American Hospital Association

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December 5, 2017

Brian Neale
Director & Deputy Administrator
Center for Medicaid and CHIP Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicaid Managed Care Rule

Dear Mr. Neale:

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 share our comments with regard to the Centers for Medicare & Medicaid Services' (CMS) re-examination of its 2016 Medicaid managed care final rule.

The AHA supports CMS's effort to modernize its Medicaid managed care regulation to more closely align with Medicare Advantage plans and private insurance. Medicaid managed care provides significant opportunities to improve care coordination and health outcomes for the populations served by the program. The AHA supports the final rule's intent to create a more accountable and transparent process for how state capitation rates are established and how health plan premium dollars are spent. Many of CMS's policy changes, such as standardizing requirements for the state capitation rate setting process and health plan medical loss ratios (MLR), provider network adequacy standards and strategies for quality improvement, support AHA members' objective to ensure access to high-quality care.

However, the AHA believes CMS should reverse its policy that prohibits supplemental or pass-through payments made to hospitals through the Medicaid managed care payment system. States have used Medicaid managed care supplemental hospital payments to support a variety of state-specific objectives. CMS's final rule even acknowledged that many states have used such supplemental payments to ensure a consistent payment stream for critical safety-net hospitals in the transition from fee-for-

service to managed care. These supplemental payments also enable hospitals to support state objectives, such as population health goals, promote health equity and access to quality care, as well as support Medicaid beneficiaries with complex health needs. The rule, however, effectively ends the states' use of supplemental or pass-through payments for hospitals in a managed care setting. **The AHA urges CMS to reverse its prohibition on hospital supplemental payments and work with state Medicaid programs and hospitals to explore how these vital funds can support state payment and delivery reform objectives, such as value-based payment arrangements**.

In addition to our concerns regarding supplemental payments, we also wish to comment on the final rule's provisions regarding state capitation rate setting, MLR requirements and expansion of inpatient psychiatric and behavioral health treatment for certain patients in a managed care setting.

The AHA recommends CMS retain the provisions that require states to adhere to greater transparency standards in developing actuarially sound Medicaid capitation rates for managed care plans. Specifically, the final rule requires states to develop rates in accordance with the American Academy of Actuaries' generally accepted actuarial principles and practices. The rule further requires that capitation rates be appropriate for the population covered and the services furnished; adequate for the plan to meet the network adequacy and access standards; and sufficient for the plan to meet the MLR requirements. To help strengthen CMS's oversight role, states are required to submit information that supports the setting of the capitation rates for every managed care plan as well as information regarding the rate-setting process, including the trend factors and adjustments used. These requirements not only ensure greater standardization and transparency in the rate setting process, but also will ensure that capitation rates – rooted in actuarially sound principles – are adequate to ensure enrollees have access to care through robust provider networks.

We also support maintaining the uniform MLR standard for Medicaid and Children's Health Insurance Program (CHIP) managed care plans set at a minimum of 85 percent. Because the MLR measures how much of a managed care plan's premium dollar is spent on patient care, it serves as an important safeguard to help ensure actuarially sound rates and adequate provider payments. **The AHA urges CMS to continue to require a uniform MLR set at 85 percent to better align Medicaid managed care with Medicare Advantage and private insurance markets.**

Lastly, the AHA supports allowing states to pay a capitated payment to managed care plans for enrollees aged 21 to 64 who are subject to the Medicaid Institutions for Mental Disease (IMD) exclusion, but we urge the agency to consider expanding the 15-day limit on enrollees' stay. Specifically, CMS's final rule allows 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. There is a critical need to improve access to short-term inpatient psychiatric and substance use disorder treatment for the Medicaid population. According to CMS estimates, 13.6 percent of

Medicaid eligible adults aged 18 to 64 and eligible for Medicaid have a substance use disorder and are limited in inpatient treatment options because of the IMD exclusion. In addition, the AHA supports the Administration's efforts, outside of the managed care rule, to provide states with greater flexibility through IMD waivers. As the nation tackles its opioid epidemic, these waivers are particularly important to ensure access to treatment for those with severe substance use disorders.

Thank you for your consideration of our comments. We look forward to working with CMS to ensure that the Medicaid managed care program continues to adapt to an ever-changing health care delivery environment. 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 or (202) 626-2326.

Sincerely,

/s/

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