A Passionate Voice for Compassionate Care

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS–2439–P - Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (88 Fed. Reg. 28902, May 3, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, clinics, service providers and organizations, attached are our comments to the proposed rule recently issued by the Centers for Medicare & Medicaid Services (CMS) entitled Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS–2439–P).

Medicaid and the Children's Health Insurance Program (CHIP) are the foundation of our nation's safety net and provide necessary health care services to working families, children, the elderly and the disabled, many of whom would be uninsured in the absence of a strong and vital Medicaid program. As the single largest health insurer in the United States, Medicaid funding is a critical support for America's safety net institutions, including many Catholic hospitals and nursing homes that serve a disproportionate share of the low-income, uninsured and underinsured in their communities every day. As the largest collection of not-for-profit provider care in the United States, Catholic healthcare serves millions of Medicaid enrollees at our facilities nationwide.

For decades CHA and our members have carried the message that health care is a basic human right essential to human flourishing, and we have advocated policies to ensure that everyone has access to affordable health care. The first principle in our Vision for U.S. Health Care affirms our call to pay special attention to the needs of the poor and the vulnerable, those most likely to lack access to health care, in our journey towards affordable, accessible health care for all. This commitment is why the Catholic health ministry has strongly supported public health care programs like Medicaid and CHIP.

Our comments highlight the need for CMS to ensure fair payment policies in the Medicaid program to providers which have not adequately compensated providers who work to deliver safe and high-quality care to beneficiaries. We also support many of CMS' proposals as they work towards more transparency in Medicaid managed care plans. We also urge CMS to consider new policies that

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advance innovation, health equity and the need to increase Medicaid payments to combat the workforce challenges and rising costs of care, especially in the nursing home space.

- **Access and Network Adequacy**

CHA appreciates CMS' attention throughout the proposed rule to improving and increasing access to care for participants in Medicaid managed care plans. For Medicaid coverage to be meaningful, beneficiaries must have access to the providers and services needed to meet their health care needs. Patients who cannot get timely access to the care they need are likely to forgo care and suffer poor health. Strong network adequacy standards are essential, including making sure Medicaid payments are sufficient to encourage providers to participate. CHA is pleased CMS has proposals to address timely patient access to care and to promote price transparency and sufficiency.

Appointment Wait Times and Secret Shopper Surveys

CMS proposes to create maximum appointment wait time standards for routine appointments for primary care (adult and pediatric), obstetric/ gynecological services, outpatient mental health and substance use disorder services, and a state-selected service (adult and pediatric).

Inability to get care in a timely fashion is a significant barrier for patients seeking care and CHA supports requiring states to establish and enforce appointment wait time standards. CMS has proposed wait time standards of between 10 to 15 days for the specified services. **While we agree that those should be reasonable expectations, we are concerned that they may not be immediately attainable in light of the realities of low Medicaid payments rates and the general health care workforce shortage**. We support the proposal for an exceptions process that would include consideration of provider payment rates. We suggest CMS also consider tying the proposed Medicaid wait times to those experienced in other health care contexts – Marketplace, Medicare or commercial insurance – in a given geographic area.

CHA supports the proposal to require states to contract with independent entities to conduct secret shopper surveys of Medicaid managed care plans' electronic provider directories and appointment wait times. Patients must be able to rely on the accuracy of on-line provider directories. We suggest CMS reconsider whether the 90 percent threshold with respect to wait times is the right standard to start with, given current health care workforce shortages. We also suggest the secret shopper surveys take into consideration the different ways patients make appointments – by telephone, on-line and in person.

Assurances of Adequate Capacity and Services

CHA agrees with CMS in the need for greater transparency in provider payment rates from plans and states. Low Medicaid payment rates contribute to reduced access to services and harm to beneficiaries. CMS proposes a process through which managed care plans must report, and each state must review and analyze, managed care payment rates to providers for certain types of services as part of the state's duty to ensure network adequacy and enrollee access consistent with state and federal standards. **CHA supports this proposal.** Given that plan payments are negotiated with providers and subject to no federal regulatory or statutory limit or minimum, greater oversight is essential. The importance of CMS' role in enforcing the statutory requirement that reimbursement rates be sufficient to ensure that Medicaid beneficiaries enjoy the same access to

health care services as the general population is even greater since *Armstrong v. Exceptional Child Center, Inc*., 575 U.S. 320 (2015), which ended providers' and beneficiaries' right to challenge state Medicaid payment rates in federal court.

