



October 14, 2014

Ms. Barbara Edwards
Director, Disabled & Elderly Health Programs Group
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Follow-up to Meeting with America's Essential Hospitals; Supporting Essential Hospitals under Medicaid Managed Care

Dear Ms. Edwards,

Thank you for a very informative and engaging meeting on September 5. We appreciate the thoughtful work your team is doing to consider how the Medicaid program could and should best function as Medicaid beneficiaries increasingly receive services through managed care. This work is truly important in determining the roles for states, managed care organizations, and providers under such a program.

About the Members of America's Essential Hospitals

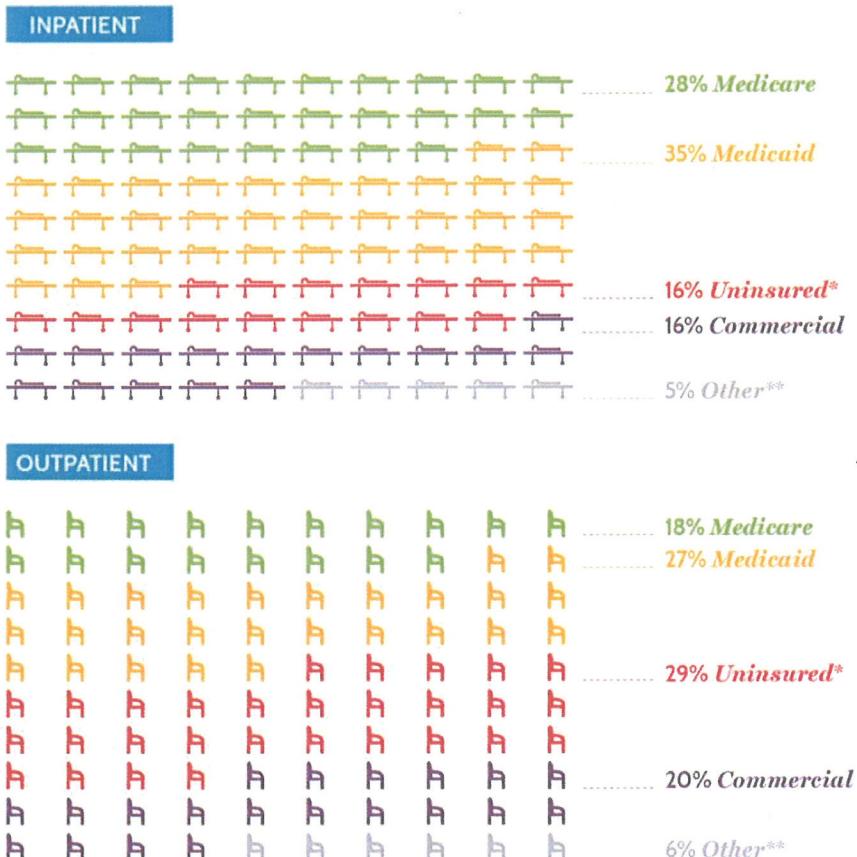
America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our nearly 250 members devote a significant portion of their care to Medicaid patients and provide a disproportionate share of the nation's uncompensated care.

- At our essential hospitals, 35 percent of inpatient discharges and 27 percent of outpatient visits are provided to Medicaid beneficiaries.
- Medicare beneficiaries compose 28 percent of inpatient discharges and 18 percent of outpatient visits at our member hospitals. Many of these beneficiaries are dually eligible for Medicaid and Medicare.

- In addition, 16 percent of inpatient discharges and 29 percent of outpatient visits are provided to uninsured individuals.¹

INPATIENT AND OUTPATIENT UTILIZATION BY PAYER MIX

Members of America's Essential Hospitals, FY 2012



More than half of all inpatient discharges and outpatient visits were for uninsured or Medicaid patients.

* Uninsured patients are those considered self pay or those covered by a hospital's charity care program or a state/local indigent care program.

** Other payers include veterans care, workman's compensation, and prison care.

Note: In this figure, outpatient includes emergency department visits.

