primarily low-income families. In addition, stratification should be utilized when there is addition of new populations. Without stratification, plans serving the expansion population would be compared to plans that are serving only member-categories that have been eligible for an extended period of time.

- **The Dual Eligible Population and Medicare Advantage STAR Ratings.** For plans exclusively serving dual eligibles, states should not be given the option to use Medicare Advantage Star Ratings in lieu of the proposed Quality Rating System. First, it would result in a different system for plans only serving dual eligible compared to plans serving dual eligible and other populations. More importantly, CMS acknowledged in the 2016 Medicare Advantage call letter that the Medicare Advantage Star Rating Program does not accurately measure quality of care for dual eligibles, and the agency continues to evaluate changes to the MA Star Rating Program to address this issue. As such, CMS should not permit states to use the MA Star Ratings Program for MCOs that serve only duals. Doing so would further institutionalize a flawed quality rating system.

CMMI Health Care Payment Learning Action Network

The Center for Medicare and Medicaid Innovation (CMMI) has kicked off an initiative with partners in the private, nonprofit, and public sectors to encourage stakeholders to begin to pay based on value over volume. Specifically, HHS and CMMI have set goals to tie 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by 2016, and 50 percent by 2018. Bringing together the public and private sectors to discuss and develop value-based payments is important to prevent unnecessary duplication and lack of alignment of quality metrics. As such, ACAP and our member plans are active participants of the network and will continue to be so. However, it is important to recognize that the Medicaid population is fundamentally different that the commercially-insured population and as such it may not be practicable or possible to use the same measure sets for value-based purchasing in both programs. For example, social determinants of health for low-income populations have significant ramifications for their medical outcomes, and thus quality metrics in this area may be appropriate to include in value-based payment arrangements for Medicaid managed care plans but not for commercial plans.

- **Federal Lag.** While supportive of this effort, our member plans have noted that in general, states are further advanced than CMS in terms of their value-based payment efforts, and many are backtracking to accommodate CMS's slower progress. We feel as though CMS should devote resources to react more quickly and efficiently to state progress.

Tensions Related to Data Submission and Value-Based Payment

In this letter's answer to question 1 related encounter data, ACAP mentioned that as contracting moves to a more value-based approach, one incentive for providers to participate is to limit the amount of reporting and submissions. This, however, naturally creates a tension with requirements related to encounter data. Solutions to the tension caused by these competing priories will be complex and will require input from all stakeholders.

- **Need for Dialogue.** ACAP encourages the Senate to support CMS in actively engaging with states and health plans in a dialogue about this tension, including how plans can address the

misalignment of incentives and actively reconcile competing demands that are inherent in the proposed approach.

3. *At present, gaps in the information collected at the federal level related to Medicaid provider payment amounts make it difficult to determine how much providers are paid. To obtain more current and comprehensive information about how Medicaid dollars are spent, and how providers and others are paid, what role should the federal government play in requiring additional, or streamlining existing, state reporting of Medicaid provider payments? Should individual provider payments be made more transparent? Should states be required to report DSH and non-DSH supplemental provider payments at the individual provider level, and if so, should this be reported into T-MSIS? Should these types of payments be audited or auditable? Should states be required to report the amount paid in provider taxes, certified public expenditures, or intergovernmental transfers or increase transparency of these payment sources?*

Need to Balance Transparency and Protection of Proprietary Data

Given the breadth and importance of the Medicaid program, ACAP agrees that transparency around how Medicaid dollars are spent is critical; indeed, this is part of the motivation behind our own quality proposal. But while ACAP supports improvements in transparency related to Medicaid spending, we also urge consideration of the sensitive market implications of sharing unaggregated or unblended proprietary information such as plan payments to providers. Unfortunately, making proprietary payment information publicly available could have unintended consequences, including increased costs, and could cause significant problems for contracting between plans and providers. At worse, public sharing of this information would be anticompetitive. In addition, assignment of individual pricing values for each service rendered during an encounter could be misleading when actual payments to providers are based on a capitation rate, rather than the individual service to an individual member for that encounter.

- **Aggregate or Blinded Data.** Increasing transparency and the understanding of the costs of the Medicaid program may lead to efforts to identify payment amounts from Medicaid health plans to providers. Any such data collected should be aggregated or blinded to preserve the ability of plans and providers to negotiate appropriately.

4. *How should federal databases be used to facilitate sharing of information across states for implementing state-specific models or demonstrations, or to facilitate academic research? Multi-state reports or evaluations on spending and utilization for dual eligibles or high-risk populations? What processes?*

ACAP Quality Proposal

As previously discussed, ACAP's quality proposal would require all states to report on Medicaid quality measures by delivery system, including managed care, fee-for-service, and primary care case management. In addition to allowing for comparisons within states by delivery system, our proposal would also provide for comparisons between states that are currently not possible because few states report the same metrics in a comparable fashion. An annual HHS report to Congress will draw on these comparisons to determine where Medicaid provides high-quality care to enrollees, and where improvements are needed. This will allow states to learn from each other and identify best practices that are transferrable across lines.

