December 21, 2016

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

RE: CMS-2402-P, Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems

Dear Mr. Slavitt,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents more than 13,000 non-profit and proprietary skilled nursing facilities (SNFs), assisted living communities as well as homes for individuals with disabilities. Thus, we play a critical role in Medicaid-financed long term services and supports (LTSS) delivery and programmatic development, both fee-for-service (FFS) and managed care. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule regarding the use of new or increased pass-through payments in Medicaid managed care delivery systems.

As states continue to transform the payment and delivery of LTSS by shifting these services to managed care programs, it is critical to ensure that states and plans are equipped and able to provide high quality and needed care for complex patients with varying needs. The shift from FFS to managed care has revealed a myriad of challenges for LTSS providers and beneficiaries resulting in delays and/or disruptions to beneficiary care. With the increasing presence of managed care, beneficiary and provider protections are critical to the delivery of patient-centered and quality care.

Use of Pass-Through Payments in Medicaid Managed Care
In the proposed rule, CMS acknowledges that “pass-through payments have served as a critical source of support for safety-net providers who provide care to Medicaid beneficiaries.” This is particularly true for nursing facilities (NFs), which rely heavily on Medicaid to pay for the services they provide to most of their patients. Approximately 62 percent of NF residents nationally are covered by Medicaid.\(^\text{1}\) Already in Medicaid FFS, provider payments are inadequate. In 2015, the national average projected NF shortfall was $22.46 per patient per day. For every dollar of

\(^\text{1}\) CASPER, Oct. 1, 2016 (Data reflects the last standard health survey of active SNF/NF; excludes complaint, federal monitoring, and special focus surveys)
allowable cost incurred for a Medicaid patient in 2015, Medicaid programs reimbursed, on average, approximately 89 cents. Some states have used supplemental payments to address these inadequate base rates. Under managed care, payments to providers are often based on the state’s FFS structure, which includes these financing mechanisms. Therefore, CMS and states should ensure providers are paid adequate base rates before making significant changes to pass-through payments. Any changes to these financing mechanisms must allow for a realistic phase in time and ensure beneficiary access to care from providers across the continuum of care to ensure beneficiary needs are met.

CMS’ proposals would significantly impact states that had not yet launched their managed care programs before the July 5, 2016 date but intended to implement before July 2022. These states made the determination to transition to managed care in advance of implementation of the Medicaid managed care final regulations which provides a transition period for states to conform their managed care contracts to the new requirements for pass-through payments. As mentioned above, many of these states already rely on these payment programs in FFS, and likely decided to transition to managed care under the assumption that they would be able to address provider payment inadequacy using pass-through payment programs. AHCA/NCAL urges CMS to provide states that had received federal approval to transition to managed care before the Medicaid managed care regulations were finalized the opportunity to implement their managed care programs using these payment mechanisms with the understanding that they would need to be phased out by July 2022.

The proposed rule also intends to apply a total dollar limit to pass-through payments to nursing facilities during the transition period to the total dollar amounts of pass-through payments in managed care contracts and rate certifications for the rating period that includes July 5, 2016 (the date that the May Final Rule was effective), and were submitted for CMS review and approval as of July 5, 2016. If the contracts and rate certifications for the rating period that includes July 5, 2016, had not been submitted for CMS review and approval by July 5, 2016, then CMS proposes that the applicable managed care contracts and rate certifications would be the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted to CMS for review and approval as of July 5, 2016. However, AHCA/NCAL is concerned about the application of a total dollar amount limit to pass-through payments.

Notably, the application of a total dollar limit would have an adverse impact on states that have greater managed care enrollment during a transition year than the rate year used to calculate the limit in proposed section 438.6(d)(3)(ii). For example, the application of a total dollar limit to a state that recently has transitioned certain populations to managed care, such as seniors and people with

---

disabilities, would result in a lower capitation amount associated with pass-through payments during the transition year than in the rate year used to calculate the limit in proposed section 438.6(d)(3)(ii). Likewise, a state with an unexpected increase in managed care enrollments may find itself exceeding a total dollar limit, because the actual enrollments exceeded the projected enrollments used to translate the total dollar limit into a capitation add-on. To the extent that CMS decides to move forward with a limit based on historical pass-through payment amounts, it should apply these limits based on the approved rate certifications on a per member per month basis.

In addition, the proposed rule indicates that, in order for pass-through payment programs to qualify for the five-year transition period, states must have had these arrangements in place in managed care contracts as of July 5, 2016. To the extent that the proposed rule would impair the vested rights of states or providers for services already rendered (i.e., for rate years beginning prior to July 1, 2017), the proposed rule would constitute invalid retroactive rulemaking. Courts have invalidated such rulemaking implicating “primary retroactivity” that have “alter[ed] the past legal consequences of past actions[,]” Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988) (CMS’ attempt to apply new rule to recoup funds from providers for services already rendered invalid) (emphasis in original); see also Ne. Hosp. Corp. v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011) (CMS’s change to the amount of reimbursement for already-provided Medicare services invalid).

This would effectively move up the start of the phase-out period from July 2017 to July 2016. However, such an earlier effective date would be at odds with 5 U.S.C. section 801, which would preclude this rule from becoming effective earlier than 60 days after the final rule is published in the Federal Register. AHCA/NCAL is concerned that this earlier limitation on pass-through payment programs could adversely affect NFs currently dependent on these payments.

In light the concerns raised above, AHCA/NCAL urges CMS not to finalize the proposed rule on use of new or increased pass-through payments in Medicaid managed care.

**Future Guidance on Federally-Approved Financing Mechanisms**

AHCA/NCAL understands that CMS intends to issue guidance regarding federally-approved structures for these payment mechanisms. As CMS develops this guidance, we encourage the Agency to promote and ensure that any program elements or standards based on quality or efficiency should be developed collaboratively involving all providers to ensure recognition of the differences among provider types and the beneficiaries they serve.

Thank you for your consideration. We look forward to our ongoing dialogue with the Centers for Medicare & Medicaid Services (CMS) about Medicaid managed care as it relates to LTSS. If you have questions about any of our comments, please contact Mike Cheek at mcheek@ahca.org.
Sincerely,

[Signature]

Mike Cheek  
Senior Vice President  
Reimbursement & Legal Affairs