Federation of American Hospitals®

Charles N. Kahn III
President and CEO

January 14, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW Room 445-G
Washington, DC 20201

Re: *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care*; 83 *Fed. Reg.* 57,264 (Nov. 14, 2018)

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the November 14, 2018 proposed rule, CMS-2408-P, *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care* proposed rule (Proposed Rule).

I.B.10 Network Adequacy Standards (§ 438.68(b))

The FAH opposes CMS's proposal to replace the requirement that states develop time and distance standards with a requirement that the states develop a quantitative network adequacy standard for Medicaid managed care plans. Network adequacy standards are essential to ensuring robust provider networks that will guarantee access to critical health care services. As we have explained previously, section 1932(b)(5) of the Social Security Act directs the Secretary (and not the States) to determine the manner of adequate assurance that Medicaid enrollees have access to care. **We believe the statute contemplates that the Secretary take a more directive role with regard to setting appropriate parameters for network adequacy standards, not the less directive role proposed by CMS here.**

Moreover, the proposed regulation fails to meet the statutory requirement that the Medicaid managed care organization provide assurances that it "maintains a sufficient number, mix, and *geographic distribution* of providers of services" Social Security Act § 1932(b)(5) (emphasis added). Of the potential quantitative network adequacy standards described by CMS, 83 Fed. Reg. at 57,279, the only standards that addresses the geographic distribution of providers are time and distance standards. **CMS lacks the legal authority to eliminate the statutory requirement that Medicaid managed care plans assure the State and the Secretary that it maintains a sufficient "geographic distribution of providers of services," and its proposal to permit States to adopt network adequacy standards that do not address the geographic distribution of providers therefore should not be finalized.**

Instead, the FAH again urges CMS to adopt and adapt the Medicare Advantage (MA) standards for use with the Medicaid managed care population. (*See* Attachment A – FAH July 27, 2015 comment letter.) Although CMS first adopted a deferential standard regarding network adequacy in the MA context, CMS's experience over time led to a change to a more detailed and standards-based framework. Given the OIG's reported concerns over current State policies on Medicaid managed care network adequacy, the FAH believes CMS should adopt the lesson of MA and move to a more proscriptive policy. In doing so, the FAH recommends that CMS adapt the MA network adequacy standards—with which the managed care industry is broadly familiar—to the Medicaid managed care context, making adjustment based on the particular needs of the Medicaid managed care population (e.g., pediatric care). As part of this process, CMS should augment the list of provider types under § 438.68(b)(1) to explicitly include other necessary services, such as inpatient and outpatient rehabilitation services, critical care services, and inpatient and outpatient psychiatric services. In the alternative, CMS should adopt quantitative minimum thresholds that address the number (*e.g.*, provider-to-enrollee ratios), mix (*e.g.*, quantitative requirements for a larger range of provider types), and geographic distribution (*i.e.*, time-and-distance standards) of providers of services.

In sum, because CMS's proposed changes to § 438.68 depart from the express requirements of the statute and jeopardizes access to care, particularly among enrollees in rural and underserved regions, the FAH strongly opposes CMS's proposal. CMS should instead explore opportunities to further standardize and develop network adequacy standards for Medicaid managed care plans, as further explained in the FAH's July 27, 2015 comment letter. (*See* Attachment A – FAH July 27, 2015 comment letter.)

I.B.4.c Pass-Through Payments (§ 438.6(d)(iv))

The FAH supports CMS's proposal to allow states to provider certain supplemental, pass-through payments to network providers when Medicaid populations or services are initially transitioning from a fee-for-service delivery system to a managed care delivery system. As the FAH has previously observed, pass-through payments have served an important role in allowing state Medicaid programs to ensure adequate rates are pad to Medicaid providers. (*See* Attachment B – FAH December 22, 2016 comment letter.) Base Medicaid rates paid to Medicaid providers are typically substantially below the rates needed to provide care for Medicaid beneficiaries, despite the requirement that states ensure that provider payments are adequate to enlist sufficient providers so that services are available to Medicaid patients to the same extent as the general population. *See* Social Security Act § 1902(a)(30)(A). As existing supplemental, pass-through payment programs are phased out under 42 C.F.R. § 438.6(d), states have fewer options to meet the standard of section 1902(a)(30(A). **Therefore, the FAH continues to urge CMS to offer additional flexibility**

around supplemental, pass-through payments or to otherwise ensure the adequacy of provider payments.

With regard to the proposed flexibility for supplemental, pass-through payments for states transitioning services and populations from a fee-for-service delivery system to a managed care delivery system, the FAH urges CMS to allow pass-through payments for network hospitals to be phased out following the end of the proposed three-year transition period, until at least July 1, 2027. Under existing § 438.6(d)(3), the base amount of pass-through payments for hospitals is being phased-out through the rating period for contracts beginning on or after July 1, 2027, while pass-through payments for physicians or nursing facilities will be eliminated for rating periods for contracts beginning on or after July 1, 2022. This approach was adopted in recognition of the disruption to hospitals and beneficiary access that might otherwise result from abruptly eliminating pass-through arrangements for hospitals before states have had the time to design and implement alternative approaches to directed payments consistent with the requirements of 42 C.F.R. § 438.6(c). *See* Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498, 27,590 (May 6, 2016). In light of the challenges associated with transitioning pass-through payments into supplemental payments that meet the requirements of § 438.6(c) (*e.g.*, value-based payment structures), additional time beyond the three years proposed by CMS would be required. CMS could adopt a similar 10-year phase-out for pass-through payments under § 438.6(d)(6), or at a minimum, permit these pass-through payments to be phased out after the three-year transition period in accordance with the existing requirements of §438.6(d)(3).

Lastly, the FAH requests that CMS consider a clarifying change to proposed §438.6(d)(6)(i). Elsewhere, CMS confirms that the proposal applies when Medicaid *populations or services* are initially transitioned from a fee-for-service delivery system to a managed care delivery system. As proposed, however, paragraph (6)(i) references only situations where the "services will be covered for the first time under a managed care contract." To clarify that pass-through payments are also permitted where a Medicaid population is initially transitioned to a managed care delivery system, the FAH recommends changing this subparagraph to read as follows: "The Medicaid population or services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period."

I.B.4.d Payments for IMD Services (§ 438.6(e))

We appreciate CMS soliciting comments on the impact of the 2016 policy which permitted federal financial participation for services provided in an institution for mental disease (IMD). We supported then and continue to support CMS allowing states to offer IMD services through a managed care arrangement. By allowing states to make these payments, CMS acknowledged the benefit that IMDs can provide to Medicaid beneficiaries.

When CMS implemented the policy in 2016, it required that for federal funds to be available, the stay in the IMD be for no more than 15 days in the month for which the capitation payment is made. While this policy was an expansion of IMD services in most states, there were a number of states, with CMS approval, that had provided for payment for IMD services for more than 15 days. As such, the implementation of the policy was a reduction in services for Medicaid beneficiaries in those states.

Given this impact, we encourage CMS to review its policy to determine how the policy can accommodate states that had policies in place that were more generous than CMS's final 2016 policy. While we appreciate CMS noting the option of state pursuit of a 1115 demonstration, we note that pursuit of such a waiver may not work in every state and that a broader federal policy preserving state flexibility would be preferable.

I.B.12. Enrollee Encounter Data (§ 438.242(c))

The FAH appreciates CMS's recognition that contractual payment terms between managed care plans and providers is confidential and trade secret information and that the disclosure of this information could harm competition among managed care plans and providers. Although the allowed amount and the paid amount for an individual encounter is often communicated to the enrollee through an explanation of benefits, the aggregation of this data presents the risk that competitively sensitive contractual payment terms could be reverse engineered from aggregated enrollee encounter data. Therefore, the FAH appreciates CMS's commitment to protect this data from inappropriate use and disclosure and urges CMS to not only ensure that contractual payment terms are safeguarded, but also that aggregated data that could be used to reverse engineer contractual payment terms is safeguarded.

I.B.1 Actuarial Soundness Standards (§ 438.4(c))

Actuarially sound capitation rates are a critical component to ensuring beneficiary access to care, and States are required to pay plans actuarially sound capitation rates. The FAH supported CMS's efforts in the 2016 rulemaking to improve transparency and accountability in the Medicaid managed care rate setting process. (*See* Attachment A – FAH July 27, 2015 comment letter.) Provisions that support an open and transparent process for establishing and evaluating Medicaid managed care plan capitation rates are an important component of ensuring beneficiaries have meaningful access to care. In light of the importance of actuarial soundness to the stability of Medicaid managed care systems, the FAH is concerned that CMS's proposal to permit states to develop and certify a rate range per rate cell within specified parameters may jeopardize actuarial soundness. If, however, rate ranges are permitted, the FAH strongly urges CMS to likewise adopt and strictly enforce the conditions and requirements set forth in proposed § 438.4(c).

More generally, the FAH urges CMS to exercise proper oversight in reviewing State data to ensure that the State process for establishing actuarially sound rates actually results in actuarially sound and adequate rates. CMS also should inform States that the rates, or any modifications thereof within a rating year, may not be based solely on budgetary needs, and should be driven by true actuarial soundness.