Privacy Rules in 42 CFR Part 2

ACAP strongly supports efforts to safeguard patient privacy. However, under certain circumstances—especially where the integration of physical and behavioral health services are involved—federal privacy requirements impede the ability of Safety Net Health Plans to improve the quality of care. In some states, Medicaid health plans are accountable for physical health services that may include all pharmaceuticals, but behavioral health services may be the responsibility of a separate entity. In some states, behavioral health services are fragmented even further, with mental health services under the purview of a behavioral health organization and substance abuse services provided in an unmanaged fee-for-service environment.

While integration is possible in these circumstances, it is dependent on the ability of responsible entities to be able to share information in a protected and secure manner. Currently, there are federal privacy rules concerning behavioral health services that make this coordination difficult and sometimes impossible, where a more balanced approach would support the dual goals of privacy and integration. In order to improve the quality of care provided to individuals with substance use disorders and health outcomes, federal guidelines must permit the sharing of information related to treatment of these disorders.

- **42 CFR Part 2 Substance Use Exclusion.** ACAP supports an exclusion to privacy rules at 42 CFR Part 2 for certain types of managed entities, including Medicaid health plans (as well as Medicare and individual Marketplace health plans). This exclusion would be highly likely to aid efforts to better integrate physical and behavioral health care because it would allow caregivers and certain types of organizations to share critical care information. Protections in HIPAA would adequately safeguard the privacy of patients while still allowing plans and providers to coordinate care for members with substance use disorder.[3]

Medicaid-Medicare Dually-Eligible Individuals

[3] ACAP Fact Sheet: The Impact of 42 CFR Part 2 on Care Coordination by Heath Plans for Members with Substance Use Disorders. January 2016. http://tinyurl.com/ACAP42cfr2

Nineteen ACAP plans operate a Duals Special Needs Plan, and 14 participate in a financial alignment demonstration. ACAP's work on issues related to coverage of dually-eligible individuals is extensive and includes, among other priorities, efforts to reform the Medicare Advantage STARS quality reporting system to ensure its effectiveness for plans serving this population.

- **Multi-State Reports.** ACAP would be interested in accessing reports related to Medicaid behavioral health services and long term services and supports (LTSS) offered, as well as spending and utilization for duals, by state.

Monitoring of Controlled Substances

Prescription Drug Monitoring Programs (PDMPs) are electronic databases that track patients, prescribers, and prescriptions associated with all controlled substances dispensed in a state. Currently 49 states operate PDMPs. These databases enable providers, professional licensing boards, and law enforcement officials to identify individuals involved in suspected abuse and illegal diversion of controlled substances, and they can help identify patients who would benefit from early intervention and treatment.

In many states, health plans are not permitted to access PDMP data. Health plans' pharmacy databases do not include information about controlled substance prescriptions not reimbursed through members' pharmacy benefits, such as those covered by State Medicaid programs under prescription drug carve-out arrangements or those purchased with cash. Without complete data on members' prescriptions for controlled substances, Medicaid health plans are unable to identify many people who could benefit from SUD treatment and counseling.

- **Allow Medicaid plans to Access PDMP Data.** ACAP recommends permitting Medicaid health plans to access state PDMP data for their membership in order to identify a larger proportion of patients in need of prescription drug abuse intervention and to initiate timely, effective outreach.

5. *A key issue with many types of Medicaid data is the lag time in reporting and delayed access to timely, quality data. What changes could be made at the Federal and state level to improve the timeliness of the submission and availability of Medicaid data? To what extent is T-MSIS addressing these timeliness issues and what else could be done?*

Effective Models for Real-Time Data Sharing

Recognizing the challenges of lag time for data as it relates to providing and coordinating appropriate care for high-needs individuals, our members have discussed various tools that their states have developed to share real-time global data relating to emergency department use. Different localities have created their own solutions for tools to alert a patient's primary care provider and insurer when they are

admitted to or released from a hospital stay or emergency department. One example is the Emergency Department Information Exchange (EDIE), used in Oregon and Washington State. This tool, used extensively in Health Homes but also available for all high-utilizing patients, is an emergency department (ED) care coordination service enabling providers across communities to develop, implement, and share care coordination strategies.

EDIE allows care coordination guidelines, including prescriptions and services, to follow patients to all points of care. The system helps providers, payers, hospitals, and Care Coordination Organizations address the needs of high-utilizing patients. EDIE also supports customizable alerts for EDs and primary care providers when high-utilizing patients seek care in an ED.

EDIE allows consistent, collaborative care across all providers a patient sees. This care coordination, which would not be possible without the data-sharing EDIE allows, in turn better manages patients' conditions, reducing ED utilization for ambulatory care-sensitive conditions

- **Encouraging Use of EDIE.** Since efficient and rapid data sharing can help plans and providers improve the care received by high-utilizing individuals, the Senate may want to consider ways to encourage and expand the use of EDIE and similar models.

Again, we thank you for this opportunity to provide our views on Medicaid reporting requirements. Awe hope they will be helpful. Please feel free to contact me (mmurray@communityplans.net, 202-204-7509) or Jennifer Babcock, our Vice President for Medicaid Policy (jbabcock@communityplans.net, 202-204-7518) if you would like to discuss any of these issues in greater depth.

Sincerely,

Margaret A. Murray
CEO