



AMERICA'S ESSENTIAL HOSPITALS

December 21, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-2402-P: Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems

Dear Mr. Slavitt:

America's Essential Hospitals appreciates the opportunity to submit these comments on the above-captioned proposed rule. The association supports the Centers for Medicare & Medicaid Services' (CMS') continued work to modernize Medicaid managed care and better align the regulations with existing standards for commercial health insurance marketplaces. However, the association is concerned about provisions in the proposed regulation that would harm essential hospitals.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only our members can provide. Our members offer this care while operating on margins substantially lower than the rest of the hospital field—a zero percent aggregate operating margin compared with 8.3 percent for all hospitals nationwide.

In addition, our members serve as cornerstones of care in their communities, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn care, and inpatient psychiatric care—which often are unavailable elsewhere. In the 10 largest U.S. cities, our members operate 45 percent of all level I trauma centers, 79 percent of all burn-care beds, and 35 percent of psychiatric beds.¹ In addition, the

¹ Landry C, Ramiah K, Rangarao S, Roberson B. *2014 Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey*. America's Essential Hospitals. June 2016. <http://essentialdata.info/>. Accessed August 2016.

average member of America's Essential Hospitals operates a network of 20 or more ambulatory care sites and delivers ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates.

Essential hospitals are pillars in the Medicaid delivery system and have the unique potential to make a real and lasting impact on the well-being of the most disadvantaged patients. Our members' background of caring for low-income, vulnerable populations has given them the expertise, passion, and commitment to apply and adapt proven models of care and to pioneer new models to meet their patients' specialized needs. Members of America's Essential Hospitals consistently find innovative and efficient strategies for providing high-quality, complex care—all while facing high costs and limited resources. But the reality is that with their patient mix and margins, essential hospitals are utterly dependent on Medicaid funding to carry out their missions and remain viable.

In short, our members are at the very heart of the Medicaid delivery system, providing access where none exists, innovating with populations others ignore, and depending on Medicaid support to stay afloat. As CMS engages in policymaking, it is imperative that the agency consider the effect on essential hospitals—and more important, on the patients who rely on essential hospitals. Providing meaningful access to care for Medicaid patients cannot be achieved without our members. In that spirit, we urge the agency to consider the following comments.

1. CMS should withdraw the proposed rule and allow all states a transition period to adapt to the new requirements of the final Medicaid managed care rule released in April.

Last April, in finalizing an overhaul of the Medicaid managed care regulations, CMS codified restrictions on states' ability to direct supplemental funding to providers through managed care organizations.² However, reflecting concerns raised by hospitals, the agency allowed states to use pass-through payments during a transition period lasting 10 years for hospitals and five years for physicians and nursing facilities. CMS allowed this flexibility because the agency recognized:

- the importance of existing pass-through payments as funding support for safety-net providers;
- the likelihood that an abrupt halt to these payments could harm beneficiary access; and
- the challenges associated with transitioning supplemental payments into payments for delivery of services.

In the final rule, CMS established a limit on pass-through payments for hospitals, which gradually phases down over the 10-year transition period. The rule did not establish a limit for physicians or nursing facilities.

² Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. *Federal Register*. 2016;81(88).

The regulation did not require that the pass-through payments be in place when the rule was released. In the preamble, CMS clarified that it expected some states to adopt new pass-through payments during the transition period.³

Less than a month after the final managed care rule went into effect, however, CMS issued an informational bulletin indicating that it intended to promulgate new rules changing the policy on pass-through payments.⁴ Specifically, the bulletin indicated that CMS intended to prohibit the establishment of new or increased pass-through payments. The proposed rule would implement this policy.

We are deeply concerned with this quick reversal of an important policy and urge you to withdraw the proposed rule. The transition period for pass-through payments is critically important to ensuring stable funding for essential hospitals, for the reasons that CMS articulated in its final managed care rule. However, those reasons apply more broadly to all pass-through payments, not just those that were in effect before the managed care rule was issued.

Essential hospitals rely on supplemental Medicaid funding because Medicaid base payment rates — the fee schedule rates that typically are incorporated into managed care rates—do not cover the cost of providing care. Base Medicaid payment rates are insufficient for providers who treat a patient base with a substantial portion of Medicaid beneficiaries or uninsured individuals. These providers rely on Medicaid to support their multiple missions, including providing access to care for vulnerable, low-income patients. Targeted, policy-based payments (including pass-through payments) are especially critical to those providers shouldering the burden of providing care to a state’s Medicaid population during times of instability to ensure patients’ access to services is uninterrupted.

As CMS recognized in its final managed care rule, establishing supplemental funding mechanisms that are value-based, related to delivery system reform, or consistent with the requirements for minimum fee schedules or payment rate increases “takes substantial time and attention.”⁵ Such a process “requires robust provider and stakeholder engagement, agreement on approaches to care delivery and payment, establishing systems for measuring outcomes and quality, planning, and evaluating the potential impact of change on Medicaid financing mechanisms.”⁶ In short, it is not a quick or simple matter to develop a compliant supplemental payment arrangement under the new managed care rules.

As states shift more Medicaid beneficiaries into managed care, and as CMS continues to change its policies regarding many supplemental payments (e.g. restricting policies around supplemental funding available through 1115 waivers), it is crucial that states be permitted to continue supporting providers they deem to be critical to the health of their Medicaid delivery systems.

³ See *Federal Register*. 2016;81(88). (providing an example in which “a state elected to include pass-through payments starting for contracts on or after July 1, 2018, rather than 2017”)

⁴ Centers for Medicare & Medicaid Services Informational Bulletin. The Use of New or Increased Pass-through Payments in Medicaid Managed Care Delivery Systems. July 29, 2016.

