

June 30, 2023

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

VIA Electronic Submission
<http://www.regulations.gov>

Re: Comments to Proposed Rule CMS–2439–P – Medicaid Program; Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality

Dear Administrator Brooks-LaSure:

Sutter Health appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services’ (CMS) Medicaid managed care access, finance, and quality Proposed Rule published in the Federal Register on May 3, 2023¹ on behalf of its 23 hospitals, 33 ambulatory surgery centers, and over 30 other health care centers and facilities serving northern California, which includes more than 53,000 dedicated team members and 12,000 clinicians providing services in support of more than 3 million patients.

Sutter Health is committed to enhancing the well-being of its patients by transforming care to achieve the highest levels of quality, access, and affordability for its communities,² and we share CMS’s vision to drive value-based care transformation, advance health equity, and promote care quality and access. While Sutter Health applauds CMS’s efforts to promote timely care access for Medicaid beneficiaries, we are seriously concerned that the proposals in this rule will achieve the opposite effect – disrupting care access for the more than 93 million Medicaid and CHIP beneficiaries³ nationwide.

If finalized, CMS’s proposed changes to State Directed Payment (SDP) programs will fundamentally and detrimentally impact the ability of California hospitals to continue to serve Medicaid managed care beneficiaries at meaningful levels.

¹ 88 Fed. Reg. 28092 (May 3, 2023) (hereinafter, “Proposed Rule”).

² Sutter Health, Mission, Vision and Values. <https://www.sutterhealth.org/about/mission>. Accessed June 29, 2023.

³ See Medicaid.gov, March 2023 Medicaid & CHIP Enrollment Data Highlights (Mar. 2023), <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

I. PREAMBLE “HOLD HARMLESS” COMMENTARY MISREPRESENTS WHAT THE SOCIAL SECURITY ACT HAS ALWAYS PERMITTED AND EXPOSES STAKEHOLDERS TO DECADES OF RETROSPECTIVE FALSE CLAIMS LIABILITY

CMS’s “hold harmless” commentary fails to consider its devastating impacts on our most vulnerable and underserved patients, in direct contravention of CMS’s objective to incorporate the advancement of health equity “as a foundational element across all [its] work, in every program, across every community.”⁴ Instead of promoting the laudable goal to address disparities in our public health system, CMS’s hold harmless provisions would irreparably divert needed investments away from our communities, critically depriving health systems of the resources necessary to expand care access and improve care outcomes for our Medicaid patients. Such a result is not only inconsistent with CMS’ goal to advance equity⁵ for program beneficiaries;⁶ the agency’s hold harmless provisions in this rule *would ubiquitously and adversely impact those most vulnerable, and indeed, most dependent upon the services and benefits SDP programs financially* ensure across states nationwide. In other words, the Proposed Rule’s hold harmless provisions, if adopted, would violently topple the foundation that CMS, in partnership with health systems like Sutter Health, has worked so hard to build to ensure quality and timely care access for our nation’s most vulnerable and underserved populations.

The law is clear that providers are not prohibited from participating in private hold harmless arrangements that do not involve state action. These arrangements ensure that sufficient resources are provided in consideration of the shared responsibility each health system has in caring for their community. Without these private arrangements, SDP policies would instead create winners and losers not only among provider SDP participants, but importantly, of the patients who are dependent upon these providers in their respective communities for timely care access. Indeed, these arrangements are paramount to the expansion of care networks and afford necessary incentives to ensure that providers can continue caring for Medicaid beneficiaries with unique and specific care needs. Otherwise, providers may be deterred from participating in SDPs given financial losses that would not bolster, but impair continued efforts to provide quality care. The absence of these providers’ participation in SDPs would further limit the amount of funds that may be drawn down to invest in our Medicaid community, destabilizing our care infrastructure and reducing care access.

⁴ CMS, Establishing the Framework for Health Equity at CMS (Jul. 8, 2022), <https://www.cms.gov/blog/establishing-framework-health-equity-cms>.

⁵ CMS has defined health equity “as the attainment of the highest levels of health for all people so that every person has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.” CMS Framework for Health Equity 2022-2032. (April 2022), https://www.cms.gov/sites/default/files/2022-04/CMS%20Framework%20for%20Health%20Equity_2022%2004%2006.pdf.

⁶ CMS, CMS Framework for Health Equity (mod. Mar. 30, 2023), <https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity>.

It is important to note that funding from SDPs is critical to Sutter Health's efforts to expand care access to our Medicaid patients, particularly specialty care and services through community providers. We estimate the impact of this funding to be significant, at approximately \$175 million annually. The simple fact is that without this funding, Sutter Health will lose its capacity to expand care access for our Medicaid community. CMS's hold harmless commentary is not a blow to our system – it is a blow to those Medicaid patients who are dependent upon the services Sutter Health provides.