Source: America's Essential Hospitals, Annual Hospital Characteristics Survey, 2012.

Essential hospitals also play a vital role in providing needed access to ambulatory care for their communities—delivering almost 30 percent of this care in off-campus locations. The average member operates a network of 20 or more ambulatory care sites. Members also deliver ambulatory care services to schools and housing developments through mobile units, many of which offer behavioral health support services, interpreters, and patient advocates who can connect patients with complex medical and social needs with support programs. In all, approximately 40 percent of the services provided in the

¹ Reid K, Roberson B, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014.

outpatient setting are specialty services. In addition, as essential hospitals, our member hospitals provide specialized inpatient, outpatient, and emergency services, such as trauma and burn care, which are not available elsewhere in their communities. In fact, in the 10 largest U.S. cities, our members operate 32 percent of all level I trauma centers and 38 percent of all burn-care beds.

Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an aggregate operating margin of -0.4 percent, compared to 6.5 percent for all hospitals nationwide.

Medicaid as a Unique Payer

From its inception and throughout its evolution, the Medicaid Program has served as a payer for health care services. But it is more than that, “carr[ying] responsibilities borne by no other payer.”² The Medicaid and CHIP Payment and Access Commission describes it as follows:

Medicaid’s role in our health care delivery system is unique: the program covers the diverse health needs of enrollees; directly supports safety-net providers; covers long-term services and supports for low-income Medicare beneficiaries, and reduces uncompensated care. Incremental additions and changes have been layered on top of Medicaid’s original foundation, expanding the scope of whom the program serves, what it provides, and its costs.³

As states increasingly rely on managed care as their predominant health care delivery system under Medicaid, they have become purchasers of managed health care well as payers. And they have had to reconcile these traditional marketplace roles with their public policy goals and responsibilities as states. Thus, as payers and purchasers of services for a defined population, states want to ensure their beneficiaries receive high-quality services at a reasonable price. But as states, they have broader Medicaid program goals around population health, training for the next generation of health care professionals, consumer protection, health equity, and systemwide access to quality care for everyone, including the poor, vulnerable, and uninsured.⁴

²Rosenbaum S, Frankford DM, Law SA, et al. *Law and the American Health Care System* Ed. 2. Washington, DC: Foundation Press; 2012.

³Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP March 2011. Washington, DC: MACPAC; 2011.
http://www.macpac.gov/reports/MACPAC_March2011_web.pdf?attredirects=0&d=1. Accessed September 25, 2014.

⁴That states would use their Medicaid Programs to achieve public policy goals, even those beyond the scope of the Medicaid Program, is not unremarkable, and has, in fact, been upheld by the Supreme Court. See *Pharmaceutical Research and Mfrs. of America v. Walsh* (01-188) 538 U.S. 644 (2003) (Stevens, J.) (Maine’s interest in protecting the health of its uninsured residents provides a “plainly permissible justification” for a challenged Medicaid prior authorization requirement).

As CMS considers modifications to the Medicaid managed care regulations, America's Essential Hospitals urges you to preserve states' flexibility to pursue these broader public policy goals.

States' Use of Medicaid Payments to Support Policy Aims

The federal Medicaid statute provides significant flexibility to states to determine payment rates that support state policy goals for the program and its beneficiaries. And indeed, states routinely take advantage of this flexibility. A study by the U.S. Government Accountability Office (GAO), for example, found that all states vary Medicaid payments for at least some services based on factors such as types of providers, service settings, and physician specialty.⁵

Because of the variation in Medicaid payment rates, states have developed a variety of supplemental payment programs to meet identified needs. Often these payments are targeted to a subset of providers, typically those with the largest Medicaid patient populations and thus the greatest reliance on Medicaid as their primary revenue source (such as safety net hospitals, public hospitals or financially distressed hospitals). States frequently provide enhanced payments to providers they have determined are essential to ensuring access to particular types of services (such as trauma or burn care, pediatric care, and other specialized services) or to people in particular geographic regions (such as underserved rural or urban areas). States may also make payments to support providers who are involved in graduate medical education (GME) to ensure an adequate supply of physicians in the future (including both teaching hospitals and teaching physicians).

