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May 22, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C.

sent via e-mail to:seema.verma@cms.hhs.gov

Re: Medicaid Managed Care Rule

Dear Administrator Verma:

We understand the Administration is reviewing the policies in the Medicaid managed care rule (88 Fed Reg 27498, May 6, 2016) to determine which policies to keep and which to revise. Access to care for Medicaid enrollees requires that the processes for setting rates, ensuring network adequacy, and maintaining the integrity of Medicaid managed care arrangements are transparent and fact-based. Therefore, the Association of American Medical Colleges (AAMC) strongly supports many key elements of the rule and, as is discussed in more detail below, urges CMS not to abandon crucial standards or weaken federal oversight that help safeguard program integrity and the appropriate use of federal dollars.

The AAMC is a not-for-profit association representing all 147 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 nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Major teaching hospitals make up only 5 percent of all hospitals, yet they provide 20 percent of all Medicare hospitalizations, 21 percent of all hospital care, 25 percent of all Medicaid in-patient days, and 35 percent of all charity care. Additionally, major teaching hospitals have large ambulatory clinics that often become surrogate medical homes for individuals living in neighborhoods without access to other sources of care. Teaching hospitals are core institutions in the health care safety net and serve a disproportionate number of Medicaid and CHIP beneficiaries. They support efforts to ensure that Medicaid patients have access to care and are all too aware when Medicaid policies threaten that access. While state Medicaid programs vary considerably, the federal government can do more to ensure that this variation is used to innovate and improve health outcomes—not to allow payment rates that are too low and networks that exclude key providers of the Medicaid population.

Rather than dictate to states the rates they should set or the standards for how to ensure access to care, the rule established a more transparent, data-driven process for states as they set rates and certify network adequacy. Both rate setting and certification of network adequacy are critical for managed care plans to meet the obligations of the Medicaid program to provide enrollees with timely access to quality care. The Medicaid statute allows a state to require beneficiaries to enroll in managed care and thereby restrict the number of providers in its network "if such restriction does not substantially impair access to services." (emphasis added). Over 90 percent of Medicaid beneficiaries live in states that contract with Managed Care Organizations to provide comprehensive Medicaid services that include larger geographic areas and patients with complex needs.

It is appropriate for states to have the primary role in assuring these protections. Yet, the Department of Health and Human Services (HHS) must continue to set minimum standards given its responsibility under the law, the significant federal funding in question, and the growth of managed care in Medicaid for those with complex medical conditions. This responsibility is all the more important in light of the Supreme Court's decision in Armstrong v. Exceptional Child Center, Inc. that held that providers may not challenge statutory violations related to states' implementation of Medicaid managed care through legal action. HHS and CMS have sole authority to ensure compliance with the law.

Below are specific provisions in the final rule that the AAMC believes should be retained and one provision that should be expanded.

The development of appropriate and adequate payment rates. The Medicaid Managed Care rule offers multiple key provisions that – both directly and indirectly – support the development of appropriate and adequate payment rates. Development of actuarially sound capitation rates as outlined in the rule, including requiring states to identify the actual rate or rates it is planning to pay, are basic, but critical components in ensuring a reasonable rate-setting process. Specifically, the following provisions must be maintained:

- The clarification that "actuarially sound" means capitation rates projected to provide for all reasonable, appropriate, and attainable costs compared to the costs associated with providing the services in a free market.
- The requirement that CMS review capitation rates to ensure actuarial soundness, including that rates are: developed in accordance with generally accepted actuarial practices and principles; adequate to meet plan requirements; specific to payments for each rate cell under the contract and do not cross-subsidize any other rate cell; meet applicable special contract provisions; developed in accordance with the plan's ability to achieve the set MLR standard; and, certified by an actuary.
- The establishment of clear procedures that must be followed for setting actuarially sound capitation rates, including that any minimum provider payment expectations included in the contract would necessarily be built into the relevant service components of the rate and that capitation rates must be appropriate for the population(s) to be covered and the services provided under the managed care contract.
- The development of clear requirements for rate certification submission, including that states must submit for review and approval all rate certifications concurrent with the review and approval process set forth for standard contract requirements.

Plan reimbursement to providers. States' ability to address key policy goals by setting specific provider reimbursement requirements is critical to ongoing delivery system reform and to assuring access to key providers and services. Specifically, we urge CMS to maintain the following provisions:

- States' flexibility to establish plan requirements for minimum payment rates to certain classes of providers. This is critical in ensuring that safety net providers - many of which are teaching hospitals and their faculty practice plans - are able to continue to provide a disproportionate share of care to Medicaid beneficiaries.
- States' ability to set higher reimbursement standards for particular types of services. This further promotes access to specialized services for the complex patients increasingly enrolled in Medicaid Managed Care - an issue of growing importance.

Network Adequacy. The rule made significant progress in addressing ongoing concerns relating to network adequacy beyond the development of appropriate and adequate payments rates. At a minimum, it is essential that no changes be made to requirements that states establish key network adequacy parameters and consider access indicators. The final rule maintains state flexibility while modernizing the current regulatory framework to reflect the increasing prevalence and maturity of Medicaid managed care delivery systems. The following key provisions of the rule should be maintained, if not expanded upon:

- Requirements that at a minimum the state establish network adequacy standards for specified provider types to ensure that enrollees have access to all services covered under that state plan in a manner that is consistent with the state-set standards for access and availability.
- Key elements of these standards include time and distance requirements for primary care (adult and pediatric); OB/GYN; behavioral health, specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types that promote the objectives of the program as determined by CMS.

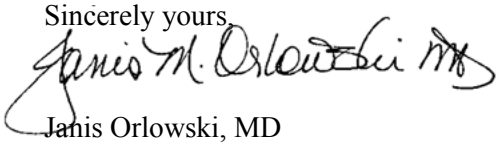
Graduate Medical Education (GME) and Other Exceptions to the Prohibition on Pass-Through Payments
The Rule constrains states' ability to ensure that payments intended for hospitals and other providers are paid and overlooks states' increasing reliance upon providers to generate sources of non-federal share for their Medicaid programs. These financing mechanisms have left hospitals increasingly reliant on supplemental payments - including those passed through managed care plans - to approximate adequate payment for services provided to Medicaid patients.

The AAMC appreciates the importance of the exceptions to the prohibition on so-called "pass through payments" - including those for GME – and urges CMS to retain this policy. The AAMC's 2016 report, *Medicaid Graduate Medical Education Payments: A 50 State Survey* found that forty-two states and the District of Columbia made GME payment under their Medicaid program in 2015. Further, 61% of the Medicaid GME payments were made under managed care. The Association suggests that CMS broaden the reasons for which states may make enhanced payments to providers. While encouraging states to implement value-based payment programs and other programs that are tied to delivery system reform, other activities also should be encouraged and rewarded, such as the provision trauma, burn and other services not found elsewhere.

I would be happy to meet with you and your staff to discuss these ideas in more detail. If you have questions regarding our comments or would like to set up a time to discuss our comments, please feel free

to contact Ivy Baer at ibaer@aamc.org or 202.828.0499 or Mary Mullaney at mmullaney@aamc.org or 202.909.2084.

Sincerely yours,



Janis Orlowski, MD