NORTH CAROLINA
DEPARTMENT OF STATE TREASURER

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

June 30, 2023

Via Electronic Submission

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
PO Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance and Quality (42 CFR Parts 430, 438, and 457)

Dear Honorable Chiquita Brooks-LaSure, Administrator,

I appreciate the opportunity to comment on the proposed regulation, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. I am concerned that the current structure of "state-directed" Medicaid payments will fuel hospital price inflation, increase hospital consolidation, and imperil the fiscal sustainability of the North Carolina State Health Plan for Teachers and State Employees.

As North Carolina State Treasurer, I am responsible for safeguarding the health care coverage for almost 750,000 lives — making the Plan roughly the size of the domestic employment base of Amazon, JP Morgan, and Berkshire Hathaway combined. The North Carolina State Health Plan already faces a $32 billion unfunded liability due to historic underfunding and high costs, and it risks falling below its mandated reserves by 2025. The vast majority of North Carolina hospitals refused to disclose or moderate the prices they charge to state employees, despite their nonprofit status, their healthy profit margins above the national average, as well as the fact that North Carolina was ranked among the most expensive states for medical care.

I strongly recommend that CMS amend its regulation that permits state-directed Medicaid payments to rise to levels as high as commercial rates. The state of North Carolina intends to continue raising Medicaid payments towards average commercial rates under a state-directed Medicaid payment plan called the Health Care Access and Stabilization Program (HASP). Academic experts have raised serious concerns that this program will accelerate hospital consolidation and create strong inflationary pressure on both commercial hospital prices and federal Medicaid spending. Consequently, I urge CMS to return to the aggregate Medicare upper payment limit that was the status quo prior to the policy change in 2017, with exceptions for safety net and rural hospitals narrowly defined.

North Carolinians cannot afford to shoulder the unintended price inflation that could be unleashed by using the state-directed payment program to raise Medicaid payments to average commercial rates. Health care price inflation is

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already costing North Carolinians their upward mobility and trapping thousands of families in medical debt. Beginning state employees must work one week out of every month to afford the family premium for the North Carolina State Health Plan. One in five families in our state is in medical debt collections, and the average worker now sacrifices 20% of a paycheck to health care costs.

My office has been contacted by officials from other states who expressed similar concerns over the use of commercial rates as a cap on state-directed Medicaid payments. In particular, officials from Colorado warned us about their own experience of the unintended consequences created by significantly raising Medicaid reimbursement rates. In 2009, the Colorado legislature increased Medicaid rates in an attempt to reduce hospital costs for privately-insured patients and employers. At the time, lawmakers believed that hospitals charged high prices because they had to shift the costs of "uncompensated care" to privately-insured patients. Under this narrative of cost-shifting, raising Medicaid rates would enable hospitals to freeze or lower commercial prices.

Unfortunately, these hopes have never materialized. Instead, health insurance rates in the individual market in Colorado soared by a staggering 80% between 2015 and 2019. Meanwhile, hospital profits jumped 280% from 2009 to 2018, until Colorado's hospitals had the highest profit margins in the nation. When presented with a sudden windfall of cash, Colorado hospitals had reacted by spending more, not by cutting their prices. Some hospitals even strengthened their market power with mergers. Hospitals' increased spending drove up operating costs, which in turn fueled an "endless loop" of price increases, higher profits, higher costs and higher rates of consolidation.

An academic article published in Health Affairs raises similar concerns. Ge Bai, PhD, CPA, professor of accounting at Johns Hopkins Carey Business School and professor of health policy and management at Johns Hopkins Bloomberg School of Public Health, wrote: "Unfortunately, North Carolina's approach to expansion, while bipartisan, puts employers, workers, and all who buy commercial coverage at risk of higher hospital prices. It also undercuts efforts to move to 'value-based care.'… When hospital payments are made by Medicaid managed care plans, federal limits on those payments no longer apply, leaving "commercial rates" as the only limit on Medicaid reimbursement. North Carolina's plan exploits this loophole, which invites hospitals to hike commercial rates to effectively raise the ceiling on their Medicaid rates at the same time."

The HASP state-directed Medicaid payment program is expected to draw down billions of dollars in increased reimbursements to North Carolina hospitals. I am concerned that this influx of cash will spark a historic level of hospital consolidation and price increases. North Carolina is already home to cities that have ranked in the top five most monopolistic metro areas for health care in the nation. Even before a rash of recent major mergers, 56 North Carolina hospitals boasted perfect monopolies in 2018. Only 10 hospitals were not deemed to be at least "highly consolidated" in North Carolina, according to the joint Department of Justice and Federal Trade Commission horizontal merger guidelines. Even an executive from a local hospital system described their system as a "monopoly," saying that Mission Health was "the 500-pound gorilla in Western North Carolina."

There is clearly appetite for further consolidation from hospital executives. An active policy provision in the proposed state budget would significantly weaken antitrust protections on hospital mergers for three large, government-owned hospitals, drawing opposition from the Federal Trade Commission, which expressed concerns that the legislation could

"lead to increased healthcare costs - in the form of higher premiums, co-pays, deductibles, and other out-of-pocket expenses - and reduced quality and access to healthcare services for North Carolina patients. It could also result in reduced wages and benefits for healthcare workers."

I applaud the steps that CMS is taking to bring more oversight and accountability to state-directed payments, but I remain deeply concerned by the magnitude and opacity of state-directed payments. CMS estimated that the total spending for these payments is nearly $48 billion, which is predicted to rise by an additional $17.3 billion by 2028. The vast majority of these payments are not tied to quality or value, according to MACPAC's issue brief from June 2023. MACPAC noted in a 2022 report to Congress: "The Commission is also concerned about the potential of some directed payment arrangements to undermine the integrity of the managed care rate setting process. … [I]t is not always clear what additional value is obtained when states use directed payments to substantially increase payments above rates that were previously certified as actuarially sound."

I thank CMS for recognizing the challenges created by state-directed payments. In order to protect the fiscal health of patients, commercial market payers, and the North Carolina State Health Plan, I recommend returning to the Medicare Upper Payment Limit cap on state directed payments. In doing so, CMS would be using this opportunity to rewrite these rules for the benefit of consumers and taxpayers.

Respectfully,

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