American Hospital Association

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December 19, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: RIN 0938-AT10 Medicaid Program; Pass-through Provider Payments in Medicaid Managed Care; (Vol. 81, No. 225, November 22, 2016)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would further limit states' ability to use pass-through payments for hospitals, physicians or nursing homes under Medicaid managed care contracts. **The AHA is concerned that through this new proposed rule, CMS would significantly change the compliance dates for the pass-through payment phase-down. As a result, state Medicaid programs and hospitals would face substantial, new payment restrictions with little time to make adjustments. We also are concerned that further limiting pass-through payments could adversely affect hospitals and the patients they serve dependent on these supplemental payments. As a result, the AHA requests that CMS withdraw this rule.**

CMS characterizes this proposed rule as a "clarification" of its policy to phase out pass-through provider payments, as established by its May 6, 2016 Medicaid Managed Care final rule. When the final rule was published, CMS assured states that due to the size, number and complexity of hospital pass-through payments, they would have a 10-year transition to phase these payments out, beginning in 2017 and ending in 2027.[1] Yet CMS has issued, well after the July 5, 2016 implementation date of the final rule, guidance and proposed rulemaking that effectively changes the transition period for the phase down of the hospital pass-through payments. Specifically, the guidance and this subsequent proposed rule would allow only those states with pass-through payments included in Medicaid managed care contracts submitted to the agency by July 5,

[1] Federal Register, Vol. 81, No. 88; May 6, 2016, Rules and Regulations p. 27590.

2016 to continue during the phase-out period. Thus, the agency has effectively moved up the start of the phase-out period a full year from July 2017 to July 5, 2016 as described below.

CMS did not inform or alert state Medicaid programs that they would need to submit detailed, complicated managed care contracts for approval in the 60 days between the final rule's publication date (May 6, 2016) and its enactment date (July 5, 2016) in order to maintain the pass-through provider payments. Instead, states and providers relied not only on the effective dates for the transition of pass-through payments spelled out in the final rule but also on supplemental information that CMS provided the public. Specifically, within a month of the final rule's publication, CMS provided states and stakeholders information on the implementation dates of numerous provisions within the final rule, which confirmed that the effective date for the enforcement of the phase-down of the pass-through payments was July 2017[2]. This action clearly supported CMS's intent to allow states and providers time to make appropriate adjustments in these supplemental payment arrangements. The agency even reiterated this concept of substantive transition time period when it stated that one of the goals from the final rule was a delayed compliance period. The agency further emphasized that enforcement of the transition period for the pass-through payments would be no later than the rating period for Medicaid managed care contracts on or after July 1, 2017 because "…an abrupt end to directed pass-through payments could cause damaging disruption to safety-net providers."[3]

In addition to concerns over "damaging disruption to safety-net providers," CMS also expressed interest in giving states, providers and managed care plans sufficient time to transition these supplemental payments into payment structures allowed by the final rule, such as value-based purchasing arrangements or enhanced fee schedules which tie provider payments to the provision of services under actuarially sound capitation rates. The agency specifically stated that the 2017 "…transition periods provide state, providers and managed care plans <u>significant time</u> and <u>flexibility</u> to integrate current pass-through payment arrangements…"[4] (*emphasis added*) However, this proposed rule provides neither the sufficient time nor the flexibility promised in the final rule.

Lastly, CMS is proposing to restrict the amount of permitted pass-through payments for each year of the transition period by establishing a new maximum amount. This new maximum amount would be tied to the pass-through amount (supplemental hospital payment amount) identified in the contract period on or before July 5, 2016. Again, we are concerned that CMS is effectively limiting pass-through payments to those in place prior to the final rule's effective date and giving state Medicaid programs and hospitals no time to transition these payments.

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[2] https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf.

[3] Federal Register**,** Vol. 81, No. 225; Nov. 22, 2016, Rules and Regulations p. 83779.

[4] *Ibid.*

The AHA has long advocated that states be allowed to continue supplemental hospital payments within the context of Medicaid managed care to support a variety of state specific objectives. CMS too, in its final rule, acknowledged that many states have used pass-through payments in the transition from fee-for-service to managed care to ensure a consistent payment stream for critical safety-net hospitals. This proposed rule, however, changes, "the rules of the game" mid-stream, leaving state Medicaid programs and hospitals no time to adjust, and the result could adversely affect hospitals dependent on these supplemental payments. **Therefore, the AHA requests that CMS withdraw the proposed rule and allow states and hospitals the full 10-year transition period spelled out in the May 6, 2016 final rule, which begins in July 2017.**

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/

Thomas P. Nickels
Executive Vice President