I.B.19 Grievance and Appeal System: General Requirements (§§ 438.402(c)(3)(ii) & 438.406(b)(3))

The FAH supports CMS's proposal to eliminate the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted while retaining the requirement that oral inquiries seeking to appeal an adverse benefit determination be treated as appeals. Although enrollees should be encouraged to provide a signed, written confirmation of an oral appeal in order to ensure that enrollees' appeals are accurately captured and documented, the FAH supports minimizing barriers to the appeal process to ensure that all oral appeals are promptly processed and resolved.

* *

Thank you for the opportunity to comment on the proposal. Should you have any questions, please feel free to contact me or Paul Kidwell at (202) 624-1500.

Sincerely,

Attachments

Attachment #1

July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*; 80 Fed. Reg. 31,097 (June 1, 2015)

Dear Acting Administrator Slavitt:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care* proposed rule ("Proposed Rule").

Overall, the FAH appreciates the direction of certain key provisions in the Proposed Rule, such as those addressing medical loss ratio ("MLR") and network adequacy, and discuss below recommendations that we urge CMS to implement to strengthen these proposals. We also urge CMS to eliminate other provisions, such as the "direct pay" prohibition, which prohibits States from making direct payments for services provided to beneficiaries in Medicaid managed care. Finally, we urge CMS to consider other provisions not addressed in the Proposed Rule, for example, applying no less than Medicare Advantage ("MA") prompt payment requirements to services furnished by non-contracted providers. Our comments and recommendations are discussed further below.[1]

I. Payment for Institution for Mental Disease Services (§ 438.3(u))

The FAH strongly supports the direction of the agency's proposal to permit Medicaid MCOs to cover short-term inpatient care for enrollees in an institution for mental disease ("IMD"). Access to care for people suffering mental illness is inadequate, and freestanding inpatient psychiatric hospitals serve as vital settings for that care. This Proposed Rule opens their doors to the mental health care Medicaid enrollees need.

The FAH has long advocated full parity between medical and surgical benefits and mental health benefits, and this proposal, which is well within CMS's statutory authority, materially advances that goal for enrollees who need care and treatment for mental illness and substance use disorders. The FAH notes, however, that CMS has proposed a 15 day per month per enrollee cap on coverage. **We believe this limit is unnecessary, arbitrary, and arguably inconsistent with parity as there is no similar limit on medical and surgical services. However, should CMS feel compelled under the IMD exclusion to apply a limit in order to define "short-term stays," we recommend a facility-wide average of 25 days.** This is consistent with CMS's long-standing length-of-stay dividing line that distinguishes long-term acute care hospitals from short-stay acute care hospitals. Alternatively, CMS could, if necessary in order to impose a patient-specific limit, couple a medical exceptions process with a preset limit. Such a process is much more patient-centric than an arbitrary, across-the-board limit, and is in line with policy approaches CMS has applied elsewhere that recognize the paramount importance of the clinical judgment of the treating physician.

II. Network Adequacy (§ 438.68)

The FAH commends CMS for proposing section 438.68, which requires States to develop and enforce network adequacy standards. Network adequacy standards are essential to ensuring robust provider networks that will guarantee access to critical health care services. While we support CMS's proposal as a step in the right direction, we believe the proposal should go further to ensure this important goal is met.

[1] Many provisions in the Proposed Rule are directed to entities such as Medicaid managed care organizations, pre-paid inpatient health plans, pre-paid ambulatory health plans, primary care case managers, or primary care case manager entities. In discussing the provisions of the Proposed Rule below, we refer collectively to these entities as "MCOs".

In a previous comment letter, the FAH recognized the commitment inherent in the Medicaid program to provide health care services to Medicaid beneficiaries is directly related to the scope of the provider and service networks established by MCOs. Indeed, CMS takes note of this important goal, drawing a link between proposed § 438.68 and existing § 438.206, which addresses availability of services. Simply put, a list of required health benefits and services is only as meaningful as the provider and service network which stands behind it.

As States expand their utilization of MCOs, including serving more complex populations such as individuals with disabilities and complex medical needs, CMS and States have an even greater obligation to ensure that plans with which a State contracts offer robust provider networks that guarantee beneficiaries have access to primary and specialty care providers, hospital networks, and other providers that in fact offer those required benefits and services.

Greater focus and attention by States on network adequacy is warranted and overdue. The current environment is characterized by minimal federal Medicaid network adequacy standards, leading to less than robust State network adequacy safeguards and inadequate federal and State oversight. In fact, the weakness in State network access standards was documented by the Office of the Inspector General ("OIG") in its September 2014 report, *State Standards for Access to Care in Medicaid Managed Care*. Among the issues cited by the OIG:

- Wide variation in standards across States (*e.g.*, primary care access standards varied from 1 for every 100 enrollees to 1 for every 2,500 enrollees);
- Failure of standards to include providers important to the Medicaid population, such as obstetricians and pediatricians;
- Application of the same standards for rural and urban areas; and,
- Lack of time and distance standards that apply to specialists.

Social Security Act section 1932(b)(5) requires that MCOs provide assurance to ***both*** the State and the Secretary:

> (5) Demonstration of adequate capacity and services.—Each Medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—
>
> (A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area; and
>
> (B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(Emphasis added.)

This statutory mandate directs the Secretary (and not the States) to determine the manner of adequate assurance that Medicaid enrollees have access to care. However, current federal regulations defer to States to ensure that each MCO "[maintains] and monitors a network of appropriate providers that is supported by written agreement and is sufficient to provide adequate access to all services covered under the contract." (*See* 42 C.F.R. § 438.206.) This regulation further details certain factors plans must take into consideration, including, but not limited to, anticipated Medicaid enrollment, expected utilization, and geographic location.

However, current federal regulations do not provide minimum, quantitative requirements regarding timeliness of access to care and services, ratios of specific provider types to enrollees, and/or requirements regarding geographic access to care. This stands in sharp contrast to MA network adequacy criteria, which stipulate, for example, minimum numbers of providers to meet enrollee requirements, as well as maximum travel times and maximum travel distances (all of which vary by county type).

The Proposed Rule includes a new § 438.68, and modifies the availability of services under §§ 438.206, 438.207. CMS discusses its approach to network adequacy in Medicaid, compared to standards employed in the Marketplace QHPs, which are more general, and MA, which are more detailed and robust. While CMS indicates that its goal is to better align Medicaid network adequacy with other public programs, such as MA and the Marketplace QHPs, the Agency proposes to follow the lead of the Marketplace QHP policy in terms of State discretion for Medicaid managed care. **We believe the statute contemplates that the Secretary take a more directive role with regard to setting appropriate parameters for network adequacy standards.**

The FAH urges CMS to adopt and adapt the MA standards for use with the Medicaid managed care population for like conditions. Where there is no comparable standard as the result of population differences (*e.g.*,, pediatric-related issues), standards should be set by CMS in instances where States have not developed their own standards. While MA first adopted a deferential standard to plans regarding network adequacy, CMS's experience over time led to a change to a more detailed and standards-based framework. Given the OIG's reported concerns over current State policies on Medicaid managed care network adequacy, the FAH believes CMS should adopt the lesson of MA and move to a more proscriptive policy now. Given their familiarity in the industry, we recommend that CMS adopt the MA network adequacy standards for Medicaid managed care. While those standards – and the forms and processes by which they are implemented – would need to be adapted to better reflect the populations served by the Medicaid program, they are known, readily available and many, if not most, plans are familiar with the forms and review process.

Short of adopting the MA rules, CMS, particularly in proposed § 438.68, suggests that States should develop and enforce network adequacy standards that, at a minimum, include time and distance standards for primary care (adult and pediatric), OB/GYN, behavioral health, specialists (adult and pediatric), hospital, pharmacy, pediatric dentist, and other provider types as determined by CMS. This list of provider types is a good start, and there is general authority to designate "other provider types when it promotes the objectives of the program…," which establishes that the list need not be exclusive. **We urge CMS to augment the proposed lists**

with further specific provider types, include inpatient and outpatient rehabilitation services, critical care services, and inpatient and outpatient psychiatric services.

CMS requests comment on whether it should set national standards for time and distance or whether population to provider ratios or other factors should be employed. CMS proposes that States use time and distance standards, but unfortunately sets the bar low at "such standards [that] are currently common in the commercial market and many Medicaid managed care programs." Yet, commercial managed care populations have vastly different needs from the Medicaid population. In addition, we believe time and distance standards should be applied simultaneously with population-to-provider ratios. To do otherwise could allow a plan or State to claim that it had met time and distance standards on paper, but ignore the practical impact on timely access to care when there are too few primary care physicians to properly serve the population in a given area.

Such standards would need to reflect varying geographic areas of the State covered by the managed care program. "Geographic areas" should be more explicitly defined to assure an adequate network, as well as to facilitate appropriate adjustments to reflect population density and likely provider availability. Here again, the MA guidance to plans, referred to in the Proposed Rule, and based on Census Bureau data, offers a useful approach with which issuers are familiar (*i.e.*, large metro, metro, micro; rural, etc.).

