Charles N. Kahn III
President and CEO

April 19, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 310-G
Washington, DC 20201

RE: Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans

Dear Marilyn:

The Federation of American Hospitals ("FAH") is the national representative of more than 1000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay rehabilitation and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. Our hospitals have long been a critical part of the health care safety net serving vulnerable patients in urban and rural communities, and our role as safety net providers will continue to expand as Medicaid enrollment increases and Affordable Health Exchanges ("Exchanges") become operational in 2014. As such, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") *Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans ("Capitated Financial Alignment Guidance").*

EXECUTIVE SUMMARY

The FAH commends the Medicare-Medicaid Coordination Office (MMCO) for its leadership in addressing the barriers to providing fully integrated care to individuals dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees), who have some of the most complex, chronic illnesses and challenging medical conditions. It is imperative, therefore, that policymakers thoroughly test and evaluate proposed state demonstration models on a limited scale before they are broadly applied to these vulnerable beneficiaries. The FAH is concerned, however, that the timelines suggested in the guidance are aggressive given the many complex financing and design issues that must first be resolved. While we appreciate the urgency in improving the care delivery system, which could generate some level of savings, the FAH cautions against expediency. Along those lines, many State proposals appear to us to be too ambitious, and to lack the level of detail necessary for CMS, potential enrollees, providers, and other critical stakeholders to assess their readiness. The focus must be on ensuring that integrated care plans have the capabilities and capacity to improve the quality and coordination of care for Medicare-Medicaid enrollees.

As detailed in our comment letter below, we offer recommendations that we believe are critical to the success of the demonstration and to further safeguard beneficiaries in the areas of access to quality care, freedom of choice, and scope of services. In summary, the FAH recommends the following:

- The primary goal of the demonstration should be to enhance quality and care coordination for dual eligible individuals. Savings should be subsidiary to these aims and should not be taken up-front.
- Savings should come from care coordination and quality improvements, not reductions to provider payment rates, which already fall well below the cost of care.
- Demonstration plans must, at a minimum, retain all current Medicare Fee-For-Service benefits and services.
- Enrollment for dual eligible demonstrations should be on a voluntary (opt-in) basis which preserves the Medicare enrollment rights of dual eligible beneficiaries. Passive enrollment and lock-in provisions should not be permitted.
- Network adequacy requirements must ensure that demonstration programs do not disrupt existing relationships between beneficiaries and their providers. Medicare Advantage network adequacy requirements are a minimum and should not be waived.
- Demonstration programs should not be state-wide; they should be limited in size to reflect the experimental nature of this program until demonstration models are independently evaluated and shown to improve care coordination and quality.
- CMS and State administration of demonstrations should reduce administrative barriers to caring for enrollees and administrative burden on providers.

GENERAL COMMENTS

(1) Plan Payment Rates and Savings

As outlined in the Capitated Financial Alignment Guidance, "[r]ates for participating plans will be developed based on baseline spending in both programs and anticipated savings that will result from integrated managed care." The guidance also stipulates that "[t]he rate will provide upfront savings to both CMS and the State. Absent savings for both payers, the demonstration will not go forward." While the current budget environment makes health care savings an important policy goal, the primary goal of the program should be to enhance quality and care coordination for dual eligible individuals. As CMS is aware, adequate funding of newly established plans will be critical to plans' ability to design and execute new programs to better serve duals. Towards this aim, the FAH urges CMS to ensure that plan rates account for existing levels of Medicare and Medicaid services. **To the extent savings is required under Section 3021 of the Affordable Care Act (ACA), it should be a subsidiary goal to quality and care improvements.**

The demonstrations will involve serving new populations and will incorporate many new service delivery options with the goal of testing whether integrated managed care can achieve both improved health outcomes and reduced costs. Given the many new factors that will be included in the demonstration plans, it will be challenging to develop capitated plan rates that are based on historical spending, account for service delivery changes, and incorporate empirically-based savings targets for both the Federal and State portion of spending. Further complexity will likely result from the difference in the health care needs of individual enrollees, the variety of states pursuing demonstrations, and the differing core competencies of future integrated plans. As a result, it is highly likely that the eventual program savings achievable will vary greatly with regard to location, demonstration size, and timing. **Given the number of challenges inherent in projecting these variables, the FAH recommends that any savings targets be very modest.**