Remedy Plans to Improve Access

CMS proposes a process that would require states to submit a plan to remedy managed care plan access issues when identified. Specifically, once a plan's access issue has been identified by CMS, the state or plan, the state would be required to develop a remedy plan and submit it to CMS within 90 days. The plan would identify specific steps and timelines to remedy the issue(s) within 12 months.

CHA supports the establishment of such a process. We suggest, however, that the requirement also be triggered by credible reports of access issues from private entities such as providers or patient advocacy groups.

Network Adequacy and Post-Acute Care

Hospital patients frequently need additional care post-discharge in settings with specialized clinical training and treatment programs critical to ensuring their fullest possible recovery and return to activities of daily living. Patients are harmed when managed care networks do not have sufficient post-acute providers such as skilled nursing homes and inpatient rehabilitation facilities. If hospitals are unable to discharge patients because there are no post-acute facilities to receive them, it also places strain on the health care system – in addition to poor patient outcomes, care is not delivered in the most appropriate and efficient setting, hospitals incur additional (often unreimbursed) costs and beds needed by others remain occupied. We hear from our member hospitals that care coordination teams struggle every day with an inability to discharge Medicaid patients to appropriate post-acute care settings, and the waits are longest for managed care patients and for children. **We recommend that CMS require managed care plans to report metrics for timely discharge to post-acute settings and develop appropriate network adequacy standards.**

- **State Directed Payments**

CMS Approval

CMS proposes permitting state directed payments (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 provide a particular service under the managed care contract. **CHA and our members support this flexibility but request clarification in the final rule on what CMS will consider "Medicare approved rates" for this purpose**. For instance, it is unclear whether an SDP that uses a hospital's hospital-specific Medicare rate as a minimum payment amount would be eligible for 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 minimum fee schedule, it is equally important for the longevity and equity of the Medicaid program that states aspire to reimburse services at levels as close as possible to commercial health plan levels.

Average Commercial Rate

Medicaid's historically low provider reimbursement has led to the growth of supplemental payments in Medicaid FFS and SDPs in managed care, which help to ensure that providers are adequately compensated for the services they provide. In practice, CMS has considered the average commercial rate (ACR) as the upper payment limit for SDPs since 2017.

Recognizing the central role that SDPs play in promoting states' access and quality goals, **CMS proposes codifying the average commercial rate (ACR) as the SDP ceiling for hospitals and certain other providers. CHA strongly supports CMS' proposal, which is particularly important for many of our members that serve a high volume of Medicaid and uninsured patients, and that consequently depend on SDPs and other supplemental payments to cover the cost of care**. In the preamble to the proposed rule, CMS notes it is considering alternatives to the ACR and other limitations on SDP payment levels in the final rule, including setting an upper payment limit at Medicare rates and/or setting an aggregate state-level expenditure cap for SDPs. CHA strongly opposes changes to SDPs that would lower allowable payment levels compared to the current state, especially given the low reimbursement of Medicare and the financial constraints of many of our members since the pandemic as well as the rising costs of labor, supplies, and equipment. This would result in significantly reduced payments for some of our members, put our members' finances at risk, and undermine access to care for Medicaid enrollees. We urge CMS to finalize the proposal to use the ACR as the upper payment limit for SDPs.

CHA also supports a critically important proposed change to the ACR calculation that would benefit high Medicaid providers. Under current practice, CMS requires states to demonstrate that any SDPs that exceed 100% of Medicare do not exceed the ACR for the class of services but only for providers included in the SDP. The proposed rule would codify the ACR demonstration requirement but allow states to demonstrate the ACR based on the set of services included in the SDP, without restricting the demonstration to the SDP provider class. Such a change benefits high Medicaid providers—including rural and safety net providers—that often receive lower commercial rates compared to providers with a larger share of commercial patients.

Non-Federal Share Financing

CHA's members have long worked with their states to sustainably 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. 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. Further, these provider attestations would be available to CMS upon request. The attestation requirements would apply to all directed payments, including those that do not require CMS prior approval.