Proposed § 438.68(c) directs that States, in their development of network standards, "must consider, at a minimum", factors such as expected Medicaid enrollment. While the listed factors are a good set, the bar of "must consider" is a low one at best. At a minimum, States should be required to take into account such factors in setting policy and must be demonstrated to the Secretary. Simply put, States, even acting in good faith, could say that they "considered" such factors, notwithstanding whether their standards reflected them. One way that MCOs and States could demonstrate compliance, regardless of how robust the standards might be, would be to submit information similar to the "MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance." This would enable CMS, using existing processes, to assess network adequacy by plan, by State and across the program. It would also enable CMS (and States) to better detect possible discriminatory networks affecting certain diseases and conditions.

The FAH also recommends that CMS include provisions to guard against "phantom" networks, in which plans appear to have a full network on paper, but because of closed panels or other factors, Medicaid recipients are unable to access the network as defined. This is a similar problem that insureds are experiencing in other types of health coverage settings as well, where certain network contracting arrangements (*e.g.*, narrow or tiered networks or reference pricing arrangements) result in certain providers not being available to furnish services under certain circumstances. These types of arrangements should be a focus of State and federal enforcement of network adequacy standards, requiring that these types of arrangements be transparently and publicly disclosed, in particular to existing and potential future enrollees.

While our preference would be that CMS employ the MA standards, we recognize that because the Medicaid program is a Federal-State partnership, CMS may choose to afford discretion to States. **If CMS does not adopt the MA standards, the Agency should adopt standards that provide quantitative minimum thresholds to serve as a floor for State-based standards upon which desiring States may add additional requirements.** This approach guarantees a minimum level of network adequacy requirement and will protect adequate access to care in all States, while allowing States that wish to do so to impose more stringent requirements. It also better comports with the statute's requirement for the Secretary to set at least minimum standards, and better takes into account not only the historic weaknesses in the program, but the evolving nature of the program with more federal financial support and more care provided through MCOs. Also, we believe it is critical to this vulnerable population that the measure of actually available services within a network must include not only time and distance requirements, but non-discrimination against certain types of providers or facilities.

The FAH urges CMS to include additional requirements related to State enforcement of network adequacy standards. For network adequacy policies to be meaningful, they must be enforced. This means that CMS should set forth specific enforcement policies for States to follow, and outline how the Agency will oversee State compliance. In particular, the FAH recommends CMS require States to conduct tests of the adequacy of specific plan networks, whether determined by a complaint-driven and/or priority-based approach. Also, CMS should employ other processes to validate plan-reported network data.

The FAH supports proposed § 438.68(e), which requires publication of network adequacy standards. It is important for all stakeholders to know the rules and to be able to file a complaint if a plan is not adhering to the rules. The FAH recommends that CMS ensure that providers and other stakeholders have the ability to raise concerns with the adequacy of specific networks, with States using such complaints as a means of prioritizing State-directed testing of networks.

III. Medical Loss Ratio (§ 438.8)

The FAH commends CMS for proposing MLR requirements for MCOs, and we believe the proposal is a significant step in the right direction. **We urge CMS, however, to strengthen the proposal in the final rule, as discussed further below. In particular, we recommend that CMS mandate that States not only apply a minimum MLR threshold of 85 percent when establishing actuarially sound rates under proposed 42 C.F.R. § 438.4(b)(8), but also enforce this minimum MLR threshold through remittances and penalties, where appropriate. The 85 percent threshold should apply on an annual basis, and also should serve as a floor, and states could adopt a higher MLR threshold as warranted.**

Strengthened MLR requirements for MCOs could more closely align the rules governing the Medicaid managed care program with those applicable to MA and commercial health plans. As CMS notes in the Proposed Rule, Medicaid and CHIP are the only major sources of health care coverage that do not currently use a minimum MLR for MCOs. The uniform application of federal MLR standards to Medicaid MCOs promotes responsible fiscal stewardship of total Medicaid expenditures and is a valuable tool for assessing the soundness of capitation rates.

Remittances and Penalties (§ 438.8(j))

The Proposed Rule mandates that MLR reports be considered in the establishment of future capitation rates, requires that capitation rates be developed to reasonably achieve an MLR of at least 85 percent, and provides States with the option to collect remittances where plans fail to meet an MLR threshold set at 85 percent or higher. However, this is in contrast to the MLR programs for MA and Part D plans and commercial health plan issuers, which uniformly require that plans make appropriate remittances or rebates when the plan fails to meet the MLR standard in a given contract or plan year. (42 C.F.R. § 422.2410(b); 45 C.F.R. § 148.240.)

The Medicaid managed care MLR program, as proposed by CMS, would be the only MLR program that fails to mandate remittances or rebates where plans fail to satisfy MLR standards. Failing to mandate collection of remittances, however, will implicitly sanction the poor financial stewardship of federal Medicaid funds, along with overcompensation of plans.

Further, Medicaid managed care plans that repeatedly fail to meet MLR standards should be subject to penalties beyond the remittance of funds. Where a MCO fails to meet the MLR standard for a number of consecutive years, this represents a significant problem with the plan's use of government funds and the care provided to the plan's enrollees. The MLR program for MA and Part D plans addresses this issue by prohibiting the enrollment of new enrollees after an MA or Part D plan fails to meet the MLR standard for three or more consecutive contract years and terminating the plan's contract if it fails to satisfy the MLR requirement for 5 or more contract years. (45 C.F.R. § 422.2410(c), (d).) Similar consequences should be established for MCOs, especially because improving the coordination and management of care for the Medicaid population has been considered a central purpose of Medicaid managed care programs.

Auditing of MLR Submissions (No provision)

The Proposed Rule does not provide for any review or audit of MLR reports submitted by Medicaid MCOs. Instead, proposed § 438.8(n) would merely require that the MCO provide an attestation that the MLR was calculated in accordance with federal standards. This is in stark contrast to HHS review of MA organizations' MLR reports as well as HHS audits of commercial issuers' MLR reports. **We urge CMS to strengthen the provision in the Proposed Rule by requiring federal audits of MCO MLR submissions.**

Responsibility for regulatory reviews of MLR reports should rest within HHS. State Medicaid Agencies lack resources and have little experience with MLR reports, and individual State reviews would bear little consistency. Without external review or audits, the quality of Medicaid MCO MLR reports may be compromised, eroding their utility in the promotion of responsible fiscal stewardship of Medicaid expenditures.

Federal review and audit by HHS, on the other hand would promote efficiency, reliability and verifiability, while assuring that the MLR process serves a valuable role in the establishment of actuarially sound capitation rates. In addition, HHS review and audit would serve as an important tool for detecting and preventing potential program integrity issues by plans that fail to adequately invest in beneficiary care.

The review process applicable to MA and Part D plans' MLR reports would provide an appropriate model for the Medicaid managed care context. (42 C.F.R. §§ 422.2480, 423.2480.) In addition, HHS could consider permitting a federal reviewer to adopt a State's audit findings if HHS determines that certain criteria were met by the State, similar to the criteria used for State audits of commercial health plans under 45 C.F.R. § 158.40. Ultimately, however, HHS should ensure that the standards for satisfying the MLR requirements through audits are applied consistently across the States.

Fraud Prevention Activities in the MLR Numerator (§ 438.8(e)(4))

CMS proposes that MCO spending related to certain fraud prevention activities (required to comply with federal regulatory requirements under 42 U.S.C. § 438.608) may be included in the numerator of the MLR, but would be capped at 0.5 percent of a MCO's premium revenues. **The FAH urges CMS to prohibit inclusion of spending on fraud prevention activities in the MLR numerator, and ensure consistency of calculating the MLR across the commercial insurance market and federal health care programs.**

We appreciate that the proposed calculation of the MLR for Medicaid MCOs largely comports with the calculation used for commercial, MA, and Part D plans, and draws from HHS' experience regulating these other lines of health care coverage. However, permitting inclusion of certain fraud prevention activities in the MLR numerator for purposes of the Medicaid managed care program is a departure from these other programs. MA and Part D plans generally undertake the fraud prevention activities, similar to those required for Medicaid managed care plans under § 438.608, to mitigate potential liability for fraud and abuse. Yet, MA and Part D plans do not include these costs in the numerator. Instead, in conformance with the National Association of Insurance Commissioners' ("NAIC") proposed MLR rules, every other MLR program adopted by HHS provides that fraud prevention activities specifically are excluded from quality improvement activities and that fraud detection expenditures only need be reflected in the numerator insofar as payment recoveries may be included in the numerator up to the amount of these expenditures. **A similar approach is warranted for Medicaid managed care because the fraud prevention activities of Medicaid MCOs are not meaningfully different from those undertaken by MA and Part D plans.**

In addition, it is unnecessary to separately account for activities compliant with § 438.608, because we understand that overpayment recoveries by plans typically exceed the cost of fraud reduction and prevention efforts, including the costs associated with compliance with § 438.608. The Proposed Rule, like other MLR rules, provides under proposed § 438.8(e)(2)(iii)(C) that incurred claims include claims payments recovered through fraud reduction efforts up to the amount of fraud reduction expenses. Because well designed fraud reduction efforts typically yield claims payment recoveries in excess of fraud reduction expenses, § 438.8(e)(2)(iii)(C) would adequately account for the full range of fraud reduction activities undertaken by plans, including those activities required by § 438.608. Thus, it is not necessary to make an additional accommodation for fraud prevention activities in the numerator.

