



January 2011

Mr. Jay Angoff  
Director, Office of Consumer Information and Insurance Oversight  
Department of Health and Human Services  
Hubert H. Humphrey Building  
Room 737 S-07  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act (RIN 0950-AA06)**

Dear Director Angoff:

The undersigned organizations write to you as members of the Patient-Centered Primary Care Collaborative (PCPCC). We represent a diverse group of over 700 stakeholders on the front lines of health care delivery, including business, consumers, insurers, and clinicians. PCPCC has a number of principles including that primary care and the Patient-Centered Medical Home (PCMH) are the foundations of a high performing health care system.

The medical home model is a key construct to focus care coordination resources, advance the meaningful use of electronic health records, enhance access to the variety of services available to providers and patients and reduce health disparities. In collaboration with supporting practitioners, technologies and health team members, the medical home can provide information and services that improve patient care and population health. A guiding principle of the PCMH is that comprehensive, continuous, coordinated, and preventive care, managed by a highly trained physician (or in certain states, nurse practitioners and physicians assistants) in a transformed practice, can *prevent* complications that could result in a patient becoming high-need or high-cost.

We strongly support enhancements in the delivery of health care through the Patient-Centered Medical Home (PCMH). By acknowledging the patient as the focal point in PCMH, with a skilled primary care provider or clinician working with a team to coordinate care, we know we can positively impact a patient's overall health while decreasing overall health spending. PCMH pilots, both in the private sector

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as well as in Medicaid programs, demonstrate that the PCMH model creates significant savings to the system.

Subsection 2718(a) of the Public Health Services Act as amended by Affordable Care Act (ACA), PL 111-148, directs the Department of Health and Human Services (HHS) to require that health insurance issuers annually report on the percentages of premiums spent on (1) reimbursement for clinical services, (2) activities that improve health care quality, and (3) all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing and regulatory fees. Further, subsection 2718(d) directs the Secretary in consultation with the National Association of Insurance Commissioners, to establish uniform definitions including for these categories. Section 2718(b)(1)(A) of the PHS Act provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year, provide an annual rebate to each enrollee under such coverage if the ratio of: (1) The amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than the following percentages:

- (1) 85 percent for coverage offered in the large group market (or a higher percentage that a given State may have determined by regulation); or
- (2) 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given State may have determined by regulation), except that the Secretary may adjust this percentage for a State if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that State).

The National Association of Insurance Commissioners (NAIC) issued recommendations on the definitions of medical loss ratio (MLR) and Office of Consumer Information and Insurance Oversight (OCIIO) has issued the interim final rule (IFR) with a request for comments. We commend the NAIC's leadership and thoughtful deliberations and the work of NAIC and OCIIO but want to offer certain comments. The issues raised by the rule are extremely complex. There are essentially two types of category of costs: (1) the preferred categories that provide credit toward the 85% or 80% requirements and (2) those costs that do not.

We recommend that OCIIO include as under the preferred categories those activities that promote practice transformation of care delivery at the practice level and those which promote the patient centered medical home and use of primary care in Accountable Care Organizations. Such activities will require continuous quality improvement and a reinvention of the practice to increase quality of care and outcomes and should be consistent with the goals of health care reform. Eligible activities should include activities and payments for related demonstrations and

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pilots. Insurer payments or support for PCMH and primary care practice transformation should be credited in the preferred categories. A more narrow definition undermines national efforts to bolster primary care and support transformation in the delivery of health care through the patient centered medical home.

We note that new Public Health Service Act section 2717 describes quality reporting activities to include those designed to:

... (A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model ....for treatment or services under the plan or coverage;...

Our reading is that the phrase, “including through the use of medical homes” modifies the phrase “implementation of activities.” In other words, use of a medical home is per se a quality improvement activity. It would be unfortunate if expenses designed to aid practice transformation through medical homes were in a category that could penalize insurers or providers.

Taken as a whole, the IFR provides credit for much of the cost borne by either the insurer or paid to providers for medical home transformation and operations as well as other practice transformations. However, there appear to be several needless restrictions and gaps.

In this respect § 158.150 (b)(1)(ii) states that only activities that are capable of being objectively measured and of producing verifiable results and achievements will satisfy the requirements. Such a qualifier raises questions that would require much additional interpretation. We believe there is broad evidence supporting the general benefits of medical homes, but questioning measures, results and achievements in such a context will be an additional source of confusion and may inhibit participation by private sector payers.

Similarly there is language of restriction in 158.150(b)(1)(iii) which states that expenses in the quality category must be “directed toward individual enrollees or incurred for the benefit of specified segments of enrollees...” This should not be read to exclude costs devoted to practice transformation for a medical home. Such activities may not be directed toward individual enrollees or benefit specified segments of enrollees.

Section 158.150(b)(1)(iv) requires that quality expenditures be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. Again, we would suggest language that makes clear that payments or activities which promote medical homes per se meets such criteria. In addition we would suggest that participation in demonstrations and pilots may well be ways to create an evidence base. The requirement of (b)(1)(iv) would seem to require evidence before a demonstration or pilot.

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The interim final rule in 158.150(b)(2)(i)(A)(1) includes case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical home model. However, this is the only reference to medical home and the reference appears limited to the prior phrases. Moreover, the whole reference does not appear to eliminate the restrictions posed in 158.150(b)(1).

We have reviewed whether section 158.140 related to reimbursement for clinical services provided to enrollees solve some of the problems we are raising. However, we remain concerned that this section does not. It is unclear whether support for practice transformation activities and demonstrations would fall under the category reimbursement for clinical services provided to enrollees. Some expenses will not be from “incurred claims.” It appears helpful that, under 158.140(b)(2)(iii), incentive and bonus payments related to incurred claims is included in the preferred category. On the other hand, 158.140(b)(3)(iii) does not credit amounts paid to a provider for professional or administrative services that do not represent compensation or reimbursement for covered services. So money provided to participate in demonstrations or to support medical homes may or may not be covered.

The PCPCC payment reform task force has recommended piloting of several models and hybrids to gain further experience in the context of appropriate payment policies. Insurance companies and health plans should not be constrained by a fee-for-service model with respect to the general payment structure for patient care. One of the important issues for the country, for medical homes and Accountable Care Organizations (ACOs) will be to reduce uncoordinated care, unnecessary care, waste, fraud, and abuse.

Section 158.150 (c)(1) states that the quality improvement category should not include activities designed primarily to control or contain costs. This primary purpose test should not pose a restriction that penalizes reduction in uncoordinated care, unnecessary care, waste, fraud, or abuse activities or incentives related to such areas. Such an approach would be counterproductive for primary care, practice transformation, and the challenges facing our Nation. Section 158.150(c)(14) also appears to make it difficult to credit specific activities that reduce unnecessary utilization. PCPCC has worked on issues related to value-based insurance design and practice transformation. There are strong expectations among employers and payers that we must address these problems as part of practice transformation, medical homes, and ACOs. These expectations are, of course, tied in to efforts to improve quality in the overall approach. However, we would be concerned if the rule segregated individual efforts to control cost when they are part of a matrix of efforts which also improve quality. Moreover, as there are limited resources the ability to redirect payments toward quality activities by other cost-reducing activities should not be penalized.

Sincerely,

Academy of Managed Care Pharmacy  
American Academy of Family Physicians

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American College of Osteopathic Family Physicians  
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Association of Departments of Family Medicine  
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Central Jersey Physician Network  
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Employers Health Coalition of Ohio, Inc.  
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