The FAH also recommends that CMS defer savings to the end of the demonstration period, rather than requiring upfront savings. As states and plans launch these new programs, they may initially need to make investments in infrastructure to better serve Medicare-Medicaid enrollees. Newly enrolled individuals may require increased levels of health care when they enter an integrated plan, adding to the upfront program costs. When combined with the challenges discussed above regarding the initial rate setting process, it would be beneficial to structure any savings targets to be achievable only at the end of the demonstration, or, at least, in years two and three of the demonstration program. The authority under Section 3021 of the Patient Protection and Affordable Care Act (ACA) provides the ability to defer savings by directing that "the Secretary shall not require, as a condition for testing a model … that the design of such a

model ensure that such model is budget neutral initially with respect to expenditures." **As such, the FAH recommends that the demonstrations be structured so that savings are achieved at the end of program, rather than requiring upfront savings.**

(2) Provider Reimbursement

Successful implementation of integrated care models will require not only adequate plan rates, but also adequate provider reimbursement rates. Unfortunately, many state Medicaid programs reimburse providers at rates well below the cost of delivering care. In addition, MedPAC has documented that Medicare acute care hospital payments fall well below the cost of care. Yet, Medicare hospital payment rates are generally above Medicaid reimbursement levels, so it is critical that demonstration plans continue to reimburse providers delivering Medicare services to Medicare-Medicaid enrollees at no less than Medicare FFS amounts. **As CMS has expressed in presentations and conversations, and the FAH agrees, savings should come from care coordination and quality improvements, not provider rate reductions.** Therefore, as CMS develops the MOUs with participant States, and the three-way contracts between CMS, the State, and the plan(s), it is critical that CMS explicitly stipulate that any targeted savings are to be achieved through better care coordination, and not through provider rate reductions. This will be an important safeguard to ensure enrollees have meaningful access to a complete network of providers.

As CMS considers the beneficiary safeguards necessary to ensure adequate provider reimbursements and thus adequate provider networks, **the FAH urges CMS to specifically ensure that all services that would otherwise be covered and paid for by Medicare are reimbursed at no less than the Medicare FFS payment amount providers would be entitled to under Medicare policy. This should include disproportionate share payments (DSH), indirect medical education (IME) payments, outliers, and rural add-ons.** Additionally, it is particularly important for providers to continue to receive Medicare bad debt payments, which partially reimburse hospitals for any unpaid deductibles or other cost-sharing obligations incurred while caring for Medicare-Medicaid enrollees. As currently structured, Medicaid is designed to 'wrap-around' Medicare for dual eligible enrollees, and thus pay the Medicare deductibles and other cost-sharing on behalf of enrollees. However, as CMS is aware, many states set reimbursement rates below Medicare reimbursement levels, and therefore do not pay providers these cost-sharing obligations. Medicare currently reimburses hospital providers about 70% (soon to be 65%) of these unpaid deductibles and co-pays through Medicare bad debt payments. **Medicare bad debt payments are critical to providers serving this population, and the FAH recommends that CMS stipulate that plans include these payments in their Medicare reimbursement levels.**

(3) Coverage of Benefits

The FAH is pleased to see that the sample MOU document requires integrated plans to cover "the full continuum of Medicare and Medicaid covered services to enrollees," and that "Medicare covered benefits shall be in accordance with 42 C.F.R. 422.101," which requires coverage of all services covered by Part A and Part B of Medicare. As CMS, States, and plans develop integrated delivery models to better coordinate care for Medicare-Medicaid enrollees, it is important that the new models augment and improve upon the current benefit structure, rather than reducing the level of current services or rates. **As CMS further develops the MOUs and three-way contracts that will govern the demonstration programs, the FAH urges CMS to monitor adherence to this requirements to ensure that all current Medicare Part A and Part B FFS benefits are covered as part of any integrated plan**.