In the alternative, FAH requests that CMS defer addressing the impact of compliance costs under § 438.608 on the MLR calculation in order to study plan behavior and costs before engaging in rulemaking. The FAH is concerned that Medicaid managed care plans will attempt

to repackage current compliance programs and administrative costs as programs under § 438.608 in an attempt to maximize the plan's profitability. It appears that CMS shares these concerns when it indicates a preference for addressing § 438.608 compliance costs in the MLR calculation in ways that focus on expenditures for new activities undertaken by plans, instead of recurring expenditures for activities historically undertaken by the plans. Deferring rulemaking on this aspect of the MLR calculation will enable CMS to evaluate data from States and plans in order to: (1) determine whether special treatment of certain costs associated with § 438.608 is in fact warranted; and, (2) identify with particularity any specific fraud reduction costs that are appropriately counted toward the numerator. To the extent that fraud reduction expenditures are offset by payment recoveries included in the numerator under proposed § 438.8(e)(2)(iii)(C), it may ultimately be unnecessary to diverge from the established MLR methodology that applies to commercial, MA, and Part D plans.

Capitated Payments and Delegated Entities (§ 438.8(e)(2)(i)(A))

Proposed § 438.8(e)(2)(i)(A) provides for the treatment of payments to network providers under capitated contracts as direct claims costs. Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management are expressly excluded from incurred claims under proposed § 438.8(e)(2)(v)(B)(A). While CMS does not expressly address payments to delegated entities in this Proposed Rule, previous guidance and statements by CMS have indicated that certain payments to clinical risk-bearing entities are counted as incurred claims, even where those payments fund activities that would be considered administrative activities if undertaken by the plan.

The FAH requests that CMS reconsider this approach because it places Medicaid managed care plans on an uneven playing field, decreases amounts spent on beneficiary services, and increases federal and State expenditures for the Medicaid managed care program. Current policy with regard to commercial and MA plans places health plans that do not utilize significant delegation to clinical risk-bearing entities at a significant financial disadvantage as compared to plans that engage in extensive delegation. Expanding this policy to Medicaid managed care plans would further incentivize plans to meet the MLR threshold by increasing the number of services provided in a delegated manner instead of pursuing efficiency and coordination of care. As a result, public expenditures for the Medicaid managed care plan would likely increase while expenditures for health care items and services would stagnate or decline.

The FAH requests instead that CMS only permit plans to count 85 percent of capitation payments made to organizations that provide network development, administrative fees, claims processing, and utilization management services as incurred claims. In the alternative, the FAH requests that CMS require health plans to account for the portion of payments made to clinical risk-bearing entities for delegated administrative functions.

MLR Data Collection (§ 438.8(k)(3))

Under proposed § 438.8(k)(3), Medicaid managed care plans would have to require that "any third party vendor supplying Medicaid services to its enrollees" provide all underlying data

associated with MLR reporting by the sooner of 180 days after the end of the MLR reporting year or 30 days after the plan's request, regardless of current contractual limitations. The application of this proposed requirement does not appear to be restricted to vendors that supply claim adjudication services. Rather, it appears to broadly apply to all third party vendors supplying Medicaid services, including contracted health care providers.

The FAH urges CMS to clarify that the requirements of proposed § 438.8(k)(3) do not apply to health care providers and other vendors that do not provide claim adjudication services to Medicaid managed care plans. Other vendors – including health care providers – will not possess additional data necessary for a plan's MLR calculations and should not be subject to reporting requirements. Clarifying that § 438.8(k)(3) only applies to vendors that provide claim adjudication services would promote consistency between the MLR rules applicable to Medicaid managed care plans and MA and Part D plans. The rules applicable to MA and Part D plans appropriately limit data reporting obligations to those third party vendors that "supply[] drug or medical cost contracting and claim adjudication services." (42 C.F.R. §§ 422.2480(c)(2), 423.2480(c)(2).)

If CMS nonetheless applies § 438.8(k)(3) to vendors and providers that do not provide claims adjudication services, contrary to our foregoing request, the Medicaid MCO should only be obligated to require that the vendor report underlying data associated with MLR reporting in a timely manner. The Proposed Rule would require reporting by the sooner of 180 days after the end of the MLR reporting year or 30 days after the plan's request. This aggressive timeline would be unduly burdensome for third party vendors and is disproportionately short as compared to the one-year period during which plans prepare their MLR reports. **The FAH, therefore, requests that the Proposed Rule be modified to align with the analogous rule applicable to MA and Part D plans, which only obligates plans to require that vendors submit data in a "timely manner."** 42 C.F.R. §§ 422.2480(c)(2), 423.2480(c)(2).

IV. Actuarial Soundness and Transparency (§§ 438.5, 438.602(g))

CMS proposes six steps that States must follow in setting actuarially sound rates. States would be required to: (1) collect or develop appropriate base data from historical experience; (2) develop and apply appropriate and reasonable trends to project benefit costs for the rating period; (3) develop appropriate and reasonable costs for non-benefits costs for the period; (4) make appropriate and reasonable adjustments to the historical data, trends or other rate components to establish actuarially sound rates; (5) consider historical and projected MLRs for the plans; and, (6) for those programs using risk adjustment, select an appropriate risk adjustment methodology applied in a budget neutral manner to make adjustments to plan payments.

Actuarially sound capitation rates are a critical component to ensuring beneficiary access to care, and States are required to pay plans actuarially sound capitation rates. Unfortunately, plans and providers still have concerns that not all States fully comply with this requirement, and further, that the lack of transparency in the MCO rate setting process makes monitoring difficult. The FAH appreciates CMS's effort in the Proposed Rule to ensure that States meet specific requirements to establish actuarially sound rates, and commends the CMS for its proposal to mandate that States post or otherwise make publicly available MCO contracts and various pieces of data relevant to actuarial soundness determinations, the MLR calculation, and the adequacy of

the plan's provider network, as proposed under § 438.602(g). **This is crucial information for providers and the public, and the FAH supports CMS' proposal to significantly improve transparency and accountability in the Medicaid managed care program by ensuring it is accessible to all stakeholders.**

As CMS develops the final rule, the FAH recommends additional safeguards that CMS could adopt to further its efforts in ensuring that States fairly apply actuarially sound rates. For example, CMS could require that States publish their rate-setting methodology with sufficient data and methodological detail to allow plans and other stakeholders to replicate the methodology. In addition, States could be required to assess any capitation rate reductions for the impact on access to care.

Further, it is imperative that States be held to timeliness requirements regarding the establishment of rates and approval by CMS. Provisions of this nature – that support an open and transparent process for establishing and evaluating MCO capitation rates – are an important component of ensuring beneficiaries have meaningful access to care.

Finally, we urge CMS to exercise proper oversight in reviewing State data to ensure that the State process for establishing actuarially sound rates actually results in actuarially sound and adequate rates. CMS also should inform States that the rates may not be based solely on budgetary needs, and should be driven by true actuarial soundness.

V. State Rate Setting Within Medicaid Managed Care (§ 438.6(c)(iii)(A))

The rates paid to in-network providers for services provided through Medicaid managed care contracts generally are determined through a private negotiation between the provider and the plan. Services provided under these negotiated arrangements are not subject to section 1902(a)(30)(A) of the Social Security Act ("Section 30(A)"), according to CMS's proposed regulation, entitled *Medicaid Program: Methods for Assuring Access to Covered Services*, dated May 6, 2011. Section 30(A) sets forth requirements that a State Medicaid plan must meet to ensure that payments are adequate for enlisting enough providers so that services are available to Medicaid patients. In the May 2011 regulation, CMS noted that Section (30)(A) discusses "access to care for all Medicaid services paid through a State plan under fee-for-service ["FFS"] and do[es] not extend to services through managed care arrangements."

Some State Medicaid agencies have adopted the practice of mandating rates that Medicaid plans must pay for specific services.[2] In such cases, Section 30(A) applies to the "provi[sion of] such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan[.]"[3] As such, where a State establishes floor rates that

[2] CMS appears to authorize such State rate-setting practices in proposed 42 C.F.R. § 438.6(c)(iii)(A) and (B), which permit a State to require the plan to: (A) adopt *a minimum fee schedule* for all providers that provide a particular service under the contract; or, (B) provide a uniform dollar or percentage increase for all providers that provide a particular service under the contract.

