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Advancing Health in America

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June 28, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Attention: CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244-8013

Submitted Electronically

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed policies related to access, finance and quality in Medicaid and Children's Health Insurance Program (CHIP) managed care programs. CMS advances many important policies in this wide-ranging regulation that will reshape the regulatory landscape for Medicaid managed care programs. While we commend CMS on many of the proposals that would, if finalized, improve access to coverage and care, we are concerned that certain policies may undercut these efforts by jeopardizing states' access to critical financial resources.

The Medicaid program is critical to providing access to health care services for approximately 90 million individuals, many of whom are some of the most vulnerable patients hospitals and health systems treat. However, enrollment in Medicaid is not enough to ensure access to quality care. There must be an adequate supply of providers who are available to care for Medicaid beneficiaries within a reasonable amount of time; a goal which is fundamentally linked to payment adequacy. In fact, achieving adequate access to care has been a particular challenge within the Medicaid program, and one of the ongoing causes is the chronic underpayment of providers. Specifically, Medicaid programs routinely pay providers less than the cost of delivering

care, including when benefits are administered through managed care plans. As such, many Medicaid programs have struggled to attract and retain an adequate supply of providers. CMS and states have taken steps in the past to address these issues. However, gaps remain. Therefore, the AHA commends CMS for proposing a variety of regulatory changes that aim to address payment-related barriers to care, as well as better monitor enrollee access to care. Specifically, we appreciate CMS' proposals to review provider payments for adequacy, as well as proposals to adopt wait time standards and secret shopper surveys to ensure managed care plans maintain adequate networks.

A substantial portion of the rule relates to state directed payments (SDPs) — supplemental payments that states can operationalize in the managed care context. SDPs are a key funding tool enabling states to recruit and retain an adequate supply of participating providers, and, as such, have become a crucial component of provider payment for care provided to Medicaid beneficiaries. This is especially true as base reimbursement rates in most states — including in managed care arrangements — have not kept pace with either the cost of providing services nor with recent rapid increases in inflation. Even taking SDPs and other supplemental payments into account, hospitals receive only 88 cents for every dollar they spend caring for Medicaid patients.[1] Therefore, preserving states' flexibility to use SDPs to augment woefully inadequate base reimbursement rates is a priority for the AHA — and for hospitals and health systems nationwide who depend on these funding mechanisms to support their ability to care for their community.

States must also have the resources they need to fund their Medicaid program, including SDPs. To that end, while we support many of the proposals in the regulation, we are concerned about the interaction between this rule and the sub-regulatory guidance CMS issued in February 2023 on health care-related taxes. Provider taxes are an important and legally-permissible source of funding for states to use as a portion of their share of the costs of operating the Medicaid program. **Further restrictions on states' use of these taxes to finance Medicaid payments could have dire consequences for coverage and access to care, as it is unlikely that states would be able to replace any lost funds with other sources of revenue.**

As CMS is aware, now is a particularly precarious time to put additional stress or restrictions on state Medicaid programs. States face unprecedented challenges with the unwinding of the COVID-19 public health emergency and will certainly require all available resources to mitigate unnecessary coverage loss during this time. In this effort, America's hospitals and health systems continue to be ready and committed partners to ensure the individuals and families in their communities are aware of the need to undergo the Medicaid redetermination process and have access to the

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[1] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

appropriate information to engage in this process. They also are prepared, as always, to help connect anyone who loses Medicaid to alternative forms of coverage.

Below, we provide more detailed comments on a number of provisions in the proposed rule. We recognize that these are complex issues that CMS seeks to regulate and welcome additional opportunities to work with CMS on how best to achieve our shared objectives of increased value, coverage and access in the Medicaid program.

STATE DIRECTED PAYMENTS

Medicaid's historically low provider reimbursement rates have led to the need for and growth of supplemental payments. These payments help enable providers to participate in the Medicaid program and improve beneficiary access to covered services. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), supplemental payments account for a quarter of all Medicaid payments made to hospitals, including those made by managed care organizations (or "health plans").[2] Despite these supplemental payments, total Medicaid payments still fall far below hospitals' cost of caring for Medicaid patients. As noted above, in 2020, Medicaid programs compensated hospitals for only 88 cents of every dollar they spent caring for Medicaid patients, even after accounting for supplemental payments.[3] This underpayment of hospital services by Medicaid programs resulted in a Medicaid shortfall of $24.8 billion in 2020.[4]

There is broad recognition that the inadequacy of Medicaid payment rates exists in the managed care context as well. To address this, beginning in 2016, CMS established the option for SDPs in managed care arrangements to help mitigate concerns regarding payment-related barriers to care. These additional payments have been critical in paying for services provided to Medicaid beneficiaries and help to offset the losses caused by inadequate base rates. The need for and impact of SDPs has only grown as more states have transitioned more populations into managed care, resulting in a more limited ability to use existing fee-for-service (FFS) supplemental payment mechanisms. As a result, SDPs are a fundamental component of Medicaid providers' reimbursement and, without them, patient access to critical health care services — and the overall stability of providers — would be in jeopardy.

According to CMS, SDPs total 11% of Medicaid managed care spending at approximately $50 billion annually.[5] Seventy five percent of that spending goes to

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[2] https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

[3] Total Medicaid payments include both FFS and managed care payments, as well Disproportionate Share Hospital (DSH) payments, non-DSH supplemental payments, directed payments and other adjustments, as reported by member hospitals.