Along with our members and other hospital associations, **we ask that CMS clarify the scope of this attestation requirement,** including exactly what parties are attesting to generally and particularly with respect to hold-harmless relationships. This is particularly important given the uncertain legal status of the February 2023 sub-regulatory CMS bulletin on hold-harmless

arrangements.[1] **We urge CMS to clarify in the final rule that the attestation would be with respect only to requirements specified in federal regulation or federal statute.**

Interim Payments and Reconciliation

Current regulations require that SDPs be tied to the utilization of services provided under the contract. Under a common SDP methodology previously approved by CMS, 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 payment expenditures and creates a predictable schedule of payments for providers and health plans. CMS proposes to prohibit this payment methodology, as CMS notes tying interim payments to utilization from a prior rating period is not consistent with risk-based managed care. **We urge CMS not to prohibit interim payments with reconciliation and to continue allowing states to have this flexibility**.

Participation of Non-Network Providers

Current regulations limit most SDPs to providers that are in network with plans. The proposed rule would permit SDPs for both network and non-network providers, allowing states to set minimum provider payment levels regardless of whether a provider is in network with a plan. This flexibility could give states a new tool to promote access to care, particularly for geographic areas and/or specialty services where plans have few in-network providers.

CHA and our members hope that CMS will closely monitor this proposal to ensure that in contracts with managed care organizations, in-network providers are not harmed with the addition of non-network participation data.

Reporting Requirements to Support Oversight

In addition, we note that CMS' proposal would require substantial new public, provider-level reporting on SDPs. Given the complexity of the Medicaid program's payment and financing mechanisms, it is essential that this new provider-level reporting includes appropriate context (e.g., providers' uncompensated care costs and/or Medicaid utilization) such that SDPs can be evaluated with sufficient information on the role providers play in the health care safety net. We also share in concerns about the potentially significant burden that could arise out of CMS's proposed provider attestation and encourage CMS to shift the onus on states to ensure and attest to the statutorily compliant structure of any established SDP(s).

- **In Lieu of Services**

"In lieu of services" (ILOS) policies allow states to give Medicaid and CHIP managed care plans the option to pay for alternative services instead of standard Medicaid and CHIP benefits when it is medically appropriate and cost-effective to do so. The proposed rule both expands plans' ability to include ILOS and established guardrails, including requirements that states limit ILOS spending,

[1] On June 30, 2023, the U.S. District Court for the Eastern District of Texas, Tyler Division, issued a preliminary injunction barring CMS from implementation or enforcing the February 2023 Bulletin pending the outcome of litigation in *Texas v. Brooks-LaSure.* Case No. 6:23-cv-00161.

provide documentation on medical appropriateness and cost effectiveness and make an annual report of the actual cost of delivering ILOS. **CHA supports these proposals.**

Plan participants must be willing to use an offered ILOS as a substitute for the state plan-covered service or setting to which they are otherwise entitled**. CHA agrees that it is vital to ensure patients' rights are protected and supports explicitly stating state such rights and protections in a new and specific code section.**

States are increasingly using the ILOS authority to address non-medical but health related needs of the Medicaid population including social drivers of health such as short-term housing and medically tailored needs. Based upon the experience of some of our members working with social service organizations providing ILOS, we recommend CMS help states create infrastructures to support these programs, including technical assistance to social service providers new to interacting with Medicaid requirements and to primary care and other providers who need support connecting patients to services. We also urge CMS to work with states so ILOS services are available consistently throughout the state, especially in California where Medicaid programs are administered by counties.

- **Medicaid Managed Care Quality Rating System**

CMS proposes a Medicaid and CHIP Managed Care Quality Rating System that would include mandatory measures, a rating methodology, and a mandatory website display format**. CHA supports a national quality framework applicable across all state Medicaid programs.** Alignment and coordination of quality measurement programs across and within federal programs is essential to reduce provider burden, minimize administrative complexity and focus on the measures that will lead to meaningful quality improvement for patients. We urge CMS to keep this principle in mind as it develops and implements this program, particularly concerning the proposed flexibility to allow states to seek approval for alternative measures. CMS should also consider using the consensus-based pre-rulemaking measure review process for input on its proposed measure set and future updates, both to ensure the suitability of the measures and to promote alignment with other quality programs.

In closing, thank you for the opportunity to share these comments regarding the proposed Medicaid managed care access rule. We appreciate and share CMS' commitment to reimbursing providers at a level that will ensure access to beneficiaries in need of health care. If you have any questions about these comments or need more information, please do not hesitate to contact me, Kathy Curran, Senior Director Public Policy, or Paulo Pontemayor, Senior Director, Government Relations, at 202-721-6300.

Sincerely,

Lisa A. Smith

Vice President
Advocacy and Public Policy