[3] As CMS acknowledges in the Proposed Rule, the two primary authorities for the implementation of managed Medicaid programs are through a State plan amendment or through a 1915(b) waiver. 80 Fed. Reg. at

a MCO must pay to a class of healthcare providers or for specific healthcare services, these are "methods and procedures relating to . . . the payment for[] care and services available under the plan[.]" **The FAH therefore urges that, when a State establishes rates for certain services or providers, CMS require the State to comply with existing law that applies to Medicaid FFS, *i.e.*, Section 30(A). Specifically, CMS should require these States to include in the State Plan methods and procedures related to rates that the State mandates that a MCO pay to a provider, which are not governed by the privately negotiated contract between the MCO and the provider. The FAH further urges that pursuant to Section 30(A), CMS review these payment methods, procedures and rates to ensure they are consistent "with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."** This review should ensure efficiency, economy, quality of care and access for enrollees in a State's Medicaid managed care program to the services subject to the mandated MCO rates. This will provide protection for beneficiaries and providers against States setting artificially low payment rates from MCOs to providers.

VI. Supplemental Payments and Medicaid Managed Care (§ 438.60)

CMS proposes minor revisions to 42 C.F.R. § 438.60 to clarify the intent of the existing prohibition of additional payments to network providers that are contracted with a Medicaid MCO. Specifically, the proposed changes would make clear that capitation payments made to providers are to be inclusive of all service and associated administrative costs under the contract with the MCO. CMS further would clarify that additional payments made to providers, as provided for under Title XIX of the Social Security Act, are permitted only when the statute and regulation specifically stipulates that the State make those payments directly to a provider.

The FAH urges CMS to eliminate this "direct pay" prohibition, which prohibits states from making direct payments for services provided to beneficiaries in Medicaid managed care. Alternatively, we urge CMS to amend 42 C.F.R. § 438.60 to accommodate State programs that provide supplemental payments to offset the payment shortfalls experienced by providers caring for Medicaid beneficiaries, as discussed below.

Under these programs, States are able to make additional payments to certain hospitals, subject to aggregate upper payment limits ("UPLs"). The UPL is a reasonable estimate of what Medicare would have paid for the services furnished by certain groups of hospitals. Subject to the UPL, and other regulations to safeguard appropriate use of federal funds, the Medicaid statute provides States the freedom and flexibility in the FFS program to target these supplemental payments to safety net providers to ensure a stable network. However, the prohibition under 42 C.F.R. § 438.60 removes States' flexibility to make these payments to providers under Medicaid managed care programs.

As States have increasingly looked to shift the Medicaid population to managed care, this direct pay prohibition has forced some States (and CMS) to invest significant resources and time

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31,100. Unless the rate-setting provisions are waived under a waiver, State rate-setting under a managed Medicaid system should be subject to the standards applicable to rate-setting for "care and services available under the plan."

into developing waivers that attempt to preserve supplemental funds in a managed care environment. Other States have elected not to work with managed care plans, or have tried to pursue public policy goals through voluntary arrangements with managed care plans. Yet, these "workarounds" do not provide efficient mechanisms for States wishing to pursue laudable public policy goals, *i.e.*, providing coordinated care in a capitated arrangement, while ensuring that critical supplemental payments are targeted to safety net providers serving Medicaid beneficiaries. Additionally, the time involved in developing and getting approval of State waivers or "workarounds" results in a portion of provider payments being made on a periodic lump sum basis, and at unpredictable intervals. This is a significant obstacle for providers because it creates a delayed and de-stabilized cash flow environment, and makes it difficult for providers to engage in budgeting on many fronts that can affect access to, and quality of, care for patients. Removing the direct pay prohibition would result in a more stable payment environment that would in turn promote patient care.

At the same time, the FAH is sensitive to CMS's desire to ensure that capitation payments be "inclusive of all service and associated administrative costs under such contracts." However, Medicaid provider base payment rates are often well below the cost of care, and these rates are treated as the underlying service costs in calculating the capitation rates. Therefore, the capitation rates do not truly capture the costs of serving Medicaid beneficiaries. This disparity may be addressed by permitting States to provide supplemental payments to providers in a managed care environment so long as those funds are excluded from the capitation payments.

Accordingly, in the event that CMS does not eliminate the direct pay prohibition altogether, the FAH alternatively recommends that CMS amend the prohibition to read as follows:

> **The State agency must ensure that no payment is made to a network provider other than by the MCO, PIHP, or PAHP for services covered under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are specifically required to be made by the State in Title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to account for any such payments.**

This proposed amendment would allow States to pursue Medicaid managed care opportunities while at the same time supporting safety net providers through supplemental payment programs when warranted. The proposed amendment would not impact federal oversight of these supplemental payment programs, as these programs will continue to require CMS approval, nor would it cost additional federal dollars. Instead, it would create additional flexibility for States, and avoid a number of the regulatory issues raised by the "workarounds" being considered today.

Finally, the proposed prohibition on supplemental payments in 42 C.F.R. § 438.60 applies only to "network providers." The preamble discussion in the Proposed Rule suggests that the direct pay prohibition is only applicable to "health care professionals contracted with the MCO, PIHP, or PAHP." **The FAH requests that CMS clarify that this provision is only applicable to "professionals," and not to institutional providers, and only to situations in which the professional contracts with the MCO.**

VII. Prompt Payment for Services Provided by Non-Contracted Providers (No Provision)

In addition to addressing payment levels for services provided by non-contracted providers, CMS also should establish prompt payment provisions for these services. Without reasonable standards to ensure prompt payment of non-contracted providers, MCOs may realize a further financial benefit from enrollee reliance on out-of network hospital providers if they can delay payment without recourse. The Social Security Act, at 42 U.S.C. §1396a(a)(37), currently establishes prompt payment standards for services furnished by health care practitioners through individual or group practices or through shared health facilities. In some cases, States have required MCOs to comply with these standards for non-institutional providers, but not for hospital providers. This is in contrast to the MA program, which requires a MA organization to pay 95 percent of clean claims within 30 days and all other valid claims within 60 days for non-contracted providers. **The FAH therefore recommends that CMS establish minimum prompt payment standards for all non-contracted providers no less than that required of MA organizations, while maintaining State flexibility to establish more stringent standards if desired. If MCOs do not comply with these timelines, providers should have further recourse. Specifically, States should be directed to establish and operate an enforcement mechanism to penalize non-compliant MCOs. Additionally, States should be required to implement a complaint process, available to non-contracted and contracted providers who are not paid timely. This process would allow States to better monitor MCOs and alert the State to persistent or recurring payment problems that would adversely impact access to care for Medicaid enrollees.**

VIII. Emergency Services Furnished by Non-Contracted Providers (No Provision)

Hospital providers have been experiencing significant contracting problems with certain managed care plans due to a combination of: (1) weak network adequacy requirements; and, (2) very low out-of-network payment rates for emergency medical care as well as post-stabilization services, which in combination act as a disincentive to plan contracting for adequate hospital networks. In such cases, plans are actually financially incentivized not to contract with hospital providers, as their medical costs are lower when their beneficiaries use out-of-network providers. The result is an inadequate hospital network that provides insufficient access to hospital care and is financially unsustainable to the safety net providers that serve Medicaid enrollees.

Many managed care plans have attempted to restrict payments to non-contracted hospitals by relying on State laws that establish ceilings on payments by Medicaid plans for emergency rates provided by non-contracted emergency service providers at a fraction of the Medicaid FFS rates. The Medicaid statute does address payment for emergency services furnished by non-contract providers under 42 U.S.C. §1396u-2(b)(2)(D), which requires non-contract providers to accept as payment in full no more than what they would receive under Medicaid FFS. As worded, this language serves only as a ceiling for payment, resulting in the unfortunate circumstance described above that leads to inadequate hospital network contracting by plans. This is not the case in the MA program, which has language regarding payment for non-contracted providers that establishes FFS payments as the floor. As a public policy matter,

we believe that similar to the MA program, Medicare FFS payments should serve as a floor for State programs, including managed care plans, to ensure proper payment for Medicaid enrollees. **As a regulatory matter, however, we urge CMS to use its authority to adopt Medicaid FFS payments as a floor for Medicaid managed care plans with regard to payment for emergency services, including emergency admissions.**

The use of FFS as a floor for non-contracted providers has not resulted in any provider disincentives to contract in the MA program, nor would it do so in Medicaid. Providers would still have every incentive to contract with plans in order to serve Medicaid enrollees and negotiate favorable terms with the contracting plans, especially with Medicaid expansion efforts, which have created incentives for provider to join networks. The addition of such language in fact, would improve the contracting environment by removing any disincentive plans have to contract for an adequate hospital network. **Additionally, the language should clearly state that the policy applies to emergency services and care, including emergency admissions, and post-stabilization care services.** If MCOs are permitted to pay lower than Medicaid FFS for post-stabilization care services (in addition to emergency services), this only increases MCOs' incentives not to build an adequate provider network nor promote continuity of care.