Supplemental payments also help make up for the increasing insufficiency of base payment rates to support services provided to Medicaid beneficiaries. Payment adequacy is a complex notion. While below-market and even below-cost rates may be manageable for the average provider with the average payer mix, this shortfall is unsustainable for essential hospitals, which rely on Medicaid as a substantial part of their payer mix. The expansion of Medicaid coverage, while critical and a long-standing priority for the members of America's Essential Hospitals, is not a panacea for all reimbursement issues. This is especially the case when persistent shortfall is further combined with the continued significant uncompensated care from treating the remaining uninsured. Under these conditions, essential hospitals would not have the flexibility to compensate for losses of this magnitude.

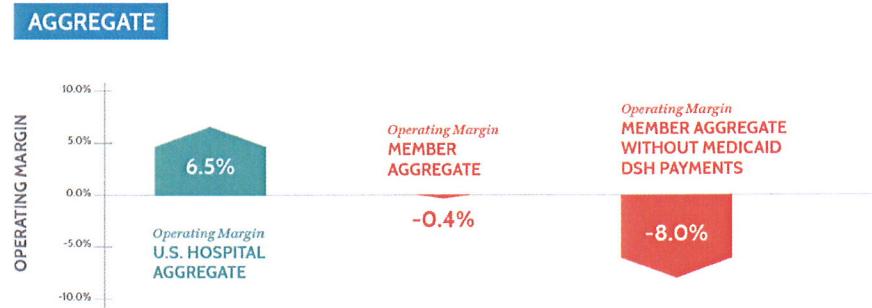
With ever-tighter budgets, states constantly feel the pressure to cut payment rates. While we believe CMS could relieve some of this pressure by more stringently enforcing the

⁵The GAO reported that under the efficiency, economy, quality, and access standard of Section 1902(a)(30)(A) of the Social Security Act, "all states vary Medicaid payments for at least some services based on the circumstances under which the services were provided ... Many of the states varied payment rates by at least one of the factors we were able to explore in detail: provider type, service setting, and/or patient age. Some states also varied their payment rates for other reasons, such as by geographic region or by physician specialty." GAO-14-56R Medicaid Payment Rates, January 6, 2014.

equal access requirements embodied in Section 1902(a)(30)(A) of the Social Security Act, until such time, targeted supplemental payments will remain essential to maintaining access to vital health services for low income, vulnerable patients. Indeed, without these payments, the average essential hospital margin of -0.4 percent drops even lower, and the ability to provide such vital services is at risk.

NATIONAL OPERATING MARGINS

Members of America's Essential Hospitals Versus All Hospitals Nationwide, FY 2012



Payment adequacy is a difficult issue even in states that have the will and resources to improve payment rates. And when states face tough economic times, it generally remains easier to cut payments to providers rather than limit services or eligibility. Faced with such realities, CMS must allow states to maintain the supplemental payments that have become vital to the providers whose mission is to serve Medicaid patients and who form the backbone of the Medicaid program.

The Challenge of Maintaining Support for Essential Hospitals under Medicaid Managed Care

Under fee-for-service (FFS) Medicaid programs, states can directly target additional support to particular providers by varying base payment rates or providing supplemental payments. However, federal Medicaid regulations generally prohibit states from providing targeted support when the payments are for services provided to Medicaid beneficiaries under a managed care contract—the direct pay prohibition.⁶

The Medicaid statute prohibits states from incorporating Medicaid disproportionate share hospital (DSH) payments into managed care capitation rates.⁷ And by regulation, CMS only permits states to make payments for managed care beneficiaries directly to providers for GME, provided the capitation rates are adjusted to account for such direct payments. Therefore, states that make supplemental payments for other purposes under

⁶The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education. 42 CFR § 438.60.

⁷SSA §1923(i).

