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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

Attention: **File Code CMS-2439-P**

To Whom it May Concern:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH), a group of private community safety-net hospitals that serve economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed Medicaid managed care rule that was published in the Federal Register on May 3, 2023.

ASH shares CMS's desire to improve access to Medicaid services and boost quality outcomes for low-income beneficiaries. The Social Security Act directs CMS to assure that payments are consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and Medicaid state plan services are available at least to the extent that such care and services are available to the general population in a given geographic area. Attempts to meet this mandate over the years, such as the 2015 requirement for states to complete access review monitoring plans, the abandoned 2019 effort to rescind that requirement, and most recently the 2022 request for information on ways to improve Medicaid access, have not improved access to Medicaid services. Safety-net hospitals continue to struggle to meet the needs of their low-income communities in part because of the inadequate Medicaid payments they often must accept. ASH appreciates the administration's renewed efforts to improve access through improved network policies and payments.

As safety-net providers, our member hospitals serve a disproportionate number of Medicaid and uninsured patients, so we need adequate Medicaid payments to enable us to provide high-quality, whole-person

services and supports in our communities. Our experience with these patients has shown that state Medicaid programs are in a better position than CMS to craft reimbursement policies that work for patients, providers, and state policy goals while accounting for each state's unique needs, such as the mix of managed care and fee-for-service programming, the size of the hospital community, and the health and social needs of low-income Medicaid beneficiaries.

Many aspects of this proposed rule call for states to relinquish the prerogative to develop Medicaid reimbursement policies based on their first-hand understanding of the challenges of serving their own Medicaid populations in favor of broad federal policies that may – or may not – reflect a similar understanding or offer appropriate policy solutions. ASH believes this would be a backward step in the development of Medicaid payment policy and urges CMS not to move in this direction.

In this letter, we offer feedback on those proposed policies, with particular focus on proposals that address state directed payments.

State Directed Payments

State directed payments (SDPs) have become a vital tool for states to improve the adequacy of their Medicaid payments. This is vital for health care providers – and especially for community safety-net hospitals, which care for disproportionately large numbers of low-income, uninsured, and Medicaid-covered patients. In some states, SDPs have made a considerable difference in the adequacy of Medicaid payments, enabling providers to do more for their Medicaid patients and to enhance equitable access to care in the communities they serve. For this reason, efforts to alter the current federal approach to SDPs must be undertaken carefully.

CMS Approval

CMS proposes permitting SDPs to be implemented without prior approval through the pre-print process if a state's SDP program adopts a minimum fee schedule using Medicare-approved rates for providers that deliver a particular service under the managed care contract. ASH supports this flexibility. In tandem with finalizing this state flexibility to use Medicare rates as minimum payment, we hope CMS will still encourage states to consider another flexibility being proposed: to use the average commercial rate as an upper payment limit for SDPs. While Medicare reimbursement should be considered a floor through a Medicaid minimum fee schedule, it is equally important for the equity of the Medicaid program that states aspire to reimburse services at levels as close as possible to commercial health plan levels because this ultimately is the best way, and perhaps the only way, to ensure equitable access to care for underserved communities. ASH believes the residents of the communities safety-net hospitals serve deserve nothing less.

Average Commercial Rate

ASH appreciates CMS's incorporation of the average commercial rate as the benchmark comparison for determining SDP limits. In an increasingly managed care world, Medicaid beneficiaries expect their health plan to operate like any other commercial market health plan and Medicaid needs to pay rates that keep

pace with commercial payers to ensure equitable access to care. Average commercial rates, ASH believes, are the appropriate benchmark for 21st century Medicaid payments.

Given the nature of the Medicaid program to adjust to the needs of each state, we ask CMS to give states the option to calculate average commercial rates among state-defined classes of providers if a statewide average does not fit the needs of a given state's diverse geography and population. States may find it best to calculate an average rate among like hospitals, such as rural providers or academic medical centers, whose commercial reimbursement and negotiating power can vary greatly.

We further encourage CMS to urge Congress to make conforming changes to the upper payment limit that fee-for-service and DSH payments must follow. State and federal regulators have begun to recognize that average commercial rates are appropriate reimbursement for these services, so ASH believes Medicaid fee-for-service and DSH payment policies should reflect this same perspective. Again, we believe our Medicaid patients deserve no less.

SDPs as a Portion of Total Expenditures

In the proposed rule CMS notes a wide range of SDP spending in Medicaid programs across the country, from one percent to 58 percent of total state Medicaid managed care expenditures. CMS expresses interest in limiting SDP expenditures as a percentage of total spending and has offered for comment a limit as low as 10 percent or as high as just 25 percent.