The adoption of Medicaid FFS as a floor for non-contracted providers should be the primary payment policy governing these circumstances. However, there may be some instances where a Medicaid FFS rate is not available. In such cases, some States have set out-of-network rates based on a percentage of what Medicare would pay, and, in many cases, the rates set by the State are well below Medicare payment rates. For example, TennCare has established a "57 percent rule," which sets payment for out of network ("OON") services provided by non-participating hospitals at 57 percent of Medicare. These rates are far below the cost of care, and serve to create a significant disincentive for plans to contract with providers, as described above. **The FAH therefore recommends that CMS include language in the final rule establishing a payment floor for States relying on a percentage of Medicare methodologies. The floor could be set based on an analysis of reimbursement levels in States relying on Medicaid FFS reimbursement for non-contracted providers.**

In addressing the current flaws with 42 U.S.C. §1396u-2(b)(2)(D), the FAH also urges CMS to clarify the second sentence of the section, which reads:

> In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

There is currently confusion regarding the interpretation of this sentence, which has caused varied and inaccurate applications across States and further weakens incentives for plans to develop adequate hospital provider networks. Some stakeholders have attempted to interpret the phrase "average contract rate" to be a reference to the average MCO contract rate. This interpretation, however, does not make sense, as the introductory clause is clearly referring to rates paid under the State plan. Further, such an erroneous interpretation would mean that non-contracted providers would have no access to the applicable payment rates, as the "average

contract rate" would not be publically available. Given the extensive misinterpretation and misapplication of this language, the FAH thus recommends that CMS clarify that the average contract rate methodology in 42 U.S.C. §1396u-2(b)(2)(D) only applies in States where payments directly from a State to a provider (*i.e.*, FFS rates) are negotiated by contract, and does not in any way apply to negotiated MCO rates.

IX. Protection of Emergency Care Services for Enrollees (§ 438.114)

CMS sets forth in the Proposed Rule various provisions to addressing MCOs' responsibility to cover and pay for emergency services, and preventing MCOs from arbitrarily denying or reducing payment for such services. (Some of the provisions are proposed, while others are current regulations). For example, the Proposed Rule states that –

- MCOs are responsible for coverage and payment of emergency services and certain post-stabilization care services.
- MCOs are required to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO.
- The term "emergency medical services" is defined using a "prudent layperson" standard.
- MCOs are prohibited from denying payment for emergency treatment when a Medicaid enrollee had an emergency medical condition, even if the absence of immediate medical attention would not have resulted in: putting an individual's health in serious jeopardy or serious bodily impairment or dysfunction.
- MCOs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Our member hospitals' experience is that many MCOs arbitrarily deny or reduce coverage and payment for certain emergency medical services, as discussed below. We believe the provisions set forth above prohibit these MCO practices across the country.

Our hospitals have ongoing serious concerns regarding State Medicaid Agency and Medicaid MCO practices in certain marketplaces that target payment for the provision of emergency care services for Medicaid enrollees. In these cases, described below, payments for emergency services provided to Medicaid enrollees are severely restricted by: (1) the introduction of 'triage' codes; and/or, (2) the downcoding of emergency department claims billed after services have been provided. As described below, in both cases, these practices ignore the *Emergency Medical Treatment and Labor Act* ("EMTALA") and/or prudent layperson standards that hospitals apply to all patients. As such, these practices should be prohibited.

Triage Payments – Some Medicaid MCOs, acting either independently or in concert with the State Medicaid agency, have created codes that only reimburse providers for so-called "triage

services."[4] However, no hospital provides only triage services to a patient. Hospitals are required under EMTALA to provide a medical screening examination to determine if an emergency condition exists, and to provide stabilizing treatment for patients that have emergency medical conditions. No such "triage payment" exists in any other payer context (Medicare, commercial, etc.) because providing only triage services would be an EMTALA violation. Medicaid enrollees and the providers that serve them should not be treated differently. **States should be prohibited from establishing "triage payments" directly or through their contracting MCOs, and any State and their contracting MCOs that have created triage payments should be required to eliminate them.**

Downcoding – In the case of downcoding, a MCO will retroactively downcode a claim for emergency services provided to a patient, asserting that the emergency services were not actually necessary and therefore refusing payment for the level of emergency care provided to the patient. However, this practice ignores the application of the prudent layperson standards that hospitals apply when determining whether a patient has an emergency medical condition. Hospitals must screen and stabilize patients based on EMTALA, and expend resources to perform these duties, regardless of whether the patient is ultimately found to have an emergency medical condition. **Therefore, CMS should prohibit MCOs from downcoding claims for emergency services and care.**

We support the provisions described above ensuring that MCOs must cover and pay for emergency services and post-stabilization care services, including defining "emergency medical condition" using a "prudent layperson" standard. These provisions clearly prohibit States and MCOs from inappropriately denying or limiting coverage and payment for emergency services, including making payment only for triage services, downcoding claims for emergency care and services, or engaging in other similar forms of reducing coverage and payment for these services. **To ensure that MCOs do not continue to engage in such behavior, we urge CMS to reiterate expressly, in the final rule, that the provisions discussed above, and enumerated in the Proposed Rule, require payment and coverage of EMTALA-mandated services, including:**

- **All services and supplies medically necessary to adequately screen, stabilize, and treat a patient, including post-stabilization care; and,**

- **Emergency services and care, including all stabilization and treatment services, including all screenings, evaluations and examinations that are reasonably calculated to assist the provider in determining whether the enrollee has an emergency medical condition, even if an emergency medical condition is later determined not to have existed.**

Finally, we urge CMS to include a provision in the final rule to require that coding, level-of-care and corresponding payments be consistent with American College of Emergency Physicians ("ACEP"), CMS and National Uniform Billing Committee ("NUBC") criteria.

[4] Plans also engage in different, yet similar approaches for arbitrarily denying or reducing payment and coverage for emergency services, as required by EMTALA.

X. Subcontracting Requirements (§ 438.230(c)(2))

CMS has proposed that the States require that contracts between MCOs and healthcare providers specify that the "individual or entity agrees to comply with all applicable Medicaid laws, regulations, subregulatory guidance, and contract provisions." **The FAH is concerned about two aspects of this requirement: (1) managed Medicaid plans have historically attempted to broadly impose Medicaid laws and regulations on hospitals, even if those laws and regulations have no direct application to hospitals; and, (2) requiring that providers comply with subregulatory guidance and contract provisions undermines the procedural protections of law in the guise of a contract.**

As a preliminary matter, the FAH requests that CMS clarify that "applicable" in this context means Medicaid laws and regulations that require specific action or inaction by the subcontractor. In the experience of FAH member hospitals, many managed Medicaid plans incorporate "regulatory addenda," which purport to identify the hospital's legal and contractual obligations. These regulatory addenda are often overly inclusive, attempting to obligate contracting hospitals to comply with State or federal requirements that are only applicable to plans and third party vendors accepting delegation of certain plan functions (*e.g.*, claims adjudication). Clarifying the extent of "applicable" laws and regulations, for example, by specifying "laws and regulations applicable to health care operations of the licensed entity" with which contracting hospitals must comply as a contractual term, would ensure that managed Medicaid plans appropriately meet their regulatory obligations to the States and CMS with such subcontracted entities.

The FAH further requests that proposed § 438.230(c)(2) be amended to read "individual or entity agrees to comply with all applicable Medicaid laws, and regulations, ~~subregulatory guidance and contract provisions~~[.]" Neither subregulatory guidance nor "contract" provisions (presumably between the States and managed Medicaid plans) undergo notice and comment rulemaking, and are therefore not law. This is because subregulatory guidance is issued and contract provisions are negotiated without the requisite level of procedure to satisfy the requirements of due process and the requirements of the State and Federal Administrative Procedure Acts. Including a requirement such as this invites States to bypass the transparency of formal legal processes and to rely instead on subregulatory guidance and contract terms to govern managed Medicaid programs, while at the same time, limiting the ability of providers and other stakeholders to challenge illegal, incorrect, or ill-considered subregulatory guidance.

Requiring hospitals to execute contracts that require broad compliance with the provisions of contracts to which they are not parties subjects hospitals to uncertain legal obligations and may render the hospital contracts unconscionable pursuant to various State laws. Hospitals and other providers are not parties to the contracts between States and Medicaid managed care plans and therefore do not participate in their negotiation. Contracts between States and Medicaid managed care plans may change after the execution of a subcontract; Medicaid managed care plans may attempt to assert that these after-the-fact amendments are binding on the subcontracting hospitals in the absence of any assent by the subcontracting hospital to such an amendment. Requiring hospitals and other providers to comply with contracts to which they are not parties, over which they have no control and which may change

in the future after the meeting of the minds with the Medicaid managed care plan is patently unfair to those hospitals and other providers. This gives rise to serious constitutional concerns and jeopardizes the enforceability of the provider contracts. Accordingly, the FAH requests that the reference to "contract provisions" be stricken from proposed section 438.230(c)(2).

XI. Program Integrity (§ 438.608)

Provider Screening and Enrollment Requirements (§ 438.608(b)

The FAH supports proposed § 438.608(b), which requires the State, through its contracts with MCOs, to ensure that all network providers are enrolled with the State as Medicaid providers as required by the general regulatory Medicaid requirements for program integrity. While a network provider need not furnish services to Medicaid FFS recipients, all providers providing services to Medicaid recipients should operate under uniform provider screening and enrollment requirements. The quality and safety of care for Medicaid patients depends on these important screening requirements.