[4] AHA. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf

[5] FR 88, May 3, 2023

hospitals for inpatient and outpatient services, which underscores how critical this funding source is for hospitals.[6] In this rule, CMS has proposed a number of policy changes to the Medicaid SDP requirements. Many of the proposed policy changes would improve and support hospital participation in these payment programs. Others, however, could further restrict how states fund and manage these important supplemental payments. Of particular concern are those policy changes that could restrict how states finance their SDP programs. We elaborate on our concerns below.

Financing Restrictions

For over 30 years states have turned to providers to help finance their Medicaid programs. Nearly every state has a provider tax program that includes hospital-based taxes as a funding source for the states' non-federal share of the Medicaid dollar.[7] As such, these arrangements have become core sources of funding for state Medicaid programs that are not exclusive to SDPs. Restricting state sources of financing, particularly when states are facing significant challenges with Medicaid eligibility redeterminations and the uncertainty of an economic recession, could compromise access for many historically marginalized populations served by the Medicaid program. It is unlikely that many states would be able to make up the gap in Medicaid funding for the non-federal share through other sources, if restricted, meaning the net effect is less money for the Medicaid program and fewer resources available to care for Medicaid beneficiaries. In this proposed rule, CMS seeks to reinforce its interpretation of Medicaid provider tax hold harmless arrangements based in statute and regulation by imposing new compliance measures. **CMS' proposal to further restrict state sources of financing and use hospitals to police such financing arrangements through this rule is of great concern to the AHA.**

Specifically, the AHA has serious concerns about subsections 438.6(c)(2)(G) and (H) of the proposed regulations. Taken together, these proposed subsections require providers to attest to the lawfulness of any hold harmless arrangements that they have. To be clear, hospitals and health systems always seek to comply with the law, and the AHA does not have any objection with requiring providers to do so or, in the appropriate circumstances, attest to their compliance. But here, the proposed language of this regulation is potentially overly broad in ways that may harm hospitals, patients and their communities. CMS needs to clarify the scope of the attestation requirement, including exactly what parties are attesting to generally and particularly with respect to hold harmless relationships.

While the text of proposed subsection (G) requires compliance "with all Federal legal requirements for the financing of the non-Federal share," the AHA is concerned that

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[6] Ibid.
[7] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-provider-rates-and-taxes/

HHS will add in sub-regulatory guidance or its own novel interpretations of federal law, such as using the regulatory phrase "including but not limited to." **Consequently, the final rule must make clear that any provider that makes an attestation based on its own good faith belief of compliance with federal statutes or regulations — not sub-regulatory guidance — has satisfied subsections (G) and (H), and the AHA urges CMS to ensure such clarification.** Put another way, HHS may *not* seek to elevate sub-regulatory guidance into "Federal legal requirements" via this proposed attestation requirement; the only way sub-regulatory guidance can become a federal legal requirement is through notice-and-comment rulemaking. *See Azar v. Allina Health Services, Inc.*, 139 S.Ct. 1804, 1812 (2019) ("Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements. On the contrary, courts have long looked to the *contents* of the agency's action, not the agency's self-serving *label*, when deciding whether statutory notice-and-comment demands apply."); *see generally id.* at 1810 (holding that notice and comment rulemaking is required for any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing ... the payment for services").

CMS' Feb. 17, 2023, informational bulletin exemplifies the AHA's concerns.[8] That document addresses the same general subject matter as subsection (H) of the proposed regulation. But CMS issued that sub-regulatory guidance, which is indisputably a substantive legal standard, without notice-and-comment. For that reason and others, it is currently the subject of litigation in federal district court. Specifically, the state of Texas has sued CMS, alleging, among other things, that the informational bulletin "is inconsistent with the plain language of the Social Security Act and CMS' own regulations." *Texas v. Brooks-LaSure*, Case No. 6:23-cv-00161, Compl. ¶ 6 (Dkt. 1) (Apr. 5, 2023). Texas further alleges that the informational "bulletin follows years of failed rulemakings and unsuccessful threats to compel Texas's compliance with the agency's preferred interpretation of the Act." *Id.* ¶ 6. These carefully-reasoned arguments, made in good faith by Texas, would support an attestation that it and its providers are acting in accordance with "all Federal legal requirements." (A decision by the federal district court is expected by the end of June.) **The final regulation must make clear that "Federal legal requirements" under subsection (G) — and described for the particular context of hold-harmless relationships in subsection (H) — are *only* those set forth in statute or notice-and-comment rulemaking, and**

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[8] https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf The proposed rule addresses similar subjects in its preamble. Because the proposed regulatory text does not address these issues, and because "the 'real dividing point' between the portions of a final rule with and without legal force is designation for 'publication in the Code of Federal Regulations,'" the AHA has not commented on the substance of those issues here, apart from their potential relationship to the proposed attestation requirement. AT&T Corp. v. Federal Communications Commission, 970 F.3d 344 (D.C. Cir. 2020) (quoting Brock v. Cathedral Bluffs Shale Oil Co., 796 F.2d 533, 539 (D.C. Cir. 1986) (Scalia, J.)); see id. ("For example, if a preamble purports to establish the regulatory treatment of 'high wind events' but the regulations as published in the Code do not, then the preamble statement is a nullity.")

that the agency will not seek to enforce sub-regulatory interpretations through any attestation requirements.

