

December 22, 2016

Mr. Andrew M. Slavitt  
Acting Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2402-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, D.C. 20201

**Re: CMS-2402-P; Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery System (*Federal Register*, Vol. 81, No. 225, November 22, 2016); Proposed Rule with Comment Period**

On behalf of our more than 200 member hospitals and 50 healthcare systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule on the use of new or increased pass-through payments in Medicaid Managed Care. **IHA is deeply concerned that the November 22, 2016 proposed rule significantly changes the directions provided in the May 6, 2016 Medicaid managed care final rule. We also believe the November 22 proposed rule creates disparate treatment between those states which had pass-through payments and those which had not fully implemented such approaches prior to July 5, 2016. As such the NEW proposed rule would create further constraints on many states' ability to manage the transition of the Medicaid program in an orderly manner. Therefore, we encourage CMS to withdraw the proposed rule and informational bulletin.**

In the preamble of the November 22 proposed rule, CMS states that the proposed rule addresses changes, consistent with the CMS Informational Bulletin (CIB) issued July 29, 2016. In the referenced bulletin, CMS stated its intent to publish rules to supposedly “clarify” that certain payments not approved or submitted to CMS on or before July 5, 2016 would not be approved for consideration as “pass-through” payments as defined in the May 6 final rule.

IHA believes that the November 22 proposed rule, does not simply clarify the May 6 2016, final rule, but actually attempts to apply a new policy retroactively to the implementation date of that final rule – July 5, 2016. Additionally, we believe the new policy articulated in the CIB and the November 22, 2016 proposed rule, is inconsistent with the stated intent of the final rule, as published on May 6, 2016. Specifically, the proposed rule significantly changes the transition methodology to phase down the use of pass-through payments. State Medicaid programs and hospitals will face substantial new payment restrictions with little time to make adjustments. Such significant changes could result in the loss of significant funding which is critical to preserving access to care for vulnerable urban and rural communities. **We therefore recommend that CMS withdraw the proposed rule and CIB.**

**The proposed rule is inconsistent with the May 6 final rule and treats similarly situated states differently, thereby jeopardizing access to care for vulnerable communities.**

The new policy that CMS proposes in the November 22, 2016 proposed rule would result in

application of new regulations in a disparate manner among the states. The May 6 final rule states that state Medicaid programs must begin to phase-down “pass-through” payments effective for contracts beginning on or after July 1, 2017. The rule requires each state to develop a “base amount” as a starting point from which the state will measure the phase-down each year. The final rule outlines a phase-down timeline of 10 years for hospitals. During the 10-year phase-down for hospitals, each state must reduce the initial year’s pass-through base amount by at least 10 percent annually, resulting in total elimination of all pass-through payments for contracts beginning on or after July 1, 2027.

The May 6 final rule further defines that the initial base-amount shall be based upon the 12-month period, 24 months prior to the beginning of the initial “reporting period”. The rule defines “reporting period” as the Managed Care contract period.

Therefore, if an initial reporting period begins July 1, 2017, the 12-month period immediately 2 years prior would begin July 1, 2015. Alternatively, for a reporting period beginning October 1, 2017, the base amount period would begin October 1, 2015. Therefore, the May 6 final rule provides for a variable base period depending on each state’s Managed Care contracting period and provides reasonable notice and a reasonable transition period for states to adjust to the new policy.

In contrast, the proposed rule attempts to apply a hard, uniform stop date of July 5, 2016 for the base amount period and would treat states differently. By proposing to adopt a uniform end date for the purpose of determining the base amount period, the proposed rule is seeking to adopt a policy that is in direct conflict with the express provisions of the May 6 final rule.

