MISSISSIPPI HOSPITAL ASSOCIATION

July 20, 2018

Drew Snyder, Esq.
Executive Director
Office of the Governor, Division of Medicaid
550 High Street, Suite 1000
Jackson, Mississippi 39201

Re: Comments on Managed Care Quality Strategy Initial Draft 2018

Dear Mr. Snyder:

Thank you for the opportunity to provide input regarding the above referenced Managed Care Quality Strategy ("Quality Strategy"). On behalf of its member hospitals, the Mississippi Hospital Association ("MHA") submits the following comments and concerns.

We understand the requirement to produce the Quality Strategy, but we generally question many of the required reporting items which seem heavily weighted on process and administrative oversight, rather than encouraging improved health care outcomes for Medicaid patients. The reporting requirements described in both the 22 page, 252 item MississippiCAN Reporting Manual and the 19 page, 204 item Mississippi CHIP Reporting Manual do not necessarily equate to improved quality outcomes. We suggest that some of the reporting requirements be combined to streamline the process and make it less administratively burdensome. The administrative time required to prepare and review the reports consumes administrative resources at both the Care Coordination Organizations ("CCOs") and at the Division of Medicaid ("Division") that could perhaps be better spent on improving quality. Rather than focusing so heavily on the reporting requirements, it seems that the real opportunity to improve health care outcomes lies in how the Division requires the CCOs to use those reports to improve quality and how the Division holds the CCOs accountable for improving quality.

By comparison to the voluminous Reporting Manuals, the Child and Adult Health Quality Measures are neatly described in 61 items measuring improved health outcomes and 18 items measuring the consumer's assessment of the health plan. These Quality Measures cover less than 3 full pages compared to the Reporting Manuals' 41 pages. Of the 61 Quality Measures related to improved health outcomes, only 19 are for adults – the most expensive population per member per month served by managed care. While we applaud the Division's focus on improving health outcomes for children, the sickest and most expensive population enrolled in managed care is the adult population, particularly the SSI-Disabled members. The adult population presents the greatest opportunity to bend the cost curve by improving health outcomes. Ostensibly, improving quality is the primary argument for contracting with the CCOs

116 Woodgreen Crossing ♦ P.O. Box 1909 ♦ Madison, MS 39130-1909 ♦ (601) 982-3251 ♦ (800) 289-8884 ♦ Fax: (601) 368-3200
www.mhanet.org

since the state experienced less program growth in its budget prior to the launch of the managed care program than it has since implementing managed care. Furthermore, state law now requires that the CCOs be evaluated as to whether costs have been contained by improving health outcomes. It would behoove the Division to focus more resources on the CCOs improving these Quality Measures.

Despite filing the voluminous reports over the last several years, the managed care program has experienced significant declines in some of the major performance measures tied to quality outcomes established by the Mississippi Legislature. From SFY 2015 through SFY 2017, the percentage of MississippiCAN diabetic members aged 17-75 receiving HBA1c tests decreased from 86.20% in SFY 2015 to 82.12% in SFY 2017. During the same period, the percentage of MississippiCAN members with persistent asthma which were appropriately prescribed medication decreased from 79.44% in SFY 2015 to 75.39% in SFY 2017. Similarly, the rate of EPSDT well-child screening decreased from 69% in SFY 2015 to 53% in SFY 2017.

Given the above, it is not altogether surprising that the number of emergency room visits for the Medicaid population increased from 390,825 in SFY 2015 to 555,665 in SFY 2017 despite declines in overall enrollment. Promoting after-hours clinic care and urgent care centers by paying enhanced rates and making 24-hour nurse call centers available to members have been promoted by the CCOs as tools to avoid unnecessary emergency room visits. Not improving health outcomes for members and not working collaboratively with providers are leading to these increased visits.

If the CCOs have promised the Division that they can improve health care outcomes for their members and are being paid a handsome sum to do so, then MHA believes that the CCOs should be held accountable. The reality, however, is that health care providers – physicians, nurses, pharmacists, therapists, nursing homes and hospitals – are best positioned to manage patient care and more care management resources should be provided to these health care providers to do so. The Quality Strategy does not clearly connect the CCOs and providers to collaborate in a way that improves access to care through network adequacy and improves quality outcomes. Financial resources not spent on direct patient care could be more effectively spent on collaboration with providers. The difference between what the Division has paid the CCOs in premiums and what the CCOs have paid to providers since the inception of the MississippiCAN program exceeds one billion dollars according to data obtained from the Division and from the reports filed by the CCOs with the Mississippi Insurance Department.