Payment Rate Limitations

Upper Payment Limit: Average Commercial Rate

CMS currently requires states to demonstrate that SDPs result in provider payment rates that are reasonable, appropriate and attainable.[9] We understand that current agency practice is to use the average commercial rate (ACR) as the benchmark for total payment rates for SDP review.[10] Because Medicaid managed care plans must compete with commercial plans for provider participation in their networks in order to provide comparable access to care, the agency notes that benchmarking provider payment rates to the ACR has greater relevance.[11] As such, CMS is proposing to codify current practice by establishing the ACR as the upper payment limit for SDPs made for inpatient hospitals services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. CMS further explains that, while to date, the agency has not approved an SDP above the ACR, establishing an upper payment limit for the most prevalent SDPs would appropriately balance the need for additional fiscal guardrails with providing state flexibility to pursue provider payment initiatives and delivery system reform that advance access to quality care for beneficiaries in Medicaid managed care.[12]

The AHA supports CMS' codification of current practice in establishing the ACR as the upper payment limit for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center. Over 70% of Medicaid beneficiaries are enrolled in Medicaid managed care.[13] As a result, managed care represents an increasing proportion of hospital payment with SDPs providing a critical funding source for hospitals. As we have previously noted, these additional payments have been critical in paying for services provided to Medicaid enrollees and offsetting Medicaid base rates that are often well below hospital cost. Establishing the ACR as the upper payment limit for SDPs for hospital services will better position hospitals to meet CMS' key objective of improving access to high quality health care services for Medicaid beneficiaries.

Modification of the ACR Calculation

Currently, CMS requires states to demonstrate that an SDP does not exceed the ACR for a specific service type (e.g., inpatient or outpatient hospital services) or for providers

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[9] FR, 88, May 3, 2023, p. 28114
[10] FR, 88, May 3, 2023, p. 28121
[11] FR 88, May 3, 2023, p.28122
[12] FR 88, May 3, 2023, p 28123
[13] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

in a specific provider class (e.g., rural or urban hospitals). States are currently required to use ACR data from only providers in the provider class that are receiving the SDP. However, the agency recognizes that certain types of providers could be disadvantaged by this approach and is proposing to provide states with added flexibility in how to calculate the ACR. The proposed changes will allow states to use ACR data from a broader set of providers, such as all providers in the state, if that would better align with state access and quality goals. For example, rural hospitals or urban hospitals with historically lower commercial payer mix would likely benefit from the state using ACR data from a broader set of statewide providers, which could have the effect of raising their ACR cap and thus increasing the SDP amount. As CMS notes, this added flexibility would allow state Medicaid programs to target funding to providers with certain financial needs without affecting other hospitals.[14] This added flexibility proposal however is silent on whether states could use ACR data from a subset of providers within a state, such as a certain region of a state, which we believe may be helpful to advancing goals related to quality and access in some circumstances. **The AHA supports CMS' proposal to increase state flexibility to use ACR data from a broader set of providers to allow states to improve SDP resources and better target funding for financially vulnerable providers such as urban or rural hospitals.** The AHA encourages CMS to consider adding to that flexibility by allowing states the option to use regional provider ACR data if it would be most beneficial to the providers receiving SDPs or to advancing state access and quality goals.

<u>Upper Payment Limit Alternatives to the ACR and SDP Expenditure Limit</u>

CMS notes that while it believes that the ACR as the upper limit for the four select services is appropriate and balances CMS' need for fiscal safeguards with states' flexibility over their SDPs, CMS identifies potential concerns about how states may respond to an ACR limit.[15] Specifically, CMS expresses concern that the codification of the ACR as the upper limit would incentivize states to expand the use of SDPs, in part because of providers' role in helping states finance their non-federal share of Medicaid funding to support these SDPs. CMS explains that restricting state financing would be one way to mitigate possible incentives for states to further expand programs beyond what may be necessary to meet quality and access goals. **The AHA has discussed concerns in the prior section regarding CMS' proposal to restrict permissible financing approaches**. CMS also explores several highly problematic alternatives to the ACR limit to address the perceived threat of uncontrolled SDP growth. Such alternatives, according to CMS, could include setting the upper payment limit for SDPs to Medicare rates, limiting the upper payment rate to ACR for only SDPs that are value-based purchasing initiatives, and/or implementing an aggregate expenditure cap for all SDPs.

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[14] FR 88, May 3, 2023, p 28125
[15] FR 88, May 3, 2023, p 28123

The AHA strongly opposes these possible alternatives to artificially limit the growth in SDPs, particularly for hospital-based SDPs. As CMS notes, these alternatives are likely to lead states to reduce provider payment from current levels, which could have a negative impact on access to care and health equity initiatives, which are important priorities for this Administration, as well as for states and providers.[16] The identified alternative to set the upper payment limit at Medicare rates, for example, would result in a significant reduction in critical funding support for hospitals that SDPs have provided. Currently, Medicare pays hospitals on average only 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries.[17] According to the Medicare Payment Advisory Commission (MedPAC), overall Medicare hospital margins were -6.2% in 2021 after accounting for temporary COVID-19 relief funds.[18] Without these funds, the overall Medicare margin for 2021 remained depressed at -8.2% after hitting a staggering low of -12.3% in 2020.