As ASH stressed at the outset of this letter, we believe state Medicaid agencies, rather than the federal government, are in the best position to understand the needs of their populations and providers and they have historically used SDPs to target those needs. Limiting SDP spending will only limit the ability of states to ensure access to care in communities of high need and high Medicaid enrollment.

The broad variation in SDP spending by states demonstrates why states need to retain their authority to decide how to use SDPs within their capitation payments and overall Medicaid budgets. ASH objects to limiting SDPs to a set percentage of total Medicaid managed care expenditures and urges CMS instead to use its existing approval authority to monitor what it views as inappropriate growth of SDPs as a portion of total spending. If state programs can construct payments that meet other regulatory criteria, including the requirement that SDPs improve quality in the Medicaid program, we see no need for an arbitrary limit for SDP spending.

Appeal Process

ASH disagrees with CMS's proposal to establish an appeal process for rejected SDP pre-print applications because we believe doing so will elongate the approval process, adding uncertainty for Medicaid managed care plans and the providers that rely on those payments to support access and innovation. CMS and states should continue using remedies that are in place today, including judicial intervention.

Value-Based Programs

CMS proposes to prohibit Medicaid managed care plans from using pay-for-reporting measures in their value-based payment policies that underlay SDPs and instead focus solely on pay-for-performance programs. In the rule, though, CMS acknowledges the importance of establishing provider reporting requirements, learning collaboratives, and similar activities to help further states' goals for performance and quality improvement. While it may be inappropriate for pay-for-reporting initiatives to continue indefinitely, ASH disagrees with the proposal to prohibit them entirely. Such a provision would limit states' abilities to support quality initiatives that may provide long-term benefits for beneficiaries through pay-for-performance *after* a ramp-up period of two or three years of a reporting-only program. Instead, ASH urges CMS to continue supporting pay-for-reporting in the initial years of a new SDP program, giving time to states to establish the data infrastructure for reporting and allowing for experience with new measures before providers are moved into a value-based arrangement.

CMS also should give states the option to develop performance metrics based not on a provider's ability to improve on baseline data but on their ability to shift a predicted trend. For instance, many states are currently focused on improving maternal mortality, and Medicaid managed care organizations should be encouraged to establish value-based payment programs that reward providers for progress that can improve the predicted mortality trends in future years.

ASH appreciates that states have the flexibility to develop quality metrics and value-based goals that matter for their population and that fit the sophistication of the data collection mechanisms of their providers. We do not support federally-standardized programs or measures in this area because such an approach would undermine the goal of Medicaid value-based programs: to improve health outcomes for the *state's* patient population and find efficiency in *state* spending. We do, however, support standardization to the extent that CMS requires states and MCOs to collect quality data on a calendar year basis, just as Medicare does.

CMS further proposes that managed care plans must use quality measure data that is no more than 12 months old for the basis of value-based payment programs, yet providers have up to six months to file claims from which the data for these measures are derived. The proposed 12-month window is not long enough for the managed care plan to receive accurate and auditable quality data and state programs and plans should have the flexibility to define this quality look-back window in a way that fits their individual program needs.

Interim Payments and Reconciliation

CMS proposes to prohibit states from requiring managed care plans to make interim payments based on historical utilization and then reconcile those interim payments to utilization and delivery of services covered under the contract after the end of the rating period for which the SDP was originally approved. CMS is concerned that this practice is shifting risk away from managed care organizations, but we are more concerned that this policy would incentivize health plans to deny claims as a way of keeping SDP spending under the total amount contemplated by the actuary and avoid a loss.

Based on its predictive nature, it should be reasonable for an actuarial analysis to need amendment based on actual utilization. Today, for example, some state Medicaid agencies need supplemental budget allocations from state legislatures to meet the cost of actual utilization in a fiscal year. ASH does not view this as a shift in risk but rather as a way to keep up with beneficiary needs and corresponding service costs.

States should retain the authority to require reconciliation within certain limits. For instance, MCOs could be permitted to correct interim payments up to five percent at reconciliation or states could be given a reconciliation margin under which they would not be required to revise their rate certification with CMS. States and their MCOs need a way to meet present patient needs through reconciliation or risk detracting from access to care.

Non-Network Providers

ASH appreciates CMS's proposal to remove the in-network requirement for a provider to be eligible for SDPs and agrees with its rationale laid out in the rule but we request continued scrutiny from CMS to make sure this change does not create a disincentive for providers to contract with managed care organizations.

