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**COMMENTS OF THE MISSOURI DEPARTMENT OF SOCIAL SERVICES, MO HEALTHNET DIVISION, REGARDING PROPOSED RULE ON MANAGED CARE ACCESS, FINANCE AND QUALITY**

**CMS-2439-P**

The Missouri Department of Social Services (DSS), MO HealthNet Division (MHD) submits the following comments on the proposed rule from the Centers for Medicare & Medicaid Services (CMS) regarding Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (May 3, 2023).

MHD has joined several other States in filing Joint Comments, but is supplementing that response with a Missouri-specific comment on proposed 42 C.F.R. § 438.6(c)(2)(ii)(G) and (H), which impose new requirements regarding the hold harmless provisions of health care-related taxes with respect to State Directed Payments (SDPs), on proposed 42 C.F.R. § 438.207(f), which imposes a remedy plan to address access issues, and on a proposal to put a limit on SDP expenditures.

**Comment on Proposed § 438.6(c)(2)(ii)(G) and (H) Regarding Hold Harmless**

As explained in the Joint Comments, MHD believes that CMS's interpretation of the hold harmless provisions in Section 1903(w)(4) as prohibiting private redistribution arrangements is not consistent with the statute or CMS's implementing regulations at 42 C.F.R. § 433.68(f)(3).

Missouri providers have had various private agreements to redistribute funds among themselves for decades, with the full knowledge and approval of CMS, pursuant to the State's "Medicaid Partnership Plan" with CMS. The Medicaid Partnership Plan, which has been in place since 2002, arose out of a similar concern expressed by CMS's predecessor, the Health Care Financing Administration (HCFA), that these private agreements violated hold harmless principles.

While MHD disagreed then, as it does now, that the statute or regulation prohibited these private agreements, to address HCFA's concerns, Missouri agreed that providers would have to establish that any pooling arrangement would be "generally redistributive" according to the "B1/B2" analysis described in CMS's regulations at 42 C.F.R. § 433.68(e)(2). The Medicaid Partnership Plan, signed by both CMS and DSS, provides that health care-related taxes in which the providers have a redistribution arrangement will be recognized as "permissible funding

sources" subject to an "annual demonstration" that "there is no explicit hold harmless in state law, regulation, or policy" and "the tax program structure at issues meets the B1/B2 standard of 1.0 or above . . . after taking into account the redistribution arrangement."

When the Medicaid Partnership Plan was announced in 2002, HCFA issued a press statement in which then-Administrator Thomas Scully described the agreement as ensuring that the program was "compliant with federal law" and expressing hopes that "this will be a model for other states."

We note that requiring providers to meet the B1/B2 test fully addresses CMS's concerns, as expressed in the current SDP proposal, that redistribution arrangements only work when funds are transferred from "providers with relatively higher Medicaid volume" to "providers that serve a relatively low percentage of Medicaid patients or no Medicaid patients," contrary to the purpose of the Medicaid program. 88 Fed. Reg. at 28130. Application of the B1/B2 test ensures that the redistribution benefits providers with relatively higher Medicaid volumes. As CMS explained when it adopted the test in 1992, the "generally redistributive" regression analysis measures "the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class of items or services (or providers of these services), and to use these revenues as the State's share of Medicaid payments. To the extent that a tax is imposed more heavily on providers with low Medicaid utilization than high Medicaid providers, the tax would be considered redistributive." 1992 Fed. Reg. 55118, 55128 (Nov. 24, 1992).

For purposes of seeking a waiver of uniformity, CMS's regulations provide that "[i]f the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, CMS will automatically approve the waiver request." 42 C.F.R. § 433.68(e)(2)(ii). To the extent that a redistribution means that different providers pay different effective rates of tax (after redistribution), application of the B1/B2 test means that these differing rates are generally redistributive and would be automatically approved.

While Missouri continues to be of the view that private arrangements among providers is outside the scope of the hold harmless statutory and regulatory definitions, it offers its positive experience with the Medicaid Partnership Plan as a different approach to addressing CMS's concerns.

**Comment on Proposed § 438.207(f) Regarding Remedy Plans to Improve Access**

The new rule says that states "must submit to CMS for approval a remedy plan" in situations in which the state or CMS "identifies an area in which an MCO's…access to care under the access standards in this part could be improved."

The rule makes suggestions as to areas in which the remedy plan could approach the problem (increasing payment rates, faster credentialing, etc.), but it doesn't identify when the remedy plan requirement is triggered. Put another way, the level of CMS's involvement in these issues is not clear. At what point does the state *have to* submit a remedy plan? Upon request? Also, at what scale does the problem have to be before CMS starts enforcing this requirement? In its current form, the rule is leaving it up to states to identify the specific issues. For example, we get two complaints from providers about credentialing taking too long. We investigate and determine that the state law governing credentialing needs to be tweaked to clarify a definition, so we submit a legislative proposal. Did that just trigger the remedy plan requirement? The rule seems to give CMS a lot of discretion as to how heavy-handed it wants to be, on a case-by-case basis, without providing expectations that states can rely on. The states needs some level of assurance from CMS as to when they need to be acting. It's entirely possible that CMS will issue guidance over the next four years addressing this, but it nevertheless will need to be addressed.

**Comment on Proposing a Limit on SDP Expenditures**

MHD strongly disagrees with issuing a cap on SDPs as a share of program costs. Capping SDPs as a percentage of total program costs, such as 1.5 percent or 2.5 percent, would severely limit a Medicaid agency's ability to advance access, quality, and value-based purchasing goals through managed care. In addition, the regulation language appears to be using the percentage cap as a way of placing more scrutiny on certain types of payments arrangements such as supplemental payments or add-on payments. If the goal is to target certain supplemental payments then why not limit the percentage cap to those arrangements. Missouri currently has a minimum/maximum fee schedule SDP on both the entirety of its inpatient and outpatient hospital services which has been approved by CMS and recommended by CMS to other States. The combined hospital services SDP is for the entire provider class and is roughly 50% to 60% of the capitation rate and is not a supplemental payment. This SDP provides a negotiation range for providers between the Medicaid Fee-For-Service (FFS) rate and not to exceed the Average Commercial Rate

(ACR). In Missouri's opinion and from what we had gathered was also the opinion of CMS prior to the issuance of this proposed rule, the provider class min/max SDP allows for flexibility in value based arrangements, advances access and quality initiatives, and at the same time limits the payments to a reasonable negotiated rate under the ACR and at a minimum of the Medicaid Fee Schedule. Without the use of this SDP mechanism, the State would be unable to ensure the reasonability of negotiated rates within a provider class. In effect, it appears the regulation is placing such a burden on States as to dissuade the use of the SDP. This does not appear to align with improving the efficiency and quality of the Medicaid program.