Moreover, overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023.[19] Limiting SDP amounts to the Medicare rate, or an aggregate cap in total payments as a percentage of managed care spending, would only add to the financial stress hospitals currently face. Hospital budgets are particularly stressed by continued underpayments from the Medicare and Medicaid programs, which generally account for more than half of all hospital revenue, as well as the historic spike in inflation and dramatic growth in the costs of labor, prescription drugs, supplies and equipment.[20] It is Medicaid beneficiaries that are at most risk if states are faced with little option but to cut program funding under these highly problematic potential alternatives. **The AHA strongly urges CMS to adopt its proposal to establish the upper payment limit for SDPs at the ACR and reject further consideration of any of the suggested alternatives.**

Provisions Specific to Fee Schedule-based SDP Arrangements

Interim Payments and Reconciliation

We understand that current and proposed regulations require that SDPs be tied to actual utilization of Medicaid services covered under the managed care contract during the current rating period. Under many current SDPs, states require plans to make interim lump sum payments to providers based on historical utilization from prior rate years, with a subsequent reconciliation to actual utilization after the end of the rate year. This approach allows state flexibility to manage the operational aspects of directed

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[16] FR 88, May 3, 2023, p 28131
[17] https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf
[18] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[19] https://www.aha.org/costsofcaring
[20] Ibid.

payment expenditures and creates a predictable schedule of payments for both providers and health plans based on historical utilization.

The proposal to eliminate this flexibility and prohibit interim payment methodologies with subsequent reconciliation is a significant concern for many Medicaid providers who face pressing financial challenges, especially amidst rising and unsustainable labor, drug and supply costs. Interim payments are an important tool states adopt to help mitigate cash flow challenges that Medicaid providers may experience by permitting SDP payments to be made on an interim basis throughout the year. This may be especially meaningful for providers that contributed to financing the non-federal share of the SDP up front. Without this flexibility, many hospitals and health systems who serve historically marginalized communities will face greater cash flow strains and states will have fewer tools to support providers in financial distress.

In addition, many states have fixed dollar amounts of funding for SDPs based on available state general fund dollars or provider tax revenue, among other permissible funding sources, and reconciliation allows the state to ensure accurate distribution of the available funding based on discharges and outpatient claims during the contract year. Reconciliation allows for adjustments if utilization is higher or lower than expected and provides states with tools to ensure fixed funding sources are adequate to finance the payments based on actual utilization.

We recognize that CMS' proposals regarding how states incorporate SDPs into managed care rate certifications through separate payment terms allows states continued flexibility in structuring payments but believe interim payments and reconciliation are important tools available to states to ease provider cash flow burdens while also tying fixed funding sources to actual utilization. **As a result, we urge CMS not to prohibit interim payments with reconciliation and to continue allowing states flexibility in their approach to tying SDPs to utilization of Medicaid services.**

Participation of Non-Network Providers in SDPs

Participation in SDP arrangements, including fee schedule amounts or uniform rate increases, is currently limited to providers who are contracted with Medicaid health plans. **We appreciate and support CMS' proposed change to permit non-network providers to be eligible for participation in SDPs.** In some cases, it is impractical for every plan to obtain individual network agreements with all facilities and providers who may serve Medicaid beneficiaries, so this requirement has served as an arbitrary factor limiting payment to certain providers. There also may be tangible access and quality benefits associated with including certain non-network providers in SDPs, such as rural emergency hospitals that may provide services to Medicaid beneficiaries who are traveling or otherwise require services outside of a health plan's contracting service area but may not have the leverage or ability to negotiate network contracts with all health plans. Further, in some cases, our members report that health plans recognize

that Medicaid providers are unable to access SDP funding streams if they are not in-network and this dynamic is used as a leverage point in contract negotiations to pressure providers into accepting lower-than-average base rates to be in the network. The proposed change removes this unintended leverage point that unfairly favors health plans in contract negotiations. It also would allow states to more easily establish minimum fee schedules or rate floors that apply to both in and out-of-network providers for services where the state identifies that payment inadequacy is interfering with access. Accordingly, we support this proposed change and believe the additional flexibility will enable states and CMS to more equitably shape policy and target payments in a way that promotes access and quality for Medicaid beneficiaries.

Provisions Specific to Value-based SDP Arrangements

CMS proposes several changes intended to reduce barriers for states that are interested in implementing value-based payments (VBP) and delivery system reform initiatives through SDPs. The proposed rule would remove requirements that prohibited states from setting the amount or frequency of the plan's expenditures. It also would remove requirements that prohibit states from recouping unspent funds allocated for these SDPs. The rule would revise and clarify how performance in these types of arrangements is measured for participating providers, including a prohibition on payment conditioned upon administrative activities such as reporting or learning collaboratives. The regulation would require states identify a baseline level for all metrics used to measure performance. And it would establish requirements for use of population-based and condition-based payments in these SDP arrangements.

Medicaid has been a leader in promoting VBP and delivery system reform initiatives. Many states and other stakeholders attribute this to the close collaboration that occurs between state Medicaid agencies, providers, and the patients and communities they serve, as well as the program's administrative infrastructure and authority. Historically, states used supplemental payments and Section 1115 demonstration waivers, among other authorities, to implement VBP programs. As Medicaid managed care enrollment has grown, CMS has thoughtfully preserved states' ability to implement these programs through SDPs. More recently, many states and other stakeholders have expressed interest in using delivery system reform initiatives to improve health equity and population health outcomes.