Reporting and Returning of Overpayments to Plans (§ 438.608(c))

Proposed § 438.608(c) would require that Medicaid managed care plans "report . . . payments in excess of amounts specified in the contract" within 60 days of identification. It appears that this provision is intended to implement the requirements of section 1128J(d) of the Social Security Act in the Medicaid managed care context. This provision, however, fails to meet the requirements of section 1128J(d) insofar as it fails to require Medicaid managed care plans to repay identified overpayments within 60 days. In fact, the Proposed Rule makes no mention of any repayment obligation on the part of Medicaid managed care organizations.

A Medicaid managed care plan that has received an overpayment is statutorily required to "report and *return* the overpayment to . . . the State" within "60 days after the date on which the overpayment was identified." Social Security Act, § 1128J(d)(1)(A), (2)(A) (emphasis added). The omission of this repayment obligation in these Medicaid managed care program integrity rules may create confusion regarding the scope of plans' obligations. In addition, the Proposed Rule references "excess" payments based on the contract between the State and the plan rather than "overpayments" to which the plan is not entitled under title XIX of the Social Security Act, creating further ambiguity. It is unclear to us why CMS would deviate from this standard nomenclature, especially when it uses the proper terminology in the next subsection regarding plan overpayments to providers.

Therefore, the FAH recommends that CMS instead adapt its regulations on the reporting and returning of overpayments by MA and Medicare Part D Plan Sponsors, 42 C.F.R. §§ 422.326, 423.360, to the Medicaid managed care context. In the alternative, we request clarification that the excess payment reporting provision in proposed § 438.608(c) does not satisfy Medicaid managed care plans' obligations under section 1128J(d).

Recovery of Overpayments to Network Providers (§ 438.608(d))

Proposed § 438.608(d)(2) addresses the reporting and repayment of network provider overpayments from plans. Under this provision, a Medicaid managed care plan must require

network providers to report and return overpayments within 60 days of their identification. This is the first time that CMS has proposed to establish overpayment repayment obligations between network providers and plans, yet the preamble does not present any reasons for this significant departure from the broad policy of allowing plan-provider issues to be resolved through contractual terms. **Consistent with other comments, we urge CMS to adopt and adapt the MA approach, which does not impose a mandatory 60-day requirement and leaves it to a contractual matter.**

Mandating that plans require network providers to report and return overpayments within 60 days, also presents significant legal concerns under many State laws. State laws often establish a period of repose, after which a plan may no longer audit or demand repayment of provider claims. To the extent that § 438.608(d)(2) would impose repayment obligations beyond those permitted under State law, the provision raises federalism concerns and risks upending the established practices of providers and plans.

While the obligation to report and return identified overpayments to the government is accepted and statutorily mandated in the FFS context, it is ill-suited to the managed care context. Managed care agreements between plans and providers generally address the scope of any repayment obligations. Some agreements only permit recoupment by the plan in the course of an audit, while others impose broader repayment obligations. The timeline for repayments also varies between agreements. Furthermore, agreements generally establish a time beyond which the parties bear no further obligation to investigate, report, or reconcile non-fraudulent overpayments and underpayments. Permitting plans and providers to negotiate these terms allows them to reasonably balance efficiency, finality, and accountability. On the other hand, the repayment obligation required by proposed § 438.608(d)(2), is rigid and significantly expands the administrative burdens on providers participating in Medicaid managed care networks.

Overpayment Definition and Contractual Obligations. Furthermore, the proposed definition of "overpayment" in proposed subsection (d)(5) creates ambiguities and uncertainties. A network provider's right to payment derives from the managed care agreement, applicable State managed care laws, and possibly even common law. The proposed regulation, however, suggests that the provider's entitlement to payment derives from and should be assessed under title XIX of the Social Security Act. A network provider that is contractually entitled to payment by the plan should not be required to assess whether it is also entitled to payment under title XIX or to determine whether the contractual right to payment is coterminous with any right to payment under the title XIX. At the very least, the FAH requests that CMS clarify that a provider's entitlement to payment is based exclusively on the contract negotiated between the plan and provider. Any alternative interpretation would erode the reasonable expectations of network providers.

In sum, the FAH seeks clarification from CMS that this Proposed Rule does not suggest that section 1128J(d) imposes repayment obligations on network providers of Medicaid managed care plans. Section 1128J(d) only applies to overpayments returned to the Secretary or a State either directly or through an intermediary, carrier, or contractor. Unlike repayments to Medicare Administrative Contractors, repayments to Medicaid managed care plans are not repayments to an agent of the government. In fact, CMS clarified in the proposed rule that Medicaid managed care plans would retain overpayment recoveries, 80 Fed. Reg. at

31,131, thereby confirming that repayments obligations with regard to managed care plans are not repayment obligations to a government agent.

In light of these concerns, the FAH requests that CMS only require that each Medicaid managed care plan have in place a mechanism to receive reports and returns of overpayments, providing the plans and providers the flexibility to negotiate the appropriate timeline for investigations and repayments and the scope of repayment obligations. The FAH also requests that the definition of "overpayment" in subsection (d)(5) be removed or altered to reference the provider's entitlement to payment under the terms of the applicable managed care agreement.

If CMS moves forward with its 60-day report and refund policy, there needs to be a clear determination that an overpayment exists before the obligation to report and refund is triggered. Often, whether there is an overpayment is a contested issue, as is the amount of overpayment when both sides agree one exists. **For this reason, the Agency should not permit MCOs to take unilateral action to recover overpayments; they should be directed to notify providers that they believe an overpayment exists and seek confirmation from the provider before any further action is taken.** Finally, if there is an overpayment, CMS's policy should allow for providers to enter into a repayment plan if necessary, and deem that entering into the repayment agreement satisfies the 60-day report and refund obligation, unless the provider breaches that agreement in a material way.

Suspension of Network Provider Payments (§ 438.608(a)(8))

The FAH understands that government programs should not continue to make payments to providers engaged in fraudulent activities. Proposed § 438.608(a)(8) would magnify the impact of current § 455.23 by requiring Medicaid managed care plans to suspend payments to network providers where the State determines there is a credible allegation of fraud. This proposed change underscores the importance of assuring that providers have an opportunity to contest or refute a fraud allegation before suspension is implemented.

The FAH has previously encouraged and continues to encourage CMS to permit States to place providers on notice and provide an opportunity to provide evidence to the contrary before a payment suspension is imposed. Furthermore, if the concern persists, the provider should be afforded the opportunity to post a bond or other financial security that will allow it to continue to receive payments to protect cash flow and patient care operations while program funds are protected.

Likewise, the FAH continues to urge CMS to refine its definition of "credible allegations of fraud." A State should only be required to address suspension of payments when faced with allegations that provide specific assertions, from identifiable persons, who articulate identifiable claims or practices with facts that reflect actual knowledge of clearly fraudulent activities that are designed to harm the program or not to provide items or services to patients. We also believe the allegations should be made reasonably close in time to the events alleged, and be made by someone who is not known to be not credible based upon past experience. We think this approach would produce an appropriate level of reliability before the significant remedy of suspension is taken, particularly now that suspension will impact both FFS and managed care reimbursement.

Consideration of the Impact of Suspension on Network Adequacy and the Clarification of Provider Rights on the Termination of Suspension. The extension of payment suspension to network providers in Medicaid managed care plans also raises unique issues, including consideration of the impact of a suspension on network adequacy and clarity around a Medicaid managed care plan's obligations once a suspension is terminated. The FAH requests that CMS address both of these issues to protect beneficiaries' access to care and to protect non-fraudulent providers in the aftermath of a payment suspension.

In certain situations, the suspension of payments to a provider by a Medicaid managed care plan may jeopardize beneficiary access to items or services. Under current law, a State may find that there is good cause not to suspend payments based on access concerns when (a) an individual or entity is the sole community physician or the sole source of essential specialized services in a community, and (b) the individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area. (42 C.F.R. § 455.23(e)(4).) To the extent that CMS requires Medicaid managed care plans to suspend payments to providers based on a State's determination regarding credible allegations of fraud, the FAH requests that CMS do so in conjunction with an amendment to § 455.23 requiring States to examine the impact of such a determination on the adequacy of Medicaid managed care networks.

Finally, the FAH requests that CMS clarify that, where a Medicaid managed care plan suspends payments to a provider under the Proposed Rule, the plan must promptly reinstate payment upon the State's termination of the suspension and pay interest on claims that had been pended during the period of suspension in accordance with State laws. The Proposed Rule does not address provider rights with regard to the reinstatement of payments, creating the risk that a provider's payment risk might continue past termination of suspension and that the financial burden from the delayed payment of claims will be borne exclusively by a provider against whom there was insufficient evidence of fraud. Instead, a provider which was not engaged in fraud should be made whole, to the extent possible, to mitigate the lasting impact on the provider's financial condition.

XII. Resolution and Notification: Grievances and Appeals (§ 438.408)

The FAH appreciates and supports CMS's proposal to align the grievance and appeal provisions in Part F with those applicable to MA plans and private markets. This has long been an area of confusion for hospitals and beneficiaries alike due in part to overlapping rules that may apply to Medicaid managed care appeals. For example, CMS has established rules governing this area, as have States (for Medicaid managed care plans generally, for health plans as a condition of licensure, or both), while many plans have adopted their own policies. The Proposed Rule simplifies current procedures, such as requiring a single level of appeal, and clarifies various grey areas for States, plans and providers, such as clarifying the timing of the State fair hearings.

