



July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

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 the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, we are pleased to present CMS with the following comments 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.

The Medicaid program is critical to providing access to health care services for approximately 2.3 million Arizonans, 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. 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.

Unfortunately, gaps remain. Therefore, AzHHA 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 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 across the country receive, on average, 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 critical to ensuring that Medicaid recipients have adequate access to care.

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.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. This underpayment of hospital services by Medicaid programs resulted in a Medicaid shortfall of \$24.8 billion in 2020.³

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. 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. We elaborate on our concerns below.

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. States must demonstrate this by comparing the rates to a benchmark such as Medicare rates or the average commercial rate (ACR). 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.⁴ As such, CMS is proposing to codify current practice by establishing the ACR as the upper payment limit for SDPs made for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center.

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

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

³ <https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf>

⁴ FR 88, May 3, 2023, p.28122

AzHHA supports CMS' codification of current practice in establishing the ACR as the upper payment limit. 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.

While AzHHA agrees that the ACR should be applied as an upper payment limit for inpatient hospital services, outpatient hospital services, and nursing facility services, **we recommend broadening the definition of "academic medical center" to "include a health professional school with an affiliated teaching hospital."** Currently, Arizona has at least one SDP which provides supplemental payments for hospitals with a graduate medical education program. This, and other programs which Arizona has implemented have been critical in increasing the number of residency slots in Arizona and increasing Medicaid rates for Arizona providers. AzHHA opposes defining "academic medical center" as "a health professional school with an affiliated teaching hospital" as this would exclude many academic medical centers that are affiliated with but do not include a health professional school, including those with rural affiliations located in areas with severe provider shortages.

Upper Payment Limit Alternatives to the ACR and SDP Expenditure Limit

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. 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. 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.

AzHHA 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. 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.⁵ According to the Medicare Payment Advisory Commission (MedPAC), overall Medicare hospital margins

⁵ www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf

were -6.2% in 2021 after accounting for temporary COVID-19 relief funds.⁶ 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 2023.⁷ 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.⁸ 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. AzHHA 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.

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 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. **AzHHA supports this added flexibility.**

Interim Payments and Reconciliation

The 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 of the current Arizona SDPs, plans are required 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 has allowed Arizona to begin implementing new SDPs sooner and have allowed hospitals to have more advance notice of their payments which have allowed them to make better decisions when planning their budgets.

⁶ www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

⁷ www.aha.org/costsofcaring

⁸ Ibid.

The proposal to eliminate this flexibility and prohibit interim payment methodologies with subsequent reconciliation is a significant concern for AzHHA members who face pressing financial challenges, especially amidst rising and unsustainable labor, drug and supply costs. Interim payments are an important tool 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 is 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.

Additionally, Arizona has fixed dollar amounts of funding for many SDPs and reconciliation allows Arizona 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 strongly support CMS' proposed change to permit non-network providers to be eligible for participation in SDPs.** While we recognize that CMS' intention may have initially been to encourage providers to be more willing to contract with health plans, we are concerned that the requirement to contract has been 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.

Hold Harmless Interpretation

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 a concern for AzHHA.**

Specifically, AzHHA has 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 AzHHA does not have any

objection with requiring providers to do so or, in the appropriate circumstances, attest to their compliance. Nor is AzHHA aware of any hold harmless arrangements in Arizona. 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,” AzHHA is concerned that a future Administration could 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 AzHHA urges CMS to ensure such clarification.**

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. 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.

However, since delivery system reform initiatives are challenging to establish and implement, AzHHA 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.

NETWORK ADEQUACY METRICS AND OVERSIGHT

AzHHA 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.

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.

AzHHA 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. **Additionally, with CMS' renewed interest in wait times, CMS should consider additional programs which would increase the pipeline for medical professionals in high professional shortage areas (HPSAs) and rural locations.**

Strengthening Network Adequacy for Post-Acute Care Settings

In addition to enhancing network adequacy requirements for primary care, obstetrics, outpatient mental health and substance use disorder services, 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 long-term acute care, 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.

MEDICAL LOSS RATIO STANDARDS

The proposed rule establishes the importance of plan adherence and accurate reporting of the medical loss ratio (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. AzHHA 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.

CONCLUSION

AzHHA 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.

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Amy Lyster".

Director of Financial Policy and Reimbursement, AzHHA