However, delivery system reform initiatives are challenging to establish and implement. In MACPAC's June 2015 Report to Congress, the commission noted that delivery system reform initiatives are often resource intensive.[21] States and other stakeholders reported that they hired additional administrative and clinical staff to implement and monitor them to ensure that they achieve their performance goals. Such initiatives also

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[21] https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf

often require the adoption of new costly technology or modifications to existing technology. States have also reported that finding a source for the non-federal share has been a challenge. These lessons learned should be applied to VBP and delivery system reform initiatives that are implemented through SDPs.

In addition, the AHA specifically urges CMS to reconsider prohibiting the use of pay-for-reporting metrics in delivery system reform initiatives that are included in SDPs. There are circumstances when this authority and payment would be critical in driving system change, and best viewed as a pathway to accelerating progress toward pay-for-performance measures. These payments could allow a state to develop a baseline for performance measures they have not historically tracked or hire new staff necessary to get an initiative off the ground and running. For example, pay-for-reporting may also be a useful tool to establish baseline performance in the early years of an SDP in priority areas such as health equity measurement where there may not be well-established baseline data. Delivery system reform collaborators, including states, plans, and providers, have the shared goal of improving value and providing better quality health care for our patients and beneficiaries, and no one thinks that it can be done with pay-for-reporting metrics alone. However, we believe they are an important tool that can serve as a catalyst to achieve our broader goals.

In addition, we support CMS' proposal to allow states to recoup excess funds from health plans that are allocated for SDPs but not ultimately paid out to providers as intended. This can occur specifically with VBP, delivery system reform or performance improvement initiatives if providers fail to achieve performance targets. These changes would remove possible perverse incentives whereby health plans could profit by retaining unspent funds that were intended to be paid to providers.

Exemption of Certain SDP Arrangements from Prior Approval Requirements

Existing CMS regulations require states to obtain prior CMS approval for SDPs through the preprint process, except for SDPs that are based on state plan-approved rates in the Medicaid FFS program, which are exempt from this process. We support the proposed change to further exempt minimum fee schedule SDPs that require plans to pay the Medicare FFS rate from the preprint and prior approval requirements. This proposal will streamline the approval process, reduce administrative burden for states and CMS, and allow payment programs adopting standard rates to be implemented without unnecessary delays waiting for approval. The AHA also recommends that in addition to exempting minimum fee schedules based on Medicaid FFS or Medicare payment rates from prior approval requirements, CMS should also exclude these standardized fee schedule arrangements from the calculation of the proposed SDP limits.

NETWORK ADEQUACY METRICS AND OVERSIGHT

The AHA applauds CMS' efforts to enhance network adequacy requirements for Medicaid managed care programs. Network adequacy requirements are a key component of ensuring that Medicaid beneficiaries enrolled in a managed care health plan can access the services they need. Many of our members have expressed concern that inadequate networks can result in inefficient use of care. For example, some patients seek care in emergency rooms when they cannot access the care they need in a physician office or outpatient setting. Our members have also expressed concern that patients can forgo or delay care when they cannot find access or secure an appointment, which can lead to their condition or health status declining. Strengthening network adequacy standards — and oversight of these standards — would promote better health for Medicaid beneficiaries.

The proposed rule includes several provisions intended to improve network adequacy: appointment wait time standards, secret shopper surveys, and price transparency and payment rate comparison requirements that are designed to ensure adequate capacity and availability of services. As enrollment in Medicaid managed care programs has increased, so has federal and state interest in efforts to ensure network adequacy. Over the last 10 years, CMS has taken thoughtful approaches toward ensuring that Medicaid managed care enrollees are able to access care. These approaches have included requiring time and distance standards while allowing state flexibility to define their own quantitative standards.

Appointment Wait Time Standards and Secret Shopper Surveys

CMS proposes to establish new wait time standards for certain provider types. CMS proposes appointment wait time standards for three categories of providers (outpatient mental health and substance use disorder, primary care, and obstetrics and gynecology) and would allow states to determine additional standards in an evidence-based manner.

The AHA supports CMS' proposal to require states to establish and enforce appointment wait time standards. These standards are meaningful measures of realized access and would hold health plans accountable for constructing provider networks that are available and accessible for their members, and as a result, could reduce delays in care that are harmful for Medicaid beneficiaries' health. We agree with CMS' proposal to allow for exceptions in certain circumstances and that the exceptions process would need to consider the impact of provider payment rates. Although not explicitly outlined in the proposed regulations, we hope CMS also will consider whether workforce shortages for certain provider types contribute to network adequacy concerns or potential challenges in meeting the proposed requirements.

The AHA also supports CMS' proposal to require states to contract with independent entities to conduct secret shopper surveys. We agree that this is a practical way to monitor compliance with appointment wait time standards and to ensure that provider directories are up to date. Such surveys have been deployed successfully to ensure

network adequacy among Health Insurance Marketplace and commercial plans.[22] As CMS, states and Medicaid health plans gain experience with this approach to validating network adequacy, it will be important to work with beneficiaries to understand how they make appointments and adapt secret shopper surveys accordingly. For example, we presume that telephonic secret shopper surveys are most efficient and therefore preferable, but we also understand that patients may also make appointments in person and online. Excluding other methods could inadvertently deemphasize or fail to capture access issues faced by some Medicaid beneficiaries.