The FAH urges CMS to align the Medicaid appeal procedures with MA procedures. Both of these are public coverage programs and often cover similar populations. (By contrast, Medicaid beneficiaries cannot be concurrently enrolled in subsidized QHP plans.) One of the examples where the complexity of grievance and appeal processes has become especially problematic is in States that have implemented managed Medicaid programs for dual eligible

beneficiaries. In these plans, providers often have to identify whether the service would have been covered under MA or Medicaid in order to determine which grievance and appeals rules to apply. Alignment between the two grievance and appeal systems would help better integrate these lines of services for dual eligible beneficiaries.

Accordingly, the FAH requests that CMS clarify that the grievance and appeals processes, like the MA grievance and appeal processes, only apply to providers that do not have a written contract with a MCO, PIHP or PAHP. Currently, the MA appeals process only applies to hospitals that do not contract with a MA plan. (*See* 42 C.F.R. §422.582.) This makes sense because many plan contracts include their own dispute resolution procedures. This allows the contracting parties to develop more efficient alternative dispute processes that may be more appropriate to the collaborative relationship between the hospitals and the plans and the types of disputes that are likely to arise. For example, a plan and a hospital may determine that it may be more efficient to waive timely filing requirements in order for a party to raise a dispute about multiple claims at once or to require a conference between the parties before triggering any formal dispute resolution procedures in an effort to resolve issues in a more collaborative manner. In order to allow for this sort of flexibility in dispute resolution between a plan and a hospital, the FAH believes that the grievance and appeals processes should apply only to non-contracted providers.

With respect to proposed § 438.402(c)(2)(ii), the FAH requests that CMS align the 60-day deadline for filing an appeal with the deadline for MA, which permits late filing for good cause shown. In the perambulatory text, CMS notes that its intent was to achieve uniformity with the times for filing an appeal with MA plans and private marketplace plans. The MA program permits for the filing of a reconsideration beyond 60 days for good cause shown pursuant to 42 C.F.R. § 422.582(c). This exception should also be applied to the 60-day deadline for filing an appeal with a Medicaid managed care plan. **The FAH also recommends that CMS permit States to allow a longer timeframe as many States have health plan licensing laws that require that plans allow providers a longer period of time to file an appeal.**

In the preamble language, CMS requests comment on whether an online system should be required to track the status of grievances and appeals. The experience of many hospitals is that many Medicaid plans fail to meet the currently required deadlines in State and/or federal law, but with little recourse. **The FAH supports requiring an online system to track the status of grievances and appeals to help ensure accountability by Medicaid managed care plans.**

With respect to proposed § 438.404(b), the FAH requests that providers also be given a right to request the reasons for the adverse benefit determination, including the right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's claim for benefits. Hospitals often stand in the shoes of the enrollee with respect to an adverse benefit determination. In order for them to be able to fully understand the reasons for the adverse benefit determination, hospitals should be provided the right to inspect documents underlying those determinations. Such transparency will also reduce unjustified adverse benefit determinations.

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We appreciate your consideration of our recommendations that are vital to ensuring a Medicaid managed care program that offers adequate access, and quality and continuity of care to program enrollees. If you have any questions about our comments or need further information, please contact me or Jeff Micklos or Katie Tenoever of my staff at (202) 624-1500.

Sincerely,

Attachment #2

Charles N. Kahn III
President & CEO

December 22, 2016

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

Re: *Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems* (CMS-2402-P, 81 Fed. Reg. 83777, Nov. 22, 2016).

Dear Acting Administrator Slavitt:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the November 22, 2016 proposed rule, CMS-2402-P, *The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems* ("Proposed Rule").

1. **CMS Should Support State Authority to Establish Supplemental Payment Programs**

The Proposed Rule builds on the structure put in place in a prior CMS rule, the *Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* (CMS-2390-F, May 6, 2016, "Managed Care Rule"). Under the Managed Care Rule,

CMS imposed new restrictions on the ability of states to "direct" payments to certain providers that, if allowed to go into effect, would create significant disruption in many state Medicaid programs. See 42 C.F.R. § 438.6(c)-(d). These directed payment provisions are scheduled to be effective beginning with the managed care rating periods beginning on or after July 1, 2017.

This rule, which further narrows state discretion to establish pass-through payments, will further deteriorate the ability of state Medicaid programs to ensure adequate rates are paid to Medicaid providers. Under the Medicaid statute, states are obligated to ensure that payments are adequate to enlist sufficient providers so that services are available to Medicaid patients to the same extent as to the general population. *See* Social Security Act § 1902(a)(30)(A). Notwithstanding this requirement, base Medicaid rates paid to Medicaid providers are typically substantially below the rates needed to provide care for Medicaid beneficiaries. Many states have adopted the practice of providing supplemental payments that plans must distribute, often based on revenue generated from fees or taxes on health care providers. Without these supplemental payments, rates paid by Medicaid plans would frequently be inadequate to maintain the Medicaid delivery system.

While the FAH disagrees with CMS's Managed Care Rule provision limiting the authority to provide pass-through payments, the FAH does support CMS's decision to gradually phase these payments out over a ten year period, rather than cutting them off immediately. As CMS correctly notes, a number of states rely on these payments to ensure access to hospital services by Medicaid beneficiaries. Unfortunately, the Proposed Rule reverses CMS's initial decision to begin the phase out of these payments beginning July 1, 2017 and instead seeks to freeze the availability of these payments retroactively to July 5, 2016. **By taking such action, CMS is punishing states that, relying on CMS's stated policy in the managed care rule, have already started taking action to amend existing or pursue new payments. CMS specifically and clearly granted states the regulatory authority to continue to pursue these types of arrangements prior to July 1, 2017.** It is only now, after much work has been completed in states across the country that CMS seeks to retroactively limit these payments, which would disrupt planning in place and weaken the already fragile safety net serving low-income Americans. By limiting the ability of states to oversee or direct the payments made by plans to providers, this Proposed Rule will prevent states from meeting the standard in 1902(a)(30)(A) in favor of a model where individual contracted plans are responsible for supporting and maintaining the Medicaid delivery system – a responsibility which should not be left to the plans as it is a core CMS and state responsibility. If the supplemental payment programs that support Medicaid providers are terminated or reduced, there is no expectation that plans will voluntarily make up the difference, creating a potentially harmful situation for providers that treat a high volume of Medicaid patients and for the patients who rely on those providers.

FAH urges CMS to withdraw the Proposed Rule in favor of an approach that requires states and CMS to exercise their oversight to ensure that Medicaid providers receive adequate rates, including through the use of supplemental payments.

2. **Retroactive Implementation of the Proposed Rule**

FAH is also concerned by language in the Proposed Rule that seeks to apply the changes made by the Managed Care Rule retroactively to rating periods prior to the July 1, 2017. This approach is inconsistent with the Managed Care Rule, and would harshly penalize providers in states that had not yet submitted final managed care rates by the deadline that would be retroactively imposed by the Proposed Rule, which is July 5, 2016.

> In proposed 42 C.F.R. § 438.6(d)(1)(ii) the Proposed Rule states:
>
> CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in paragraph (d)(2) of this section, to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments defined in paragraph (a) of this section.

In the preamble, CMS said this paragraph was intended to "prevent states from undermining our policy goal to limit the use of the transition period to states that pass-through payments in effect as of the effective date of the May 6, 2016." (81 Fed. Reg. at 83781).

As written, the prohibition on retroactive approvals in paragraph 438.6(d)(1)(ii) could have consequences that exceed CMS's stated policy goal: it could prevent states that have long had pass-through payment programs from finalizing and implementing those programs for rating periods prior to the implementation of the Managed Care Rule. In some cases, the state, managed care plans, and providers have developed methodologies whereby adjustments to rates to account for plan supplemental payments are submitted after the initial approval of the "base" rates, and in some cases states have experienced significant delays in the submission or approval of even base rates. As a result, many states that have pass-through payment programs did not finalize their rates to include all scheduled pass-through payments by July 5, 2016. Indeed, states were under no notice that they should do so, as CMS expressly delayed the implementation of the pass-through payment provisions of the Managed Care Rule until rating periods beginning on or after July 1, 2017.

FAH is concerned that a restrictive reading of the prohibition on retroactive approval of "new or increased" pass-through payments could prevent the implementation of pass-through payments that have long been anticipated, and which are consistent with historically approved programs. These reductions would create even greater financial instability to the Medicaid delivery system. Accordingly, if CMS finalizes the Proposed Rule, FAH urges CMS to clarify that the prohibition on "new or increased" pass-through payments does not prevent CMS from approving rates or adjustments to rates for rating periods prior to the rating period beginning on or after July 1, 2017 when those rates reflect pass-through payments that are consistent with historical practice.

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We appreciate your consideration of our recommendations. These recommendations are vital to ensuring that states have the ability and responsibility to ensure that Medicaid providers receive adequate payment levels for services provided to all Medicaid beneficiaries. If you have any questions about our comments or need further information, please contact me or Paul Kidwell of my staff at (202) 624-1500.

Sincerely,