FFS systems cannot continue to make such payments for services to beneficiaries who are moved into managed care. CMS' rules have also prevented states from requiring managed care organizations (MCOs) to provide specific, targeted support for state-designated providers under their managed care contracts (beyond, for example, a general requirement that plans use an increase in capitated rates to fund payments for hospital services overall). As a result, states with managed care programs are left to either fund a full rate increase for every provider in a class on top of the rates they pay MCOs or take the risk that enhanced capitation dollars intended to promote particular public policy purposes may never reach their intended targets.

Some states have been able to continue supplemental support for specific providers under managed care, but with varied success. For example, CMS approved an uncompensated care payment pool in Texas to enable the state to move to managed care without destabilizing Medicaid providers across the state. While CMS has approved uncompensated care pools in other states, the agency is increasingly moving away from the mechanism and phasing out existing pools. Other states have had some success increasing capitation rates for managed care plans, but both states and the providers intended to receive such support have to rely on the willingness of the plans to voluntarily cooperate. As a result, a patchwork of supplemental payment support is evolving in certain states with managed care programs, with varying success and varying support from CMS.

Proposed Solution: Amend the Direct Pay Prohibition

Rather than allowing for these uneven, sporadic solutions, CMS should amend the direct pay prohibition to allow all states to be able to support public policy goals that the states have designated as important to the Medicaid program. The prohibition at Section 438.60 already permits states to make direct payments for GME, provided actuarially sound capitation rates are adjusted accordingly. CMS should broaden that language to allow states also to make payments for “other purposes identified in the approved state plan.” (See proposed regulatory language attached.)

This proposal would allow CMS to continue to be able to ensure fiscal integrity because the direct payments would be part of the approved state plan. To the extent the supplemental payments already exist under the state’s FFS program, CMS would already have reviewed and approved the payments as economic and efficient pursuant to the state plan amendment process. In addition, our proposed regulatory change would continue to ensure that overall expenditures be no higher than actuarially sound rates. This is because adjustments to rates to carve out direct payments would happen after the rates have been deemed actuarially sound.

The proposed amendment should also allow states greater authority in requiring health plans and the states themselves to target increased capitation payments to providers. It is critical that CMS permit states to choose to make the payments directly. CMS has shown in its treatment of federally qualified health center reimbursement under managed care

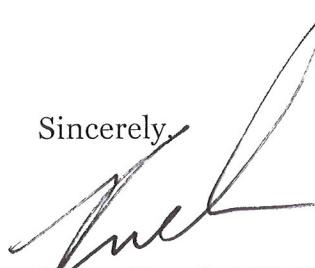
that the agency is keenly aware that requiring Medicaid plans to pay higher rates to certain essential providers could cause plans to avoid contracting with those providers. Or, they could steer patients away from using those providers' services—all to the detriment of beneficiaries and the program overall.

America's Essential Hospitals urges CMS to preserve states' flexibility when implementing Medicaid managed care and allow them to act not only as payers and purchasers but also to drive forward broader public policy goals through payment decisions. This does not preclude a role for plans in supporting the more complex needs of Medicaid beneficiaries or working with states to achieve program goals. But as states, plans, and providers acclimate to the continued evolution of the Medicaid program, our proposal will give states the ability to preserve the support on which essential hospitals rely to fulfill their mission of service to Medicaid beneficiaries.

* * * * *

America's Essential Hospitals appreciates your consideration of the above proposal to address a critical challenge to essential hospitals' viability as the Medicaid program evolves. We are in the process of scheduling a meeting with the Financial Management Group to discuss this proposal, and we hope to continue our dialogue with you as well. If you have questions or comments, please contact Xiaoyi Huang, director of policy, at 202-585-0127.

Sincerely,



Bruce Siegel, MD, MPH
President and CEO

Proposed Regulatory Changes

§438.6 Contract requirements.

...

(c) Payments under risk contracts

(5) Special contract provisions.

(v) If a State makes payments to providers for graduate medical education (GME) costs or other purposes under an approved State plan, the State must adjust the actuarially sound capitation rates to account for ~~the GME such~~ payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME such payments.

§438.60 Limit on payment to other providers.

The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education or other purposes identified in the approved state plan.