Strengthening Network Adequacy for Post-Acute Care Settings

As described above, AHA supports CMS' proposal to enhance network adequacy requirements for primary care, obstetric/gynecological services, outpatient mental health and substance use disorder services. To ensure patient access to necessary rehabilitative care post-discharge from the hospital, we further recommend that the agency adopt similar provisions to strengthen post-acute care (PAC) provider networks. Inadequate networks of PAC providers present challenges for patients referred for downstream specialized care that is not provided by the referring hospital, such as rehabilitative care provided in skilled nursing facilities or inpatient rehabilitation facilities. These settings provide care through interdisciplinary care teams with specialized clinical training and treatment programs critical to achieving patients' rehabilitation and recovery goals. Insurance constructs resulting in inadequate PAC provider networks are a critical barrier to patients accessing these specialized services.

Importantly, insufficient inclusion of PAC providers in managed care networks can also result in resource and capacity strains on other parts of the health care system when general acute care hospitals are unable to discharge patients to an appropriate post-acute care facility for the next steps in their care. Our members report this is a common challenge due to limited availability of PAC providers in the network or challenges and delays with gaining authorization from the health plan for the placement, suggesting a need for more rigorous network adequacy standards and greater oversight of health plan practices related to authorization and denial of services. Specifically, we recommend that CMS adopt more specific network adequacy standards ensuring a sufficient number and type of each PAC facility be included in plan networks. The size and bed capacity of such facilities should also be considered in developing stronger network adequacy requirements for PAC facilities, as even in cases where there are a specified number of PAC facilities available in a certain geographic area, there may not be available beds, which has the potential to further restrict patient access even when it may appear on paper that there are sufficient providers available.

Assurances of Adequate Capacity and Services

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[22] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1554

CMS plays a crucial role in enforcing the mandate established by Congress that reimbursement rates for health care providers are sufficient to ensure Medicaid beneficiaries enjoy the same access to health care services as the general population (Medicaid "equal access" standard). In the wake of the U.S. Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center, Inc.*, which ended providers' and beneficiaries' right to challenge state Medicaid payment rates in federal court, CMS has become the final arbiter in determining if provider payments are adequate to ensure access under federal statute.

We have previously noted the chronic shortfalls caused by Medicaid underpayments. However, due to the lack of publicly available data, little is known about how payments compare across Medicaid FFS and Medicaid managed care programs or other benchmarks. Accordingly, the AHA supports CMS' efforts to improve transparency among provider payment rates to assure that Medicaid managed care beneficiaries have adequate access to care. The proposed regulation would require Medicaid managed care organizations (MCO) to report, and states to review, total payments for certain services and types of providers using claims data from the previous reporting period. Medicaid MCO payment rates would be benchmarked to published Medicare payment rates. Absent these data, MACPAC's analysis of Medicaid health plan approaches to hospital payment rate setting shows that states vary in terms of whether they establish payment rate floor requirements.[23]

It is important that CMS, states and other stakeholders fully understand how inadequate provider payment may impact access to care. Medicaid beneficiaries look to hospitals and health systems to address a wide variety of complex health and social needs. Financially distressed hospitals and health systems often are faced with reducing specialty care that can result in access challenges for Medicaid beneficiaries.

Additionally, we would like to raise two more considerations for CMS as it works to finalize this policy. First, we urge CMS not to consider adopting a framework that suggests Medicare payment rates are the appropriate benchmark to ensure Medicaid beneficiaries have access to care, but rather using this approach only as a mechanism for evaluating payment adequacy in a standardized way. The AHA has expressed concerns about using Medicare as a benchmark for commercial prices, and our concerns carry over to the Medicaid program. As noted above, hospitals received payment of only 84 cents for every dollar spent by hospitals caring for Medicare patients in 2020. Second, payment rate methodologies are complex, and final payments can include a variety of adjustments.[24] We urge CMS to work with state Medicaid programs to develop a method that accounts for these differences to ensure that comparisons accurately reflect differences in base payment rates.

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[23] https://www.macpac.gov/wp-content/uploads/2018/10/Factors-Affecting-the-Development-of-Medicaid-Hospital-Payment-Policies.pdf
[24] https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/

MEDICAL LOSS RATIO STANDARDS

The medical loss ratio (MLR) measures the amount of premium dollars that go toward health care services and quality improvement activities and caps the amount that insurers can spend on administrative activities or profits. The proposed rule establishes the importance of plan adherence and accurate reporting of MLR expenses by requiring plan-level reporting of MLR information, preventing inappropriate provider incentive payments used by plans to meet necessary qualified expenditures, and ensuring that overpayments are reported timely and included in MLR calculations. The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to patients' access to care and to hold health plans accountable for how premium dollars are spent, and we commend CMS for taking steps to strengthen the MLR requirements within the Medicaid program. Particularly in light of vertical integration among large national organizations offering Medicaid health plans, we urge CMS to take additional steps to protect beneficiaries from improper manipulation of MLR by imposing additional scrutiny on plan expenditures to ensure that patient premiums are being utilized appropriately and captured as intended in the required reporting.

We are greatly concerned about the ways in which vertical integration within some of the largest insurers can enable plans to channel health care dollars to their affiliated health care and data services providers at patients' expense. Specifically, vertical integration may allow managed health plans to pay themselves or their subsidiaries for services in a way that counts as medical spending for the purpose of MLR, while allowing them to extract greater profit from government programs — and in fact, circumventing the precise reason MLR reporting exists. MLR requirements — and oversight of those requirements — is key to ensuring appropriate spending by health plans. To be clear, we do not view all plan payments to affiliated entities as problematic, such as when an integrated system's health plan pays affiliated clinicians an appropriate rate for patient care. What is problematic, however, is when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that inappropriately increase health system costs while increasing profit for the plan's parent company, as well as when plans use their benefit design to steer patients to their affiliated providers in ways that may benefit the plan financially but may not consistently align with patient needs or choice.