Hold Harmless Attestation

CMS proposes a new requirement for each provider receiving an SDP to attest that the provider does not participate in a prohibited hold harmless arrangement as part of a provider tax program. We do not believe provider attestation is an appropriate way for CMS to implement the statutory requirement that a state Medicaid program not hold providers harmless for their participation in a provider tax program that finances the non-federal share of an SDP. It is a significant administrative overreach to ask providers to disclose their use of funds and – as part of that disclosure – to estimate the MCO's or the state's intent about whether those funds were provided with some understanding that a hold harmless arrangement was in place.

CMS has consistently defined hold harmless arrangements with respect to the Medicaid state agency's participation in such arrangements or at the very least the state's knowledge of whether such arrangements exist. Regulations at 42 C.F.R. 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." Without significantly changing this long-standing definition through notice and comment rulemaking, ASH believes attestation from a provider is not an appropriate mechanism for determining whether that definition has been met.

Network Adequacy

ASH is pleased that CMS is concerned about managed care plan network adequacy and is attempting to define it in this regulation. CMS's proposal that states enforce maximum appointment wait time standards for routine appointments for specific types of services as a mechanism to ensure that Medicaid managed

care plans have adequate provider networks, however, poses potentially unanticipated problems. The rule suggests, for example, that the maximum wait time for an outpatient appointment for mental health or substance use disorder care should be 10 business days and for primary care and OB/GYN services should be scheduled within 15 business days. In the absence of any data comparing wait times in the commercial and Medicare markets these proposed limits seem arbitrary and without foundation, and ASH members' experiences suggest they would be unrealistic even for those with commercial and Medicare coverage.

ASH understands and shares CMS's concerns, as outlined in the proposed rule, that Medicaid managed care plan networks may overstate the availability of network physicians and form so-called "ghost" networks that mask the lack of access to certain services for beneficiaries, but the proposed wait time standard will not solve this problem; it will only create a new type of "ghost network." In an effort to comply with specific wait time requirements, a managed care plan could, in theory, contract with a specific primary care provider or OB/GYN or mental health provider to be on call to meet an appointment time requirement, but that on-call provider may not meet other vital needs for individual patients, such as geographic proximity and cultural competence. Thus, while the plan would be in technical compliance with such a new standard, it might in no way be meeting the needs of its members in many cases. The requirement would work but its objective would go unfulfilled.

Apart from this unfortunate work-around, the appointment wait time standard also would be ineffective because we believe it is impossible to meet in this era of severe health care workforce shortages – not for Medicaid managed care plans, not for Medicare plans, and not for commercial health plans. Rural areas and low-income areas have historically faced difficulties recruiting health care providers, especially primary care and mental health providers, and many small community hospitals have been forced to cease providing OB/GYN services in recent years to maintain financial stability. Even with a years-long glidepath for this provision's effective date, we do not believe plans and their provider networks could be staffed well enough to meet the proposed appointment wait times in the foreseeable future in virtually any insurance market but especially in the Medicaid market, where staffing barriers have always been greater.

Conclusion

ASH greatly appreciates the admirable intent behind much of this proposed regulation, which is to improve access to care for the Medicaid population. As community safety-net hospitals, serving that population is central to our mission and the guiding objective behind much of what we do.

SDPs have become a vital tool for states in helping their community safety-net hospitals fulfill their missions of service to their communities, and without question, the hospitals that play the greatest role in caring for Medicaid patients are the same hospitals that rely most heavily on SDPs. SDPs also play an essential role in community safety-net hospitals' pursuit of better and more equitable access to care and health equity – objectives we know CMS shares.

At the same time, however, some aspects of this proposal rule, in our view, would limit the ability of states to use SDPs to pursue our mutual objectives. Similarly, we are concerned that the proposed rule's approach to encouraging more timely access to care for the Medicaid population, although unquestionably well-

intended, is simply not feasible in the current environment in which some providers continue to resist serving Medicaid patients and the health care workforce is struggling to meet the health care needs of all Americans – those covered not only by Medicaid but by Medicare and commercial health plans as well.

With these considerations in mind, ASH again expresses its support for CMS's recognition of the importance of SDPs in helping providers, state governments, and the federal government pursue mutual policy objectives but cautions that some aspects of this proposed regulation would detract from that pursuit. In this letter we have identified specific aspects of the proposed rule that pose such problems and respectfully request that CMS not include these provisions in the final rule.

The Alliance of Safety-Net Hospitals appreciates the opportunity to respond to CMS's proposed Medicaid managed care regulation and welcomes any questions you may have about the perspectives we offer in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director

About the Alliance of Safety-Net Hospitals

The Alliance of Safety-Net Hospitals is a coalition of like-minded community safety-net hospitals without dedicated sources of public funding that work together to advocate policy decisions on government health care programs, most notably Medicare and Medicaid, that ensure equitable access to care for the medically vulnerable residents of the communities they serve and adequate public resources for the safety-net hospitals that serve those communities.