

January 14, 2019

Mr. Chris Taylor  
Acting Deputy Administrator and Director  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

**RE: CMS–2408–P, Proposed Rule: Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care (Vol. 83, No. 220, November 14, 2018)**

Dear Mr. Taylor:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed revisions to the Medicaid and CHIP managed care regulations.

The AHA has supported CMS’s efforts over the last several years to modernize the Medicaid managed care regulations to more closely align with the Medicare Advantage program as well as private insurance. In general, AHA believes these efforts have helped promote a more accountable and transparent process for how state Medicaid capitation rates are established and how health plan premium dollars are spent. They have included policies to standardize requirements for the state capitation rate setting process and health plan medical loss ratios (MLR), provider network adequacy standards, strategies for quality improvement, and increased flexibility for managed care payment for care that individuals receive in Institutions for Mental Diseases (IMDs). This proposed rule is intended to build on these current efforts to grant state Medicaid agencies greater flexibility to tailor their Medicaid managed care programs to meet the needs of their populations as well as address state agencies’ concerns regarding administrative burden. **While the AHA generally supports CMS’s efforts to grant greater state-level flexibility and reduce regulatory burden, we do believe the agency needs to strike the appropriate balance between federal standards and**



**state flexibility to ensure Medicaid enrollees have timely access to quality care services.** AHA's more detailed comments regarding the proposed rule follow.

### **PROVIDER PAYMENTS IN A MANAGED CARE SETTING**

The key provisions related to provider payment in the current managed care regulatory structure are the treatment of provider pass-through payments and directed provider payments supporting delivery system reform or performance improvement. The rule proposes several changes to these policies intended to increase state flexibility.

**Pass-through Payments. The AHA supports CMS's proposal to allow states new to Medicaid managed care the opportunity to transition their fee-for-service (FFS) supplemental payments to their managed care programs. AHA recommends, however, that CMS extend the transition to a longer period of time, at least five years or more.** The rule proposes to allow states new to Medicaid managed care the opportunity to transition their FFS-based supplemental payments to their managed care programs if they meet certain criteria. The pass-through amounts would be less than or equal to the amount of the existing FFS upper payment limit supplemental payments and the transition period would be three years. While CMS's 2016 Medicaid managed care regulation prohibited the use of pass-through payment programs, it did allow certain states to transition their FFS-based payments into their managed care contracts if their payment programs were in place prior to July 5, 2016. States looking to adopt managed care programs after 2016 were not able to take advantage of the pass-through payment policy. According to CMS, this policy affected a number of states. In 2016, 26 states still had more than 20 percent of the Medicaid populations under FFS and three states had 100 percent of their populations in FFS.<sup>1</sup>

**While this proposed change would provide new managed care states with ways to help hospitals dependent on supplement payments transition to managed care, the AHA continues to believe that CMS should rescind its prohibition of FFS-based supplemental payments in managed care contracts.**<sup>2</sup> States should be allowed the flexibility to use pass-through payments to ensure access to safety-net hospitals as well as enable hospitals to support state objectives, such as meeting population health goals, promoting health equity and access to quality care, and supporting Medicaid beneficiaries with complex health needs.

**Directed Provider Payments.** The 2016 regulations also allow states to direct managed care plans to support high-quality, integrated care through setting minimum reimbursement standards or fee schedules for providers, and raising provider rates in an effort to enhance access to quality services. The directed payment policy is intended to allow states to improve provider payments or use performance-based payment

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<sup>1</sup> Federal Register, Vol. 83, No. 220; Nov. 14, 2018, Rules and Regulations p. 57272.

<sup>2</sup> AHA Dec. 5, 2017 letter to Brian Neale, director and deputy administrator, Center for Medicaid and CHIP Services

approaches. CMS notes in the rule's preamble that, since the 2016 regulation, many states have sought to implement directed provider payment arrangements and based those payment arrangements on the rates already approved in the state Medicaid plan. To address issues and questions regarding these arrangements, CMS proposes several changes to streamline the approval process for directed payment arrangements linked to the state plan-approved rates, and allow states more flexibility to experiment with new payment models. The proposed changes also would redefine FFS-based supplemental payments as not a state plan-approved rate, allow directed payments arrangements that use state plan-approved rates without prior approval, and permit multi-year approval of directed payment arrangement programs in certain circumstances.