For example, the three largest pharmacy benefit managers (PBMs) — CVS Caremark, Express Scripts and OptumRx — are all owned by large, national insurers that offer Medicaid health plans throughout the country. Pharmaceutical purchasing from PBMs is a prominent expense for these plans, and the dollars spent on such procurement are classified as qualified care expenses for MLR calculations. The vertical integration of PBMs and insurers offering managed care could enable plans to manipulate their PBM expenses by paying larger sums to their affiliated PBMs to meet MLR expense requirements, allowing plans to skirt regulations while keeping premium dollars for their parent company's bottom line. To further enhance revenue for the PBM, the plans can implement coverage restrictions on where their enrollees access certain drug therapies.

Indeed, PBMs have been a primary enabler of site-of-service restrictions on physician-administered specialty drugs.

Additionally, we are concerned about the categorization of funds spent on programs designed to limit coverage as "quality improvement" expenses. We understand that health plans may be able to count some or all utilization management functions in the numerator of the MLR under the category of "quality improvement." Despite being classified as quality improvement programs, we are deeply concerned that many prior authorization and other utilization management programs have the opposite impact on quality by impeding patient access to timely, necessary care. For example, a 2022 American Medical Association physician survey found that 94% of physicians find prior authorization requirements delay patient access to timely care, with 80% reporting that the process can lead to treatment abandonment.[25]

For example, "Leveraging Utilization Management to Reduce Medical Loss Ratio Rebates," is a blog post from Medecision, a care management company owned by a large commercial insurer. In the blog, the company touts that if plans include an outcome or safety component in their utilization management programs, "then the money spent on UM will count toward a plan's 80–85%. Patient care is improved and health plans hit their numbers, thus reducing the amount of rebates. Talk about a win-win."[26] We believe that actively engaging in processes designed to shield expenses from potential patient rebates flies in the face of the goals of the MLR standard. **We urge CMS to review how insurers are categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities. Furthermore, we encourage CMS and states to ensure that MLR requirements disallow any form of manipulation, and that oversight of required reporting includes active monitoring for such potential abuse.**

QUALITY PROVISIONS

Proposed Updates to Evaluation Plans for SDPs

CMS currently requires that states develop an evaluation plan for SPDs that advances one or more goals in a state's managed care quality strategy.[27] According to CMS, MACPAC and the Government Accountability Office have noted concerns over the level of detail and quality of the state SDP evaluations. SDP evaluations are a tool for CMS to ensure SDPs support the key objectives of improving quality and access for Medicaid beneficiaries. To improve compliance, CMS proposes states must identify two metrics

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[25] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[26] https://blog.medecision.com/leveraging-utilization-management-to-reduce-medical-loss-ratio-rebates/#:~:text=If%20UM%20has%20an%20outcome%20or%20safety%20component,their%20numbers%2C%20thus%20reducing%20the%20amount%20of%20rebates
[27] FR 88, May 3, 2023, p. 28147

for its SDP evaluation plan, one of which measures access and the other measures performance at the provider class level for SDPs that are population-based or condition-based.[28] How states go about developing these metrics will be important.

The AHA urges CMS to provide state Medicaid agencies with meaningful guidance on setting performance measures that are within the control of the hospital receiving the SDP and that improves care for the Medicaid patient population it serves. CMS should allow states flexibility to select measures applicable to the type of hospital, like current practice in the Medicare program. The Medicare program includes measures applicable and actionable by different provider types such as acute inpatient and outpatient facilities, inpatient psychiatric hospitals and inpatient rehabilitation. **We would encourage CMS to provide states with meaningful guidance that further aligns Medicaid quality measures for SDPs evaluation plans with Medicare hospital measures where appropriate. This would allow hospitals to better focus on improvement while reducing reporting burden and administrative costs to both the states and providers.**

Medicaid Managed Care Quality Rating System

CMS proposes to implement requirements for a Medicaid and CHIP Managed Care Quality Rating System (MAC QRS) that would apply to all state Medicaid programs. Among other policies, the MAC QRS would require states to adopt a quality reporting website for applicable plans that permits comparison of plan performance on quality and other factors, such as the plan's drug formulary and provider network. The proposed MAC QRS framework also would require states to adopt an initial set of health plan quality measures, along with some methodological requirements for how quality data are displayed.

The AHA appreciates the basic concept of a common measure framework that would be applicable across state Medicaid programs. While the proposed list of measures could be further streamlined, we believe requiring states to use the same set of measures has the potential to foster greater alignment on important quality and safety topics, provide important insights on health plan quality performance to patients and families, and reduce unnecessary administrative burden. Indeed, hospitals and health systems have long urged greater alignment and coordination of quality measurement efforts within and across federal programs, and a focus on "measures that matter" the most to improving outcomes and health. Over the past several decades, the health care field has experienced a maturation of quality measure methodologies, and a rapid expansion in the number of available quality measures. Unfortunately, this rapid expansion of quality measures has often proceeded in an uncoordinated fashion, leaving the field with large numbers of measures concentrated on the same topics but also persistent measure gaps. Even worse, hospitals have frequently experienced

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[28] FR 88, May 3, 2023, p. 28149

multiple payers asking for quality data on the same topics but using differing definitions and data collection approaches. This has frequently led to redundancy and excessive administrative burden for hospitals and confusion for patients.

