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January 11, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Via Electronic Submission (www.regulations.gov)

Re: Medicaid and CHIP Managed Care Proposed Rule, File Code CMS–2408–P

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled, *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care*, 83 *Fed Reg* 57264 (November 14, 2018).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Among the missions of major teaching hospitals is the provision of care to large numbers of Medicaid and uninsured patients. Representing only five percent of all U.S. nonfederal, short-term general hospitals, major teaching hospitals are the sites for approximately a quarter of all Medicaid hospitalizations. As vital providers in the Medicaid health care delivery system, teaching hospitals and their associated clinical faculty are committed to participating in reforms aimed at improving access to timely care and effective quality improvement activities. Ensuring that teaching hospitals and their networks of physicians who work through their faculty practices are able to participate in Medicaid managed care networks is more important than ever to achieving these aims now that increasing numbers of Medicaid beneficiaries are enrolled in managed care.

CMS reviewed the current Medicaid and Children's Health Insurance Plan (CHIP) managed care regulations with the goal of achieving a better balance between federal oversight and state flexibility, while still protecting Medicaid enrollees and improving their quality of care. The proposals involved areas such as actuarial

soundness standards, special contract provisions related to payment, and certain pass-through payments including for GME. Our comments below focus on the following:

- Medicaid Graduate Medical Education (GME) Payments
- Directed Payment Prohibition
- Network Adequacy Standards
- Setting Actuarially Sound Capitation Rates for Managed Care Programs

GRADUATE MEDICAL EDUCATION

Investments in (GME through state Medicaid programs are vital to the training of our nation's physician workforce and represent a large source of funding for physician training. As of 2015, 42 states and the District of Columbia provided GME payments through their Medicaid programs.[1] These investments in local physician training are essential to ensuring an adequate healthcare workforce to meet the needs of newly insured populations and all Americans.

The AAMC appreciates CMS's prior rulemaking affirming GME's appropriate place as a State expenditure eligible for federal financial participation (FFP). The Association also lauds the Agency's reiteration of that position in the current proposed rule and the Agency's decision to maintain State flexibility regarding how Medicaid payments for GME are structured. Allowing GME funding to be distributed to providers directly or through managed care capitation contracts enables each state to target its workforce training investments in the most effective manner for its unique Medicaid program and healthcare marketplace.

DIRECT PAYMENT PROHIBITION

CMS Must Expand Flexibility for Minimum Payment Rates to Providers

The current exception allowing states to direct minimum payment rates made by managed care plans mandates that such minimum rates are applied uniformly across a class of providers. This means that states cannot target their scarce resources where they are most needed, resulting in unnecessary waste. CMS could best address this issue by removing 438.6(c) from the final rule and adding a new paragraph (c)(iv) providing that the state may require plans to make enhanced payments to providers to account for CMS-approved, policy-based supplemental payments in their Medicaid state plan.

The AAMC appreciates CMS's clarification that states may dictate minimum payment rates to certain classes of providers paid through managed care plans and that such minimum rates may be based on a variety of different methodologies, not simply rates paid in fee for service (FFS). Allowing states to base minimum payment rate determinations on other reasonable standards, including Medicare rates, commercial market rates, and new innovative models will give states more tools to improve access for Medicaid beneficiaries.

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[1] Henderson, T.M. (2016) Medicaid Graduate Medical Education Payments: A 50-State Survey. *The Association of American Medical Colleges.*

While the Association understands CMS's interest in precluding such minimum payment rates from being based on relative federal financial participation (FFP) rates, other specifications within provider types may be necessary to achieve state policy goals around access and quality. The AAMC encourages CMS to clarify that states may set minimum payment rates for providers within a class that meet a certain criterion. Such criteria could include provision of particular types of services, especially those for which the state is concerned about access, or participation in new delivery reform models or public health initiatives.

CMS Should Finalize Multi-Year Approval of Direct Payments

CMS proposes to allow multi-year approval of directed payment arrangements under certain conditions, rather than requiring annual federal approval. The AAMC supports this added flexibility and asks CMS to finalize this policy as proposed. Academic medical centers have been on the cutting edge of developing and participating in innovative payment models and delivery system reforms. These new payment arrangements are most effective when payers and providers make multi-year commitments to quality outcomes and savings goals so that new initiatives have time to be implemented. Providers and plans must know that state investments in these new payment arrangements will be reliable through the length of the contract, and CMS's proposed policy will help to achieve that aim.