**In general, AHA supports the proposed increase in flexibility for states in designing directed payment arrangements. The AHA, however, is concerned that some of the proposed changes could restrict states' ability to use certain types of provider payments in directed payment arrangements or be used by states to restrict provider payment. The AHA recommends that CMS reconsider some of these proposed changes, as well as provide sufficient oversight to ensure beneficiary access is not affected by limiting these provider payment arrangements.**

One of the rule's proposed changes would allow states to benchmark directed payment arrangements based on already approved state plan rates. While this proposal could enhance state flexibility, it also could become problematic for providers under certain scenarios. For example, a state could establish a rate that is not adequate to reimburse providers for the cost of care provided and then proceed to use that rate as a benchmark for the managed care directed provider payment arrangement. In this scenario, the benchmark rate would run counter to the original intent of the directed provider payment concept established in CMS's 2016 Medicaid managed care regulation. That original intent was to allow states to direct managed care plans, through the directed payment arrangements, to support high-quality, integrated care through setting minimum reimbursement standards or fee schedules for providers, and raising provider rates in an effort to enhance access to quality services.<sup>3</sup> If the benchmark rate is not adequate, it would make it difficult for managed care plans to use directed provider payment to enhance access to quality services.

The Commonwealth of Massachusetts, for example, currently has used the directed payment arrangement authority to tie hospital payments to a minimal percentage of the state plan FFS rate. This state policy has resulted in restricting managed care organization (MCO) payments to hospitals, interfering with the ability of MCOs and hospitals to negotiate payment based on value and service, ultimately running counter to the original intent of directed provider payment arrangements. In addition, it appears that the Commonwealth of Massachusetts used the directed payment arrangements in managed care as a budget tool rather than a tool to tie payment to value.

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<sup>3</sup> Federal Register, Vol. 81, No. 88; May 16, 2016, Rules and Regulations p. 257588.

Another concern of the proposed changes would be redefining state supplemental FFS payments so they no longer could be considered a state plan-approved rate. The effect of this proposed change would be to exclude supplemental payments from directed payment arrangements. The group of states that would be affected by this definitional change are those states with pass-through payment programs in place prior to July 5, 2016 that are still transitioning these payment programs into managed care contracts. For example, California has directed payment programs based on its transitioning pass-through payments, which would no longer qualify under this new definition of supplemental payments. This proposed change ultimately conflicts with CMS's 2016 regulation that intended to grant states time to integrate these supplemental payments into managed care arrangements and envisioned that the directed payment arrangements could serve as one pathway to accomplish that integration.<sup>4</sup>

#### PROVIDER NETWORK ADEQUACY

**Time and Distance Standards.** CMS's 2016 Medicaid managed care regulation established important Medicaid enrollee protections by requiring that states contracting with managed care plans establish minimum provider network adequacy standards to support access to care. Key components of those minimum requirements were time and distance standards for the provider types covered under the managed care contracts, including adult and pediatric specialists. The AHA supported these important Medicaid enrollee protections as well as the established flexibility for states to determine appropriate exceptions to the time and distance standards. The Medicaid and CHIP Payment and Access Commission (MACPAC) discussed the proposed rule at its December 2018 meeting, and MACPAC staff noted that all states currently use time and distance standards and that the current exceptions process grants states' considerable flexibility.<sup>5</sup>

The AHA is disappointed that CMS is proposing to replace the time and distance standard with less-defined state-established quantitative network adequacy standards. While CMS outlines several quantitative standards states could use, such as a percentage of contracted providers accepting new patients, wait times for appointments, and provider-to-enrollee ratios, these are suggestions only and not requirements. While CMS argues that the proposed change would give states needed flexibility, the AHA believes the current exception process gives states that needed flexibility. **As such, the AHA opposes CMS's proposal to weaken the network adequacy standards by replacing the requirement that states establish time and distance standards with state-established quantitative network adequacy standards.** In addition, the AHA is concerned that CMS's proposed clarification that the states have the authority to define adult and pediatric specialists for purposes of provider network adequacy could further

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<sup>4</sup> Federal Register, Vol. 81, No. 225; Nov. 22, 2016, Rules and Regulations p. 83779.