This beneficiary protection is particularly important when considering benefits that may be covered by Medicare but not Medicaid, such as acute rehabilitation care in an inpatient rehabilitation facility (IRF). Many states do not provide coverage for rehabilitation care provided in an IRF, and there are even some Medicare Advantage plans that have tried to substitute lower intensity services provided in a non-hospital setting such as a skilled nursing facility (SNF) in place of medical rehabilitation provided in an IRF. SNFs, however, do not provide the hospital-level care provide by IRFs, and thus are not a substitute. IRFs provide close supervision by a physician with specialized training, 24-hour rehabilitation nursing, a multi-disciplinary team approach, and three hours daily of intensive therapy. A Medicaid SNF benefit, while critical in its own right, does not substitute for Medicare's coverage of inpatient rehabilitative services in an IRF. As this example illustrates, it will be important for CMS to ensure all integrated care plans offer the full range of current Medicare Part A and B FFS benefits.

(4) Network Adequacy

Medicare-Medicaid enrollees often suffer from complex, chronic conditions and have developed long-standing relationships with their doctors, hospitals and other providers. As CMS, the States and plans develop new care delivery models to serve Medicare-Medicaid enrollees, it is very important that enrollees be able to maintain their existing relationships with their current providers, and that plans offer a broad network of medical, behavioral health, and support services providers.

In the Capitated Financial Alignment Guidance, CMS indicates that Medicare Advantage standards are the preferred requirement standard for medical benefits. It also notes that "[d]emonstration plans will be able to utilize an exception process in areas where Medicare network standards may not reflect the number of Medicare-Medicaid beneficiaries." **Given the**

importance of ensuring that beneficiaries have meaningful access to the full continuum of care providers, the FAH recommends that CMS establish Medicare Advantage network adequacy rules as a pre-established parameter, rather than a preferred standard. In addition, the FAH recommends that, as a general rule, these standards should not be waived. The FAH does recognize that there are a select number of areas with high levels of integrated providers and/or long-run experience with fully integrated plans (such as the Senior Care Options programs and PACE programs), which CMS may determine warrant flexibility in developing network adequacy requirements that ensure comprehensive access to benefits and services while remaining cost effective.

(5) Enrollment

In the Capitated Financial Alignment Guidance, as well as the related State Medicaid Directors' Letter (SMDL# 11-008), CMS indicates that "[f]or Medicare, States participating in the demonstration may request CMS approval for a passive enrollment process to enroll Medicare-Medicaid beneficiaries into participating health plans." In addition, certain state proposals envision using a "lock-in," which would prevent beneficiaries from dis-enrolling from a health plan, at least for part of the year. Both passive enrollment and "lock-in" enrollment policies result in diminished enrollment rights for Medicare-Medicaid beneficiaries when compared to their current enrollment rights and when compared to middle and upper income beneficiaries. Given that the proposed models are demonstrations and thus have not yet demonstrated improvements in care coordination, quality, and cost saving, separately or concurrently, beneficiary enrollment rights must remain paramount. **Therefore, the FAH strongly urges CMS to eliminate the option for States to passively enroll Medicare-Medicaid beneficiaries into participating health plans**, **and opposes any proposal to 'lock-in' beneficiaries after enrollment.**

The FAH supports the development of integrated, coordinated care plans, and the use of "opt-in" enrollment models for these plans. Integrated plans that offer seamless, high quality care offer a welcome and attractive competitive choice compared to the status quo. That advantage, in and of itself, will attract beneficiaries to their plans, and, moreover, will help ensure enrollee 'buy-in' and patient satisfaction that is critical to achieving the potential benefits of a seamless, integrated approach to care delivery. Maintaining the "opt-in" approach will also ensure that Medicare-Medicaid beneficiaries living in regions with a demonstration model maintain the same enrollment rights as beneficiaries in other parts of the country. In addition, it is important to preserve dual eligible beneficiaries' option to opt-out of a demonstration plan at any time. Many Medicare-Medicaid beneficiaries experience serious, complex medical issues, and it is important that they have the freedom to leave a managed care plan that is unable to meet their health care needs.