LONGER PERIOD NEEDED FOR TRANSITIONAL PASS THROUGH PAYMENTS FOR NEW MANAGED CARE POPULATIONS

In 2016 and 2017 rulemaking, CMS prohibited pass-through payments, as defined at §438.6(a), except in certain, narrowly defined circumstances. To allow states adequate time to transition from using pass-through payments to value-based and actuarially sound capitation rates, CMS allowed prohibited pass-through payments to continue for 10 years for hospital pass-through payments so long as the payments diminished annually and to continue for 5 years for pass-through payments to other providers. In setting these defined transition periods, CMS prohibited states from establishing new pass-through payments or increasing existing pass-through payments during these wind-down periods.

In the current proposed rule, CMS acknowledges that prior regulations did not adequately anticipate how states moving new populations of beneficiaries from fee-for-service payment systems to managed care would be expected to incorporate supplemental payments from fee-for-service arrangements into new capitation rates. CMS now proposes to allow states to create new pass-through payments via contracts covering populations newly moved into managed care, but that such new pass-through payments must sunset within three years.

The AAMC appreciates the Agency's recognition of the importance of thoughtfully transitioning supplemental payments to providers as Medicaid beneficiaries are enrolled in managed care for the first time. We support CMS's proposal to allow states to establish new pass-through payment requirements to achieve this aim, however **we believe that three years is too short a transition period**.

In many states, the beneficiaries still remaining in fee-for-service payment arrangements have complex care needs, requiring specialized services and additional State investments to ensure access and well-coordinated care. Transitioning these multi-faceted payment arrangements, including essential supplemental payments, from fee-for-service to managed care is likely to be every bit as complicated as previously established pass-through payments, if not more so. In designing payment systems to accommodate the needs of these most vulnerable of

patients, states should have every flexibility necessary to do it well. Allowing states, plans, and providers the same latitude and timeframe already granted for similar transitions is both logical and prudent.

CMS offers no meaningful justification as to why the transition period for new supplemental payments should be limited to three years. It is unclear why a three-year transition period is appropriate for all provider types in states now moving to managed care, whereas prior rulemaking established a minimum of a five-year transition period for most providers and a ten-year transition period for hospitals. The AAMC urges CMS to revise its proposal to align with the transition periods previously established for pass-through payments already in existence in 2016. **At a minimum CMS should allow a 5-year transition period for newly established pass-through payments.**

STRONGER NETWORK ADEQUACY STANDARDS NEEDED

The AAMC is alarmed by CMS's proposals to weaken network adequacy standards applied to Medicaid managed care plans. Meaningful network adequacy is vital to ensuring timely access to health care services, an all-too-frequent shortcoming of many Medicaid programs. Through prior rulemaking, CMS established that federal network adequacy standards were to be viewed as minimums – not ceilings. Under current regulations states already have the flexibility to add innovative and locally-tailored requirements to their programs to meet state needs. No additional rulemaking is required if the Agency's goal is to allow states the flexibility to improve their network adequacy standards for Medicaid managed care plans. The "flexibility" proposed in the current rule will only weaken network adequacy and diminish access for patients.

CMS Should Require Time and Distance Standards

States are currently required to impose time and distance standards on Medicaid managed care plans to ensure that patients have access to all the provider types they may need within their geographic area. As we commented previously, the AAMC believes time and distance standards to be a bare minimum network adequacy requirement, but a vital one. CMS now proposes to allow states to use any quantitative metric to ensure network adequacy and gives examples such as provider-to-payment ratios and maximum appointment wait times. CMS states that it sees the value in multiple quantitative metrics that evaluate different aspects of network adequacy and patient access. To that end CMS "encourage[s] states to use the quantitative standards in combination – not separately – to ensure that there are not gaps in access to and availability of services for enrollees." (p. 57279) Setting a federal minimum requirement for the use of time and distance standards while allowing states to select additional standards is more likely to result in a comprehensive approach to network adequacy rather the CMS proposal which will result in having no meaningful federal minimum at all.

The AAMC previously commented in favor of a federal requirement to include appointment wait times as one aspect of network adequacy standards and that CMS establish a uniform maximum appointment wait time to serve as a national standard. We continue to advocate for this addition to CMS's regulatory framework. At a minimum, the AAMC urges CMS not to finalize any proposal to diminish or loosen federal network adequacy requirements already in place.

CMS Should Establish A Minimum Federal Definition of Specialist

In its 2016 rulemaking CMS required States to set network adequacy standards for broad categories of provider types, including primary care, adult and pediatric specialists, hospitals, and others. The Agency now seeks to

clarify that the definition of 'specialist' is to be set by states "in any way they deem most appropriate for their programs." (57279). While the AAMC appreciates CMS's acknowledgement of the ambiguity in its prior rulemaking, we **urge the use of a minimum federal definition upon which states have the flexibility to expand.**

The basic intention of network adequacy standards is that all Medicaid beneficiaries have timely access to medically necessary covered services. According to CMS, some states believe that they must set a standard for every possible specialist. The AAMC suggests that CMS clarify that Agency's intent is that Medicaid managed care plans must have adequate provider networks to provide all the services they cover. If maternity care is covered, plans should be required to demonstrate that they have adequate networks of obstetricians. If care for depression is covered, plans should be required to demonstrate that they have adequate networks of psychiatrists. While a plan may have a sufficient number of overall specialists for a given population those specialists may represent an abundance of cardiologists and a dearth of neurologists or gastroenterologists. CMS must establish standards that ensure states have adequate networks of each specialty type necessary to provide the services covered under the managed care contract.

