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June 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

On behalf of our over 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to comment on CMS-2442-P, the Centers for Medicare & Medicaid Services' (CMS) proposed rule for improving access, quality and health outcomes in Medicaid fee-for-service (FFS) and home and community-based services (HCBS) programs.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small critical access hospitals, mid, and large-sized hospitals, and academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers. We also count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

WHA in general commends CMS for efforts to address payment-related barriers to care in the Medicaid program, as well as better monitor enrollee access to care. Below we provide detailed comments about a number of provisions in the proposed rule.

STATE DIRECTED PAYMENTS

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 and crucial component of provider payment for care for Medicaid beneficiaries. As in other states, base reimbursement for health care providers in the Medicaid program in Wisconsin has not kept pace with the cost of providing services. Even taking all supplemental payments into account, hospitals in our state in 2021 received just 67 cents for every dollar spent caring for Medicaid patients, according to publicly available data through the state mandated hospital fiscal survey. Provider taxes are an important and legally permissible source

of funding for states and we ask CMS to allow states flexibility in implementing payments to meet access goals and to refrain from implementing overly burdensome barriers around their use.

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. **Overall, we encourage CMS to allow states flexibility in their approaches to typing SDPs to utilization of Medicaid services.** We elaborate on our concerns below.

NEW COMPLIANCE MEASURES ON HOSPITALS

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 on hospitals. **CMS' proposal to restrict state sources of financing and use hospitals to police financing arrangements through this rule is of concern to WHA.**

Specifically, WHA agrees with the AHA and its 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 WHA 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," WHA is concerned that 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 WHA 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.

We urge CMS to make clear in the final regulation 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 that the agency will not seek to enforce sub-regulatory interpretations through any attestation requirements.

UPPER PAYMENT LIMIT AND OVERALL EXPENDITURE LIMIT

CMS currently requires states to demonstrate that SDPs result in provider payment rates that are reasonable, appropriate, and attainable. We understand that current agency practice is to use the average commercial rate (ACR) as the benchmark for total payment rates for SDP review. 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 also proposes to provide states with added flexibility in how to calculate the ACR, such as using data from a broader set of providers.

CMS indicates 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.

WHA does not oppose 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. However, WHA strongly strongly opposes the possible alternatives to artificially limit the growth in SDPs, particularly for hospital-based SDPs. The identified alternative to set the upper payment limit at Medicare rates, for example, could limit critical funding support for hospitals because Medicare also underpays providers. According to the AHA, currently, Medicare pays hospitals on average only 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. 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. Without the COVID relief funds, the overall Medicare margin for 2021 remained depressed at -8.2% after hitting a staggering low of -12.3% in 2020.

NETWORK ADEQUACY METRICS AND OVERSIGHT

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.

WHA continues to advocate for state flexibility in network adequacy standards. While we support the concept of wait times, we believe that many factors play a role in appropriate standards. Should CMS move forward with its proposal, we agree with allowances 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.

WHA 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. 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, WHA 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

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).

We have previously noted the chronic shortfalls caused by Medicaid underpayments. 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.

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 care that can result in access challenges for Medicaid beneficiaries.

We would like to raise three 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. WHA has 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. 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.

Finally, we encourage CMS to consider data related to prior authorizations, claims denials, and claims down-coding as additional sources of information that could be required as these can have significant impact on payment, access to care for Medicaid beneficiaries and add administrative burden for health care providers.

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. WHA 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.

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.**

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.

Some states are using ILOS 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. Thus, these are an important tool to achieve a shared goal of improved community health outcomes. However, WHA cautions against including these activities as a medical services for purposes of the medical loss ratio. Medicaid managed care organizations are theoretically paid to manage care. Providing housing, meals, air conditioners or similar social needs for enrollees are not medically reimbursable services for providers. As a result, they should be viewed overall as part of the

care management function of Medicaid managed care organizations, and thus should be considered part of the administrative cost in contracting with managed care organizations.

WHA 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

WHA 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 proposed rule. We appreciate CMS's proposals to alleviate provider burden and improve patient care. If you have any questions, please feel free to contact Joanne Alig, WHA's Senior Vice President for Public Policy, at jalig@wha.org.

Sincerely,

Eric Borgerding
President & CEO