July 24, 2015

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2390-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

RE: CMS-2390-P, Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies and Revisions Related to Third Party Liability

Dear Mr. Slavitt:

On behalf of our 150 member hospitals, the Missouri Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ proposed rule. We offer the following comments.

**Section 438.3(s) (2) (3) Standard Contract Requirements — Outpatient Drug Rebates and 340-B Drug Pricing Program Exclusion**

The proposed rule requires managed care plans to collect National Drug Codes for each covered outpatient drug dispensed excluding those outpatient drugs subject to discounts under the 340-B drug pricing program. The proposed rule also should exclude hospital outpatient drugs if the hospital bills Medicaid for covered outpatient drugs at no more than the hospital’s purchasing costs per Section 1927(j)(2) of the Social Security Act and confirmed by the CMS October 16, 2009, News for State Medicaid Directors Release No. 153.

**Section 438.3(u) Standard Contract Requirements — Payments to MCOs and PIHPs for Enrollees that are a Patient in an Institution for Mental Disease**

Missouri has participated in an IMD Demonstration project since 2012 and has demonstrated that eliminating the IMD exclusion expanded available psychiatric beds, reduced “boarding” of psychiatric patients in hospital emergency departments and did not result in any additional costs to the Medicaid program.

MHA supports CMS’ efforts in this proposed rule to expand the capacity of Medicaid managed care plans to use their capitated payments to fund services through an IMD. As noted in CMS’ comments, this expanded capacity should help alleviate some of the considerable challenges faced by providers and managed care plans in securing access to short-term behavioral health
care. While the proposed rule commentary notes that the agency could interpret current statutory standards to preclude any use of a capitated payment to an IMD, the agency has chosen an alternative course. This is appropriate. CMS does propose limiting this type of payment to 15-days of inpatient care in an IMD. The rationale offered for this limit is reasonable. However, we encourage CMS to consider incorporating a somewhat longer duration of payment to an IMD based on average lengths of stay. Our concern is that the proposed 15-day limit could have an adverse effect on continuity of care and outcomes if a significant percentage of IMD patients would exceed that limit.

Section 438.60 Prohibition of Additional Payments for Services Covered Under MCO, PIHP or PAHP Contracts

When a state Medicaid agency proposes to move a fee-for-service beneficiary group to managed care, historic payment streams to providers are disrupted, sometimes profoundly. The proposed rule should allow for a transition period to accommodate this disruption giving providers and plans the time needed to fully integrate these payment streams into a capitated environment. A transition option would allow policy makers to focus on delivery system objectives rather than confronting and addressing the impact of a sudden shift in payment streams. The proposed rule also should recognize additional payments when required by state law or rule consistent with the preamble language.

Section 438.68 Network Adequacy Standard

MHA appreciates CMS’ attention to developing more robust standards for network adequacy in Medicaid managed care plans. The lack of an adequate network is not only adverse for patients, it also potentially can generate inefficient use of the health care system. The Hospital Industry Data Institute, a subsidiary of the Missouri Hospital Association, has assessed rates of growth in emergency department visits generally and for treatment of mental health disorders among Missouri Medicaid enrollees. Comparing utilization between 2004 and 2013, ED visits by Medicaid enrollees increased 25 percent for managed care enrollees. The comparable rate of increase for fee-for-service Medicaid enrollees was 4 percent. Specific to ED treatment of mental health disorders, the rate of growth between 2004 and 2013 was 68 percent for Medicaid managed care enrollees and 37 percent for Medicaid fee-for-service enrollees. While further research is needed to verify a correlation between these rates of growth and network adequacy, it is possible that less robust managed care networks and the access issues they create could promote greater use of the hospital ED.

Also, we note that 75 percent of enrollees in Missouri managed care are children. Network adequacy must be defined specifically for children’s health needs. The regulation includes separate pediatric standards for primary, specialty and dental care. If done with sufficient specificity, this is a positive development. A child with specialized neurological issues who is enrolled in a Medicaid managed care plan needs a pediatric neurologist, not a neurologist who focuses on adult patients. As noted in the commentary to the proposed rule, “network adequacy is often assessed without regard to practice age limitations which can mask critical shortages and increase the need for out-of-network authorizations and coordination.” In the same vein, we support separate pediatric network adequacy standards for pediatric hospitals as well as pediatric
behavioral health providers. Pediatric hospital standards should reflect rates of patient transfers from hospitals which also treat adult patients.

The proposed regulation should require CMS to assess the reasonableness of the time and distance standards proposed by a state Medicaid agency and should require CMS approval of such standards. Also, MHA supports strong standards to ensure that managed care plans’ provider network directories are current and accurate. A means of verifying that accuracy is key. For example, the Missouri Medicaid agency is engaged in a “secret shopper” initiative to test whether listed network providers are enrolled with the plan and, more significantly, willing and able to treat new Medicaid patients. Our member hospitals have become aware of a physician group being listed as a participating network provider with a Medicaid managed care plan, when in fact only a few of physicians in that group were actually enrolled and available. These “secret shopper” or similar initiatives to verify network compliance are an effective means of verifying compliance. CMS should consider requiring states to demonstrate their enforcement of network adequacy standards for Medicaid managed care plans.

Section 438.420(a)(d) Continuation of Benefits While the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending

The proposed rule states that if the appeal is adverse to the enrollee, the MCO may recover the cost of the services furnished to the enrollee while the appeal and the state fair hearing were pending. This provision should be clarified to ensure that MCO payments to providers for services rendered are not recouped, and instead any resolution of costs is between the enrollee and the plan.

We appreciate your work on this proposed rule. If you have any questions on our comments, please contact Steve Renne, Vice President of Children’s Health and Medicaid Advocacy, at 573/893-3700, ext. 1338 or srenne@mhanet.com or me at ext. 1349 or dlandon@mhanet.com.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

dl/cml