Sutter Health strongly urges CMS to consider the far-reaching implications of the hold harmless provisions in the Proposed Rule. Since the inception of California's hospital SDP program, Sutter Health, like many health systems in California, has dramatically increased our capacity to care for California's Medi-Cal⁷ community. The loss of this funding would mean health systems, like Sutter Health, can no longer invest in our communities or the capital necessary to facilitate expanded specialty care access for Medicaid beneficiaries. This would mean scaling back public wellness programs that benefit Medi-Cal patients, reducing capacity to provide Medicaid specialty care (such as, for example, pediatric neurology), and downstream consequences that dangerously risk our community's health.

Without SDP investments, Medi-Cal patients will need to travel further away to receive specialty care, which will be challenging given transportation needs, cost considerations, among other serious constraints specific to this population. This means that Medi-Cal patients may delay treatment and increasingly rely upon our emergency department (ED) to receive the care they need. Given that California is the most expensive state in the nation,⁸ the impact of CMS's hold harmless provisions would be adversarially significant to our State. The end result is that our Medicaid population will experience worse health outcomes, contend with higher costs, and impair our hospitals' capacity to care for our community through increased ED and hospital inpatient utilization. In other words, CMS's hold harmless provisions would disastrously disrupt our health care ecosystem and establish a single point of access of entry into our health care system for Medi-Cal beneficiaries – our ED system. This stands opposite to everything the Medi-Cal program stands for - to care for the people of California. Indeed, contrary to CMS's goal to promote a care pathway “that is free from inequity while optimizing opportunities, access, and outcomes for historically underserved and under-resourced communities[.]”⁹ CMS's hold

⁷ California's Medicaid health care program is called Medi-Cal. See Cal. Dep't of Health Care Services, What is Medi-Cal? (mod. Mar. 23, 2021), <https://www.dhcs.ca.gov/services/medi-cal/pages/whatismedi-cal.aspx>.

⁸ See U.S. News & World Report, Affordability (2020). <https://www.usnews.com/news/best-states/rankings/opportunity/affordability>

⁹ The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality, Michelle Schreiber, Adam C. Richards, Jean Moody-Williams, and Lee A. Fleisher (June 6, 2022),

harmless commentary in the Proposed Rule would specifically limit opportunities, reduce access, and worsen outcomes for Medicaid beneficiaries nationwide.

CMS must make an actual rule change if it wants to modify the definition of a hold harmless. Rather than propose a legally compliant rule change, CMS arbitrarily attempts to redefine a hold harmless through commentary in the preamble. This preamble commentary to the Proposed Rule demonstrates CMS is attempting to alter the meaning of an indirect hold harmless by removing the requirement of state action in determining the existence of a hold harmless arrangement. The fact that CMS relegates its position to preamble commentary, and not the actual rule, evidences the tenuous nature of CMS's position. If CMS retains the preamble commentary that inaccurately rewrites history regarding how a hold harmless has been defined, the agency will force a substantial portion of the Medicaid safety net into uncertainty and peril. Providers in virtually every state have participated in Medicaid reimbursement programs in good faith, based on CMS's historical rules and commentary, provided substantial services in reliance on that, and acted in accordance with what was clearly the historical law governing health care-related taxes.

The regulatory definition of an indirect hold harmless is clear in the statute and was repeatedly made clear in CMS's prior rulemaking efforts in 2008 and 2019. The statute and CMS rulemakings verify that all prohibited hold harmless arrangements (including those based on indirect payments) require a state action. If CMS wants to regulate a purported hold harmless arrangement where the state is not providing, directly or indirectly, for the arrangement, it must obtain a change in the statute and the rules to articulate that new regulatory standard. It is not currently, nor has it ever been the case, that an indirect payment not borne of state action gives rise to a hold harmless arrangement.

A. Statutory Requirement of State Action for a Hold Harmless

In 1991, when Congress passed the currently governing health care-related tax provisions, it set three clear hold-harmless tests: A) a positive correlation between payments and the amount of taxes assessed, B) payments varying based only on the amount of tax paid, or C) the state providing an offset guaranteeing to hold taxpayers harmless for the cost of their tax.¹⁰ CMS now claims, in its preamble commentary, that the third test actually regulates transactions that do not originate from the state.¹¹ Congress enacted this statute to support the use of health care-related taxes as a source of Medicaid financing; it did not delegate legislative authority to expand these tests in any way. CMS's predecessor agency proposed a rule in 1991 that prohibited health care-related taxes if there was any linkage

https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality#_ftnref7

¹⁰ 42 U.S.C. § 1396b(w)(4).

¹¹ Proposed Rule at 28130-28131.

between payments to the provider and the tax.¹² In response, a 1991 House report noted, “[CMS] has attempted by regulation to convert the statutory provision enacted . . . from a general authorization for States to use the revenues from provider-specific taxes into a broad prohibition against the use of provider-tax revenues.”¹³ The report further called CMS’s attempts to subvert the statute “an illogical and patently impractical result.”¹⁴ The current statutory and regulatory system makes clear states can use provider taxes to finance Medicaid payments so long as the states themselves do not sanction a hold harmless arrangement.