In addition to our concerns regarding the reporting requirements and lack of more meaningful quality measures, particularly for adults, we have specific concerns about other aspects of the Quality Strategy. The Quality Strategy is heavy on Access Standards to promote access to patient care through network adequacy standards; however, beyond the network mileage and time requirements for network adequacy, the Division could do more to ensure that appropriate care is approved, rather than denied by the CCOs. We request that the Division consider placing

greater emphasis on denial rates and clearer sanctions on the CCOs for inappropriate denials of claims and prior authorizations which limit access to timely care for patients. If needed care is inappropriately denied, it has a direct impact on patient health outcomes. Additionally, we encourage the Division to place clear requirements on the CCOs to honor the statutory requirement that prohibits the CCOs from placing additional credentialing requirements on providers. Delays in credentialing providers also hinders access to care and impacts health care outcomes. Recent amendments to state law, require that the CCOs recognize the credentialing of the providers by the Division and not place additional requirements on providers in order to receive reimbursement for services.

MHA also questions the inconsistent Performance Improvement Projects ("PIPs") for 2018 described for Magnolia Health Plan and UnitedHealthcare. Unless one plan is enrolling a disproportionate amount of patients with those relevant conditions under their respective PIP, why wouldn't the PIPs be the same for each health plan? Also, why is no PIP included for Molina for 2018 since enrollment begins in 2018? Molina is mentioned in the Quality Strategy, but is not held to the same standards as Magnolia and United? Finally, if the plans are charged with different PIPs, how is the Division able to compare plan performance? It seems as though one program objective, whether described in the Quality Strategy or not, should be to hold the plans to the same standards and compare the plans' performance in meeting the measures. This would allow the Division to better judge the strengths and weaknesses of the plans and enroll members in a plan which may be better able to improve their health. For example, if Magnolia is outperforming United for patients with asthma, the Division could use the performance measures to direct more patients with asthma to Magnolia.

It is also unclear whether there exists a direct consequence for the plans for failure to meet the Children and Adult Quality Measures. Sanctions clearly exist for failure to timely file reports or failure to satisfy other requirements of the contract, but we did not see where the Quality Strategy clearly describes the sanctions for failure to improve health outcomes described in the Quality Measures. As long as the plans are being paid to improve health outcomes, it seems appropriate to emphasize that failure to do so is more consequential than failure to timely file a report. Given the program's objectives, we believe improving quality outcomes should be more consequential for the CCOs than filing reports.

Finally, the Quality Strategy fails to incent the CCOs to work with providers to improve patient outcomes. Without meaningful consequences for the CCOs to improve patient care, the CCOs need only satisfy the voluminous reporting requirements and the minimal network adequacy requirements in order to remain compliant. The relatively few Quality Measures apply primarily to children – the least expensive population per member per month. Even the expected measures fall short of the mark to incent the health plans to make swift improvements in patient health outcomes. The majority of the adult population has been in the MississippiCAN program for 8 years – nearly a decade. The goals on quality measures are set relatively low if the state expects the health plans to make meaningful improvements in their outcomes. For example, the goal for

controlling high blood pressure for adults is less than 50%. Similarly, the goals for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment are less than 47% for Initiation and less than 10% for Engagement.

More stringent oversight and higher expectations should be demanded of the health plans. More incentives for the plans to collaborate with health care providers to improve health outcomes should be required and that collaboration should be measured. The Quality Strategy may satisfy federal requirements, but considering the resources invested by Mississippi taxpayers, it does not raise the bar enough for the CCOs.

Thank you again for the opportunity to comment on the proposed Managed Care Quality Strategy. We appreciate the challenges facing the Division and know that you are working hard to improve the program for the patients and the providers who serve them. MHA is willing to assist you in improving health care outcomes for our patients. We are also glad to discuss alternative models of care with the Division. Please feel free to contact me should you need additional clarification or information.

Sincerely,

T. Richard Roberson
General Counsel
Vice President for Policy and State Advocacy