(6) Demonstration Size

As discussed above, the FAH supports the development of integrated care models for Medicare-Medicaid enrollees, and looks forward to working with States and demonstration plans as they test new delivery models. There are models that may, with time, achieve both improved outcomes and lower costs. However, the results of these models cannot be predetermined, and it is thus critical that MMCO ensure that the size and scope of each demonstration reflects the experimental nature of the program. Many state proposals appear to consider incorporating entire sub-populations (e.g. all 21-64 year old Medicare-Medicaid enrollees), or wish to phase in their entire duals population statewide over the course of the demonstration. **Statewide programs, and those that include entire sub-populations, exceed a reasonable interpretation of a demonstration, and as such should not be approved.**

The FAH recognizes that demonstrations must be large enough to allow MMCO and the States to develop actuarially sound rates, and to allow new integrated care plans to manage risk. However, given the size of the Medicare-Medicaid populations in most states, and the amount of spending on this population, the demonstration programs should have sufficient enrollee volume without requiring a state's entire population, or specific subpopulation, to enroll in the demonstration.

It is important to ensure that the current care delivery models relied on by Medicare-Medicaid enrollees remain operational and intact, not only to preserve current options for enrollees, but also to provide a control group against which the demonstration models can be assessed. Additionally, given the experimental nature of the program, it is conceivable that not all models will achieve the outcomes required by Section 3021 that would permit the demonstration to be expanded beyond its initial scope. Therefore, in all cases, states must retain the infrastructure of the current models to ensure they are available in those cases where the demonstrations do not continue past the initial three years.

(7) Quality

In the Capitated Financial Alignment Guidance, it states that CMS and [the] State shall determine applicable standards and jointly conduct a single comprehensive quality management process and consolidated reporting process. The FAH supports the development of a quality measurement program for dually eligible Medicare and Medicaid enrollees that will enable providers to be able to improve the care and services to enrollees. The FAH recommends that such a program begin with a limited number of measures focused on high-leverage areas, where data is readily available through existing data collection mechanisms. The FAH also recommends that the selected measures be carefully aligned or drawn from the current quality measurement programs in Medicare and the core set of measures for the quality measurement program in Medicaid and aligned with the measures currently in use in the Medicare Part C and

Part D programs. The FAH long has supported using only those measures endorsed by the National Quality Forum. Finally, any measures used in the program must be fully tested for the setting in which it is being applied. The FAH opposes using new Part C and Part D measures in the Capitated Financial Alignment program until those measures are well tested and understood.

The FAH is concerned that the guidance calls for plans to be subject to increasing quality withholds with an ability to "earn back" the capitation revenue if the quality objectives are met starting with the first year of the program. Our experience in the Medicare quality programs clearly proves the value of a full year of data collection where glitches can be worked prior to the imposition of any penalty. Particularly where state quality programs and national programs vary, it is essential that the data collection and reporting processes be fully worked out before implementing a pay for performance scenario. There are many unintended consequences when measures are used in a new setting or for a new purpose. Providers need a year's experience to ensure that the data produced is accurate and valid.

The FAH encourages CMS to carefully review the Measure Applications Partnership (MAP) Interim Report to HHS developed by the Dual Eligible Beneficiaries Work Group. The report can be found at the following link:
http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx

As the MAP report details, the heterogeneity of the dual eligible population complicates the selection of measures and the development of the overall program. This report offers a framework for the selection of measures and focuses on the how to help providers and patients and their care-givers will be able to take action to improve the care delivered and the results for patients.

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The FAH commends CMS for its work developing models that align financing between Medicare and Medicaid to support integrated care delivery systems for enrollees. There are many promising opportunities to improve care coordination for Medicare-Medicaid enrollees, and the FAH looks forward to working with CMS on the Capitated Financial Alignment Models and other future programs developed by MMCO. If you have any questions about our comments or need further information, please contact me or Elizabeth Ward of my staff at (202) 624-1500.