<sup>5</sup>MACPAC, Dec. 13, 2018 staff presentation, [www.macpac.gov/wp-content/uploads/2018/12/Review-of-Proposed-Revisions-to-Medicaid-and-CHIP-Managed-Care-Rules.pdf](http://www.macpac.gov/wp-content/uploads/2018/12/Review-of-Proposed-Revisions-to-Medicaid-and-CHIP-Managed-Care-Rules.pdf).

weaken network adequacy standards for vulnerable enrollees with complex medical conditions that need specialty care.

**Provider Directories.** Current managed care regulations require states to ensure that managed care plans maintain and update provider directories and make the directories available in electronic or paper form. The maintenance and updating of provider directories continues to be an important component of ensuring an adequate network. CMS recommends that states allow managed care plans to update the paper version of their provider directory on a less frequent basis if they offer enrollees a mobile-enabled electronic directory in addition to the web-based provider directory. **The AHA supports CMS's proposed changes to allow for enhanced electronic access to provider directories.**

### **QUALITY RATING SYSTEM**

The 2016 managed care regulations established that CMS, in consultation with states and other stakeholders, would develop a quality rating system (QRS) framework, including the identification of performance measures and methodologies, which states could adopt. CMS has yet to finalize the CMS-developed QRS framework. According to the current regulations, states have the option to use the CMS-developed framework or establish a state-specific QRS producing substantially comparable information about plan performance subject to CMS approval of the alternative system. The proposed rule changes the requirement that the information yielded be substantially comparable to give states greater flexibility to meet this standard while enabling meaningful comparison across states. In addition, the proposed rule reaffirms CMS's commitment to engage with states and other stakeholders in developing subregulatory guidance on what it means for an alternative QRS to yield substantially comparable information, and how a state would demonstrate it meets the standard.

**The AHA supports the proposed updates to the QRS criteria, and appreciates that CMS is seeking to foster alignment with other CMS measurement initiatives.** We encourage the agency to further promote alignment between measures used in the QRS and the agency's "Meaningful Measures" framework. The AHA has long urged the agency to reduce and prioritize the measures used in its quality programs so that they focus on the issues that matter the most to improving care and outcomes. CMS's Meaningful Measures framework identifies six overarching quality priorities and 19 specific measurement areas aligned with those priorities. The priorities CMS identified are intended to cut across the full continuum of its quality measurement programs – hospitals, physicians, post-acute care and health plans. The AHA is pleased that most of the "meaningful measure" priority areas proposed in this rule are ones that we have consistently recommended to the agency.

## **INSTITUTIONS FOR MENTAL DISEASES AND MANAGED CARE**

CMS's 2016 managed care regulations granted states important new flexibility to use managed care to improve access to mental health services for those enrollees aged 21 to 64 and subject to the IMD exclusion. Specifically, CMS's regulations allow states to pay managed care plans for the care provided to adult enrollees who have a short-term stay of no more than 15 days in an IMD, as long as the facility is an inpatient psychiatric hospital or a sub-acute facility providing short-term crisis residential services. Since the establishment of these 2016 regulations both CMS and Congress have considered further policy changes to the IMD limitations to improve access to short-term inpatient psychiatric and substance use disorder treatment for the Medicaid population. CMS, through the 1115 waiver structure, has looked to address the IMD limitations outside of the managed care context, as it supports states efforts to improve access to services for those with severe substance use disorders such as those caused by the current opioid epidemic. The SUPPORT for Communities and Patients Act of 2018 granted states the option to provide Medicaid coverage up to 30 days for individuals with substance use disorders who are patients in certain IMDs. While CMS did not recommend changes to its current IMD policy in the proposed rule, the AHA encourages CMS to revisit its policy given the current efforts to expand access to IMD services and treatment for the Medicaid population resulting from not only the 1115 waiver activity but also congressional action. **The AHA recommends that CMS expand the 15-day limit allowing states to improve access to care and treatment through the managed care setting.**

Thank you for your consideration of our comments. We look forward to working with CMS in exploring ways continually to improve the Medicaid managed care program to ensure access to high-quality care for the Medicaid population. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at [mcollins@aha.org](mailto:mcollins@aha.org) or (202) 626-2326.

Sincerely,

/s/

Ashley B. Thompson  
Senior Vice President  
Public Policy Analysis & Development