MACPAC

Advising Congress on
Medicaid and CHIP Policy

January 14, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

Re: CMS-2408-P Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: CMS-2408-P Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care 83 Fed. Reg. 57264 (November 14, 2018).

The proposed rule would amend the Medicaid and CHIP managed care regulatory framework as part of CMS's broader strategy to address regulatory burden, state flexibility, program accountability, and transparency. The Commission previously commented on the legal framework for Medicaid managed care in its March 2018 report to Congress, noting the importance of clear, consistent rules for states and Medicaid managed care organizations (MCOs) that reflect state and federal experience in providing Medicaid coverage through managed care that have been codified over time.

The Commission discussed the notice of proposed rulemaking at our December 13, 2018 public meeting, noting that many elements of the current regulatory framework would be retained. We identified some issues for CMS to consider, including how to handle supplemental payments such as directed payments and pass-through payments, monitoring access in Medicaid, and substance use disorder treatment, all of which have been the focus of prior Commission discussion and recommendations. We address these issues below.

Medicaid and CHIP Payment
and Access Commission

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Directed payments and pass-through payments

CMS proposes clarifications to the directed payment option, which allows states to require MCOs to direct a portion of their capitation payments to providers to improve quality, care, and outcomes under a delivery system or provider payment reform model. CMS also proposes to allow states to make new pass-through payments when transitioning services or populations from fee for service (FFS) to a managed care delivery system. These pass-through payments cannot exceed the amount of supplemental payments that the state previously made under FFS. Pass-through payments must be phased out over three years.

The Commission previously raised concerns about lack of transparency of supplemental payments made under FFS arrangements, noting in particular that data are not available at the provider level. In its March 2014 report and again in March 2016, MACPAC recommended that the Secretary should collect and make supplemental payment data at the provider level publicly available.

The Commission suggests that if CMS extends the pass-through exception to more states, it should collect and make provider-level data publicly available so stakeholders can examine the amount of pass-through payments and to whom they are being made. We also suggest that CMS collect any provider-level data on directed payments that are not already included in encounter data and make these data publicly available for the same reasons. While CMS notes in the preamble to the proposed rule that a significant number of the directed payment arrangements approved since 2016 have been to require plans to adopt minimum rates, states may develop directed payment arrangements for delivery system or provider payment initiatives that involve lump-sum payments.

CMS also should clarify how disproportionate share hospital (DSH) payments will be considered when determining the amount of FFS supplemental payments that can be continued as pass-through payments in managed care. It appears from the preamble discussion that the new pass-through provision is intended to be limited to non-DSH supplemental payments, but the proposed definition of supplemental payment in § 438.6(a) could be interpreted as including DSH payments as these are not a separate category of Medicaid services but rather are considered an adjustment to inpatient hospital payments.

When the DSH allotment reductions take effect beginning in fiscal year (FY) 2020, some states may seek to transition DSH payments into increases in managed care payments to hospitals, as Louisiana is doing in 2019. If DSH payments can be included in the amount of FFS supplemental payments that can be continued as pass-through payments in managed care, the amount of potential pass-through payments in some states could be substantially higher than the non-DSH supplemental payment amount.

In addition, CMS should improve the reporting and monitoring of state quality strategy and evaluation plans to ensure that directed payments are tied to improvements in quality, care, and outcomes. While states also are required to have an evaluation plan in place that measures the degree to which the arrangement advances the state goals or objectives, the Commission is concerned about the extent to which the current requirements are being enforced. MACPAC interviews with a small number of hospitals

and states did not identify quality as a key consideration in the development of their directed payment policies although this is one of the primary goals identified in the regulation.

Network adequacy

Current managed care regulations require states to develop network adequacy standards that ensure Medicaid beneficiaries have access to needed care and involve the public in design and implementation of the managed care program. These access monitoring activities help states learn where their programs are succeeding and where there are problems that require attention. They also help the federal government assess whether states are using their federal funds in an appropriate manner and make comparisons across states.

CMS proposes to eliminate the requirement that states establish time and distance standards for providers and instead requires states to adopt a quantitative standard of their choosing. The proposed rule lists several alternative network adequacy standards that states may use, including provider-to-enrollee ratios, the percentage of providers accepting new patients, maximum appointment wait times, and extended hours of operation. CMS also proposes to make corresponding changes to requirements for states that provide long term services and supports through managed care. The proposed rule does not place additional requirements on states in terms of oversight.

The Commission supports transparency and accountability measures and notes the important role of public engagement in developing and reviewing any changes to network adequacy and availability of services standards. We note that the current rule at § 438.340 requires states to have a written managed care state quality strategy that includes the state-defined network adequacy and availability of services standards, and that the quality strategy must be subject to a public engagement process where the public can comment on the state's plans. The quality strategy (including the network standards) must also be posted online and updated at least every three years. These processes are important in serving as a means of accountability, identifying problems, and guiding program improvement.

Payment for in-lieu-of services in institutions for mental diseases

The proposed rule does not propose any changes to payment for in-lieu-of services in institutions for mental diseases (IMDs); however, CMS requested public comment on additional data sources that it should consider to support the 15-day limit on payment for such services.

MACPAC suggests that CMS use two sources of data that should be available for this purpose. CMS could use data that it is directed to collect by the 21st Century Cures Act (P.L. 114-255). The Cures Act requires the U.S. Department of Health and Human Services (HHS) to study the effects of the 15-day in-lieu-of provision and issue a report in December 2019. Among other things, the HHS study must address the range of and average number of months that beneficiaries receive services in IMDs, and their lengths of stay during those months. CMS issued an information collection request in October 2017; collected data will be used by CMS to respond to the reporting requirement.

CMS could also consider data that is available through approved Section 1115 substance use disorder (SUD) demonstrations. As of November 2018, 18 states had approved Section 1115 demonstrations to pay for SUD treatment in IMD settings. Generally, states have to maintain an average length of stay of 30 days and report to CMS on performance measures, including measures to capture average length of stay for residential treatment. Such data could be taken into account when reviewing this provision.

Sincerely,

Penny Thompson, MPA
Chair

cc: The Honorable Charles Grassley, Chair, Senate Finance Committee
The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone Jr., Chair, House Energy & Commerce Committee
The Honorable Greg Walden, Ranking Member, House Energy & Commerce Committee