Additionally, the proposed rule would treat states differently, based on whether the state had submitted its pass-through payment for CMS approval by the arbitrary date of July 5, 2016, without having provided the states adequate time to plan for and adjust to this new policy. For example, if State A submitted a new pass-through payment to CMS on July 3, 2016, but State B did not submit the identical pass-through payment to CMS until July 6, 2016, State A’s payment would be permissible, while State B’s would not. This arbitrary treatment could have significant and long-lasting financial implications for the states, hospitals and beneficiaries involved. In this example, State B and its residents are unfairly harmed by the arbitrary date imposed by the proposed rule. The proposed rule simply does not provide adequate notice to state Medicaid programs of this change in policy, so that they would be able to plan accordingly in order to provide the funding necessary to assure access to care for Medicaid beneficiaries.

Consequently, CMS should withdraw the November 22 proposed rule and adhere to the transition period for pass-through payments as set forth in the May 6, 2016 final rule. At a minimum, any “new or increased” pass-through payments should not be subject to a retroactive hard stop date, as outlined in the November 22, 2016 proposed rule, provided that the total capitated payment rate, including new “pass-through” payment, is considered actuarially sound.

### **The November 22 Proposed Rule should not apply retroactively to July 5**

It is unreasonable to believe that the May 6 final rule, defining the base period, would be interpreted by any reader as stating that “pass-through” payments must be approved or submitted by July 5, 2016, when the rule clearly defines the base period as dependent on the individual state’s reporting period. Therefore, the July 29 CIB and subsequent November 22 proposed rule cannot reasonably be interpreted as a clarification, but more appropriately must be viewed as a statement of a NEW policy of general applicability that can only be implemented after the opportunity for notice and comment by the public.

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In short, the November 22 proposed rule seeks to adopt a new policy and apply it retroactively to actions taken by a state after July 5, 2016. If CMS believed that the May 6 final rule authorized the July 5, 2016 stop date for new or increased pass-through payments, it would not have issued the November 22 proposed rule.

A cardinal principle of administrative procedure is that agency rules will only be given future effect. This principle is deeply rooted in notions of fundamental fairness, so that the public has the opportunity to conform its actions to the new rules of the government. This principle is especially applicable when the retroactive application of a new policy will have a substantial and negative impact upon states and access to healthcare for the most vulnerable populations. Additionally, the agency's policy development process benefits when the agency has the benefit of receiving comments and suggestions from the public before the adoption of final regulations. CMS has a longstanding history of adhering to such an approach. Moreover, as partners with the states in administering the Medicaid program, it is even more important that CMS provide the states sufficient time to not only comment on proposed rules, but also to adapt and transition when new federal policies are adopted by CMS.

**Consequently, IHA believes the better approach would be to withdraw the November 22 proposed rule.**

**Recent action unwarranted and overly restrictive**

IHA has long held that the mere presence of supplemental payments, if properly administered, does not expose the Medicaid program to excess spending. In many ways these tools are a highly efficient and effective approach for states to assure access to care in a fiscally prudent manner, provided that states limit total payments and by extension develop actuarially sound capitation rates, to an Upper Payment Limit calculation, consistent with 42 CFR 447.271 & 272. The premise stated in the preamble of the May 6, 2016 rule, the CIB and the November 22, 2016 preamble that supplemental payments undermine and present barriers to managed care is inaccurate and anecdotal at best.

**We encourage CMS to revisit the regulations, and in contrast to the May and November 2016 rules, which create further barriers and restrictions, CMS should examine a viable path to permit states an option to supplement rates incorporated into either its Medicaid FFS or Managed Care reimbursement systems. The flexibility associated with supplemental payments, should be a permitted reimbursement strategy retained by the states to assure access to care for the most vulnerable of its citizens.**

Mr. Slavitt, thank you again for the opportunity to comment, and we reiterate our recommendation to withdraw the proposed rule and CIB. If you or your staff has any questions about our comments, they should be addressed to Joe Holler, Vice President, Finance at (217) 541-1189 or [jholler@ihastaff.org](mailto:jholler@ihastaff.org).

Sincerely,

A.J. Wilhelmi  
President & CEO