As CMS implements the MAC QRS, we urge the agency to adopt several procedural safeguards to ensure the framework fulfills its potential. **First, the AHA urges CMS to use the consensus-based pre-rulemaking measure review process to obtain input on both its proposed measure set and any future updates to the minimum measure set.** Each year, CMS produces a Measures Under Consideration list and submits it to its contracted consensus-based entity (currently Battelle) by December 1 for a multi-stakeholder review, with recommendations due back to the agency by February 1. While not every federal quality measurement program explicitly requires CMS to use the pre-rulemaking process, CMS has generally opted to use it for most programs to obtain broad-based feedback on the suitability of measures for its programs and foster alignment across the agency. Given the agency's recently stated commitment to work towards the use of a "Universal Foundation" of measures across programs, we believe any measures required under the MAC QRS should undergo pre-rulemaking review.

CMS also should establish criteria around the types of alternative measures and measure frameworks that states could adopt. As we understand the proposed rule, states could adopt alternative measures and frameworks for Medicaid managed care plans with approval from CMS. While we recognize the potential value of customizing measures to meet particular state-level priorities, CMS must ensure these alternative frameworks do not inadvertently perpetuate the lack of alignment described above. We encourage CMS to consider reasonable criteria for alternative measures and frameworks. For example, CMS could require states to use nationally-recognized measures, such as those that have been endorsed by a consensus-based entity. CMS also could consider providing states with lists of vetted measures from which they could choose alternative measures, along with a regular process for states to submit potential future measures for inclusion on the list.

In addition, AHA urges CMS to consider adopting a measure selection criterion that considers provider administrative burden in collecting and reporting its measure set. While the MAC QRS is ostensibly a requirement focused on health plans, the measures selected have the potential to result in health plans seeking certain data from hospitals, physicians and other health care providers. Given that Medicare and private payers already have significant quality reporting requirements for health care providers, CMS should carefully consider whether any measures in its minimum measure set could add to provider burden.

Lastly, the AHA cautions about the use of single summary scores for quality performance, such as star ratings. As we understand the proposed rule, CMS is not currently proposing to require the use of star ratings or any other single quality rating; rather, the agency is establishing minimum requirements around how to display quality

performance. We believe this likely is an appropriate starting point. We also understand the potential conceptual appeal of a single summary score to provide a simplified view of quality performance. However, hospitals' experience with CMS' Star Ratings system for hospitals has been beset by questions about whether the ratings result in meaningful and equitable performance comparisons. We urge CMS to use the experience of reporting measure and measure domain-level scores in the MAC QRS and to engage with patients, health plans and providers if it considers the use of a single summary rating in the future.

IN LIEU OF SERVICE AND SETTING

CMS proposes several changes that are intended to provide clarity, protect beneficiaries and ensure that in lieu of services (ILOS) policies are fiscally responsible. The proposed rule limits ILOS to be a service or setting that would be allowed under state plan or 1915(c) waiver authority. The proposed rule also would limit ILOS spending to a portion of the total managed care costs, although it would exclude certain institutions for mental disease services from this calculation. The rule would require states to provide support for their determination that each ILOS is medically appropriate and a cost-effective substitute for a covered state plan service or setting. The rule would streamline documentation requirements for states with a projected ILOS cost percentage that is less than or equal to 1.5% of capitation payments and require additional reporting for states that exceed this benchmark. The rule also would require that states provide an annual report of the actual cost of delivering ILOS. Overall, the rule both broadens the circumstances in which ILOS can be covered by managed care plans and establishes guardrails for this authority.

The AHA supports these policies. ILOS are an important authority for tailoring coverage and benefits to the needs of a population. Some states are using these policies to provide health-related social needs for Medicaid beneficiaries, including providing short-term housing or medically tailored meals as part of a comprehensive care plan for Medicaid beneficiaries, and as such, are an important tool to achieve our shared goal of improved community health outcomes.

The AHA also supports CMS' proposal related to the treatment of short-term institutions for mental disease (IMD) stays. CMS proposes to exclude the cost of short-term IMD stays from the calculation of the ILOS cost percentage. This policy would lessen barriers for states to provide IMD coverage for those in need of these services and, in doing so, increase access to quality behavioral health care.

CONCLUSION

The AHA appreciates this opportunity to share with CMS our views on these very important proposals to improve beneficiary access to needed services. While we are generally supportive of CMS' direction with these proposals, we are mindful that states are under considerable strain as they undertake the largest scope of eligibility

redeterminations in the program's history. As CMS moves to finalize these policies, we encourage the agency to continue to consider the additional burden these regulations may impose upon states. CMS has demonstrated such consideration by proposing implementation timelines that factor in the challenges states face in making necessary operational changes. States, however, will incur additional expenses to implement many of the provisions in the proposed regulation. These expenses will come at a time when state Medicaid spending is anticipated to increase due to the expiration of the enhanced federal match as states work through the redetermination process. To offset these additional costs, states may be forced to consider reducing provider payment, which may in turn threaten beneficiary access to needed services that CMS strives to protect. As such, we ask CMS to work with states to ensure that they have adequate resources to implement the regulations, once finalized. Lastly, we encourage CMS to be mindful of states' capacity and strongly urge against any effective dates that may divert agency staff from the critical mission of eligibility redetermination.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, AHA's director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President, Government Relations and Public Policy