⁵ *Federal Register*. 2016;81(88).

⁶ *Id.*

The fact that some states had established or proposed pass-through payments before the effective date of the final rule should not preclude other states from receiving similar reasonable “breathing room” to implement supplemental support under managed care. The new restrictions on directed payments are significant and complex—it is unreasonable to expect some states to adhere to them immediately while allowing others to rely on the pass-through payment flexibility provided in the final rule.

There are many legitimate and important reasons that states target support through directed payments to a subset of providers, not only for the benefit of those providers, but also for their patients. CMS’ proposal constrains states’ ability to decide how best to provide permissible support under managed care, such as through value-based purchasing or delivery system reform models. Denying states such flexibility only serves to negatively affect service delivery and access.

Further, this rule continues to ignore the role Medicaid plays in achieving policy goals beyond simply purchasing a benefits package for eligible individuals. States use their Medicaid programs to achieve population health goals; promote health equity and access to quality care for all; support training for the next generation of health care professionals; and protect consumers, among other things. These are vital public health policy roles that other purchasers simply do not fill. Indeed, CMS suggested in the preamble of the proposed rule that provisions need “to recognize and accommodate the unique aspects of the Medicaid program”⁷ and acknowledge the “unique aspects of delivering services through Medicaid managed care.”⁸ Such recognition and accommodation must be reflected in policies on provider payment under Medicaid managed care.

CMS should not finalize the above mentioned proposed rule which would further restrict the ability of states to achieve state policy goals and support essential providers. Rather, CMS should allow states the flexibility and discretion to determine the best approach to transition away from the use of pass-through payments to providers.

2. CMS should allow the calculation of eligible hospital pass-through transition payments to reflect increases in base amounts.

If CMS chooses to implement the proposed restrictions to pass-through payments during the transition period, America’s Essential Hospitals urges the agency to allow the cap on hospital payments to reflect any yearly increases to the “base amount.” This would allow states to adjust pass-through payments to reflect significant increases in the managed care population.

Under the Medicaid managed care rule finalized last spring, states are required to phase down hospital pass-through payments by 10 percent of a “base amount” per year for each of the 10 transition years. The base amount is calculated based on inpatient and outpatient hospital services used by beneficiaries who will be covered under the managed care contracts in the rating period. The rule directs states to calculate this amount based on actual hospital services provided two years before the rating period,

⁷ *Federal Register*. 2015;80(104).

⁸ *Ibid*

both to patients who were in managed care in the prior period *and* to individuals who previously were covered through fee-for-service (FFS) programs but who will be covered under managed care in the rating period. In this way, the base amount will increase to the extent that states shift populations from FFS to managed care.

The proposed rule undercuts the flexibility built into the base amount. Instead, it imposes a strict dollar limit on pass-through payments, regardless of the population covered. Specifically, under CMS' proposal, the aggregate amount of pass-through payments eligible for gradual transition may not exceed the lesser of:

- the relevant percentage of the base amount, as specified under the final managed care rule (the “base amount limit”); or
- the total dollar amount of existing pass-through payments to hospitals contained in the contracts and rate certifications that qualified the payments for the transition period (generally the contracts for the period containing July 5, 2016 or earlier) (the “dollar amount limit”).

Rather than capping payments to hospitals at a set dollar amount, CMS should allow the limit on pass-through payments to reflect increases in the base amount annually. If the base amount increases from one year to the next, the dollar amount limit should increase at the same percentage.

For example, assume that in Year 1 of the transition period, a state had a \$10 million base amount and \$8 million in aggregate pass-through payments in the year that qualified the hospital for a transition period (i.e. an \$8 million dollar amount limit). The effective limit on pass-through payments in Year 1 would be \$8 million (the lesser of the \$10 million base amount limit and \$8 million dollar amount limit).

Then, assume that the state shifts new populations from FFS into managed care in Year 2, such that the base amount increases to \$15 million. The applicable percentage in Year 2 is 90 percent, so the base amount limit would be \$13.5 million—higher than in Year 1. This higher limit is necessary to reflect shifts in populations and to ensure adequate reimbursement. America's Essential Hospitals suggests that the dollar amount limit contain similar flexibility. In this case, because the base amount increased by 50 percent, the dollar amount limit would also increase by 50 percent, to \$12 million.

Note that if, as in this example, the base amount limit starts out at a higher level than the dollar amount limit, eventually the base amount limit will be lower and will serve as the effective limit. In our example, if the managed care population remained stable through Year 4, the base amount would remain at \$15 million, and the applicable percentage would decrease to 70 percent. As a result, the base amount limit would be \$10.5 million, and would be lower than the dollar amount limit of \$12 million, so would serve as the effective limit on the pass-through payments. Thus, the flexibility in the dollar amount limit we are proposing would *not* result in higher pass-through payment levels throughout the transition period; it would build in flexibility to adapt to changing managed care populations consistent with CMS' policy on the base amount limit.

Using this approach, the pass-through payment amounts would better reflect fluctuations in a state's Medicaid eligible populations, such as when new patient populations are shifted into managed care. Essential hospitals will continue to shoulder the burden of providing care to changing Medicaid patient populations during the transition period. Allowing greater flexibility in the limit on the amount of the pass-through payments directed to hospitals year to year ensures that Medicaid beneficiaries' access to care is not threatened.

As such, CMS should afford states flexibility in supporting hospital providers by allowing transitional pass-through payment amounts to be tied to yearly fluctuations in base amounts.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at 202-585-0111 or eomalley@essentialhospitals.org.