National Alliance of Safety-Net Hospitals

January 14, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject: 42 CFR Parts 438 and 457, [CMS-2408-P], RIN 0938-AT40, Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Attention: File Code CMS-2408-P

Dear Administrator Verma:

I am writing on behalf of the National Alliance of Safety-Net Hospitals (NASH) to convey our views on the proposed Medicaid and CHIP managed care regulation that was published in the *Federal Register* on November 14, 2018 (Vol. 83, No. 220, pp. 57264-57299).

NASH would like to address three aspects of the proposed regulation:

- payment rate ranges
- pass-through payments
- directed payments

On the whole, NASH is pleased with CMS's proposals to give states greater flexibility in the design and operation of their Medicaid managed care programs. Where we differ with some of those proposals is in our desire to see even greater flexibility than the agency has already proposed.

Payment Rate Ranges

NASH supports the Centers for Medicare & Medicaid Services (CMS) proposal to restore the ability of states to operate within actuarially established rate ranges for the payments they make to Medicaid managed care organizations. The use of rate ranges, long permitted by CMS for Medicaid managed care, was eliminated by the 2016 Medicaid managed care regulation but would be permitted once again under the proposed regulation CMS published last November.

The reintroduction of rate ranges reflects CMS recognition that while paying actuarially sound rates to Medicaid managed care organizations is essential, actuarial projections are not 100 percent accurate. It is important for states to have some flexibility when negotiating rates with managed care organizations and the restoration of rate ranges would give them that flexibility without losing sight of the importance of ensuring actuarially sound rates. Equally important, establishing the 1.5 percent range would give both

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states and managed care organizations important flexibility to adjust rates, if needed, in the midst of a contractual period without needing to seek federal approval. Thus, these two policies would give states important, much-needed flexibility while eliminating the regulatory burden inherent in seeking CMS approval for minor mid-year or mid-contract rate corrections.

At the same time, however, while NASH appreciates restoration of the use of rate ranges, we note that the proposed restoration is only partial: it would not restore rate ranges to their pre-2016 regulatory levels. NASH disagrees with this approach: from our perspective, limits are not necessary so long as the requirement of paying actuarially sound rates remains in place. If contemplated rates fall within actuarially approved ranges they should not require any further restriction or regulation by the federal government.

For these reasons, NASH supports CMS's proposal to restore the use of rate ranges to govern state Medicaid payments to Medicaid managed care organizations but asks CMS to consider restoring those rate ranges to their pre-2016 managed care regulation levels.

Pass-Through Payments

A provision in the 2016 Medicaid managed care regulation defined payments made to providers through Medicaid managed care plans that were neither for direct patient care nor risk-based as pass-through payments and required states to phase out those pass-through payments over a period of ten years. NASH opposed that policy change when it was implemented two years ago and continues to oppose it today.

Pass-through payments are a vital tool for ensuring the ability of private safety-net hospitals to serve their many low-income patients. Throughout the country, Medicaid provider payments often fail to rise to the level of even barely adequate and in some states are much less so. While most providers can absorb such shortfalls because of the many privately insured patients they serve, private safety-net hospitals are much less equipped to do so because such a greater proportion of their patients are insured either by Medicaid or not at all. As a result, Medicaid pass-through payments, whether through fee-for-service Medicaid or Medicaid managed care, have become a vital part of states' arsenal of tools for ensuring access to care for their Medicaid populations. In so many places across the country, large proportions of Medicaid recipients are served by relatively few providers – most often, by private safety-net hospitals. Many of these private safety-net hospitals struggle financially under the weight of caring for so many Medicaid and uninsured patients, and well-designed and carefully targeted pass-through payments help ensure their ability to absorb the financial losses inherent in marginally adequate Medicaid payments and, in the process, ensure their ability to continue providing the access to care that the many low-income residents of their communities need and deserve.

States have long used pass-through payments under their fee-for-service programs to direct scarce resources where they can do the most good and where they are most needed. These payments enable states to control costs while ensuring that safety-net providers, including private safety-net hospitals, are not unduly harmed.

For years policy-makers have questioned how best to ensure that Medicaid managed care programs provide sufficient access to necessary care. One such way is to ensure the continued existence of the vital community providers – providers such as private safety-net hospitals – that deliver so much of the care to Medicaid beneficiaries. Pass-through payments have long enabled states to ensure the continued viability of these providers. For this reason, NASH believes this tool should be available for use through Medicaid managed care as well as Medicaid fee-for-service programs.

As long as the overall payments made to Medicaid managed care organizations are actuarially sound, NASH sees no reason why these pass-through payments should be prohibited. Especially at a time when CMS is emphasizing giving greater flexibility to the states to tailor their Medicaid programs to their individual needs, we do not understand why the federal government continues to deny states the use of this important tool. Pass-through payments based on the needs of individual states are, in a very real way, the ultimate in flexibility that CMS can give to state Medicaid programs.

With this in mind, NASH believes the phase-out of pass-through payments should be suspended.

Directed Payments

Current Medicaid regulations limit the ability of states to make directed payments to providers through Medicaid managed care plans but the proposed regulation would ease those limits under certain conditions. Under the proposed regulation, the ability of states to make directed payments would be expanded to encompass directed payments to providers, through Medicaid managed care plans, for provider performance that meets specific guidelines, criteria, or performance standards or metrics.

NASH supports this proposed change because it would give states greater flexibility to direct how Medicaid managed care plans pay their participating providers and especially, how those managed care plans pay private safety-net hospitals that serve communities with limited access to health care services. This is especially important for ensuring adequate access to providers of vital specialty services that might not otherwise not be adequately reimbursed through a managed care plan. Broader use of directed payments would give state Medicaid programs a more powerful tool through which to help compensate for the historical failure of market forces to address the problem of access to care for low-income people and to help ensure that people who qualify for Medicaid-covered health care services actually have access to and receive such services by helping to direct much-needed resources to the very providers that play the greatest role in ensuring this access.

Further, as described above, NASH believes that giving states greater flexibility to direct pass-through payments would enhance states' ability to preserve the financial viability of vital safety-net providers, including private safety-net hospitals, and influence provider behavior in ways that achieve broader policy goals.

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more dependent on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates. Until 2019 NASH was known as the National Association of Urban Hospitals, or NAUH, and its evolution into NASH reflects its members' recognition that private safety-net hospitals can be found serving communities not only urban but also rural and suburban across the country.

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NASH appreciates the opportunity to present these comments to CMS and invites questions about the concerns we have raised.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director