Further, the AAMC reiterates its comments that the existing broad categories for which states are required to establish network adequacy standards are inadequate. The AAMC requests that CMS establish further categories to ensure that access is available for additional essential provider types. In particular, the AAMC recommends that states set separate standards for, though not limited to, ACS Level I trauma centers, inpatient psychiatric units, mental and behavioral health providers, substance abuse services, providers that offer wrap-around social services, and specific specialty providers with known workforce shortages in the state.

CMS Should Retain the Requirement for Actuarially Sound Rates for Managed Care Programs

The AAMC is disappointed to see the Agency's proposals to diminish federal oversight of the adequacy of payment rates to Medicaid managed care plans. Taken together, the policy changes in this proposed rule will undoubtedly result in lower payment rates to managed care plans and providers with minimal, if any, consideration of the effects on patient access to care.

While there are many aspects of individual State Medicaid programs that should be tailored to local needs, overarching federal standards and robust oversight are necessary to ensure that Medicaid programs adhere to federal law – paying sufficient rates to maintain network adequacy and offering access comparable to that available to Medicare beneficiaries and commercially insured individuals. Amidst state budget constraints and a rapidly changing health system, many Medicaid programs are already falling woefully short of these legal requirements.

The Agency's proposal to allow states to certify rate ranges as actuarially sound rather than requiring actuarial soundness for each rate cell is a step backwards. The AAMC urges CMS not to finalize this policy. Rate ranges obfuscate payment rates from in-state stakeholders and federal oversight. The rate-setting process calls for more transparency, not less, and assuring the adequacy of state and federal investment in patient care is not an area where states, their actuaries, or CMS should shy away from thoroughness and due diligence.

Similarly, the Agency's proposal to allow states to make "de minimus" changes to managed care plan payment rates, defined as changes of 1.5% or less should not be adopted. While a 1.5% reduction may seem minor and

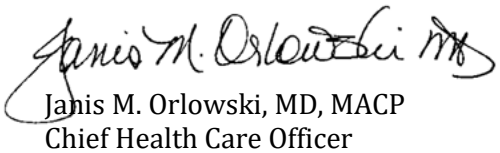
inconsequential, the size of these overall contracts means that such reductions could draw millions of dollars in resources out of the Medicaid program and away from safety net providers and the patients they serve without any oversight or recourse. CMS notes that its prior rulemaking established 1.5% fluctuations in rates to be within actuarial soundness standards. CMS now goes a step further by "clarifying" that states do not need to submit a revised rate certification or justification to CMS.to certify a change of 1.5% up or down. For those rate ranges that may already be at the lower bound of actuarially soundness a downward adjustment of even 1.5 percent may threaten access and patient care. Most alarmingly, CMS does not propose any prohibition on states using these de minimus adjustments year over year although the cumulative effect of multiple downward adjustments may be quite devastating cuts and will occur without public input or federal oversight.

The Supreme Court ruling in Armstrong v. Exceptional Child Center[2] is reminder that CMS is the sole enforcer of Medicaid payment adequacy. In that role CMS has the responsibility to set minimum payment standards and establish a direct oversight process of provider rates.

As the sole enforcer of provider rate sufficiency in Medicaid managed care plans, and with no other course of redress available to providers, CMS should make review of provider payments a standard element of capitation rate review. As part of this process, CMS should invite public comment on provider rate adequacy, and support this public comment process with transparent sharing of the analysis submitted by managed care plans to support claims of payment adequacy. In this review CMS should also consider the effective payment rates paid to providers if some of the state-share of reimbursements is derived from taxes on providers themselves. Given the longstanding concern expressed by the provider community about underpayments in Medicaid, CMS should consider its "in the event concerns in these areas arise"[3] already met and institute regular reviews as a standard course of business.

If you have questions or need additional information please contact Ivy Baer, ibaer@aamc.org or 202-828-0499.

Sincerely,



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Cc: Ivy Baer, AAMC

[2] Armstrong v. Exceptional Child Center, 135 S. Ct. 1378(2015).
[3] 80 Fed. Reg. 31120 (June 1, 2015)