The precise statutory language that controls this situation is clear: to find a hold harmless, the governmental taxing entity must be at the helm of any purported hold harmless arrangement. The statute defines the existence a hold harmless provision where “[t]he *State or other unit of government imposing the tax provides (directly or indirectly)* for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.”¹⁵ The statute leaves no room for dispute regarding the requirement of state (or other government unit) action to find a hold harmless arrangement, even through an “indirect” payment. The statute does not support CMS’s commentary in the preamble to the Proposed Rule, and the regulatory history since the statute further supports the requirement of state action to find a hold harmless.

B. Reiteration of the State Action Requirement in the 2008 Rulemaking

In its 2008 final rule, CMS reiterated that a hold harmless, whether by a direct or indirect payment, is based on state action. CMS stated: “***We believe “controlled or directed by the state” is a more accurate description of the types of payments that will be considered in evaluating whether an impermissible hold harmless arrangement exists.***”¹⁶ In the 2008 rules, CMS made clear “it makes little difference which part of the state treasury makes the funds available to taxpayer.”¹⁷ CMS went on to describe an indirect guarantee from a situation “where a State imposing a tax on nursing facilities provided grants or tax credits to private pay residents of those facilities that could be used to compensate those residents for any portion of the tax amount that the State has allowed to be passed down to them by their nursing homes. ***This represents a direct guarantee of an indirect payment to taxpayers.***”¹⁸ Providers have relied on this guidance to govern the use of health care-related taxes since 2008 and nothing in subsequent

¹² Medicaid Program; State Share of Financial Participation, 56 Fed. Reg. 46,380 (Sept. 12, 1991).

¹³ H.R. Rep. No. 102-310, at 25 (1991).

¹⁴ H.R. Rep. No. 102-310, at 25 (1991).

¹⁵ 42 U.S.C. § 1396b(w)(4)(C)(i) (emphasis added).

¹⁶ 73 Fed. Reg. 9694 (Feb. 22, 2008) (emphasis added).

¹⁷ 73 Fed. Reg. 9694 (Feb. 22, 2008)

¹⁸ 73 Fed. Reg. 9686 (Feb. 22, 2008) (emphasis added) (Additionally, there can be no “indirect guarantee” under the rule in the absence of a provider tax in excess of 6%. 42 C.F.R. § 433.68(f)(3)(i)).

regulatory history is cited by CMS or can support CMS's contradictory commentary in the preamble to the 2023 Proposed Rule.

C. CMS's Unsuccessful Attempt to Redefine Hold Harmless in 2019 Proposed Rulemaking (MFAR)

In MFAR, CMS attempted to define a hold harmless as occurring without state action by creating the “net effect” test and standards related to “reasonable expectations.”¹⁹ The current CMS Deputy Administrator and Director of Center for Medicaid and CHIP services Daniel Tsai, in his then-role as the Massachusetts Medicaid director, provided MFAR commentary explaining problems with these terms, terms that are strikingly similar to the commentary in the preamble to the 2023 Proposed Rule. Deputy Administrator Tsai stated such efforts, ***if in the language of the rule*** “introduce[d] significant new state obligations,” that “[i]f implemented, . . . would represent an unprecedented federal overreach,” “exceed[ing] CMS’s statutory authority,” contained “provisions [that] are highly susceptible to arbitrary and capricious application,” was “not supported by the underlying statute,” and “includ[ed] reporting on business dealings of private entities that are not available to the [S]tate.”²⁰ After much public comment, CMS withdrew MFAR without implementation.²¹ If the objectionable language is not even ***in the rule***, but rather only provided in the preamble commentary to the Proposed Rule, the damage would be substantially greater than any issue created by changing the rule itself.

CMS proposed a regulatory change in the preamble commentary only because it knew, in 2019, it did not have the authority to regulate private-only hold harmless arrangements that involve no state action. CMS now claims (in the 2023 Proposed Rule preamble commentary) that CMS has also regulated transactions solely between private parties. If CMS had the authority prior to 2019, it would not have proposed that language in MFAR. But neither the statute nor the historical regulatory guidance support the CMS narrative it now espouses in its preamble commentary to the Proposed Rule. If CMS wants to regulate this issue outside of state action, it should propose language to alter the rule and, because the statute does not support such a rule, CMS should also petition Congress for a legislative change.

D. Contradiction of Proposed Rule's Preamble Commentary with Statutory and Regulatory History of a Hold Harmless

In the absence of specific language altering the tests set by 42 C.F.R. § 433.68(f), CMS cannot alter the legal applicability of the hold harmless standard through preamble commentary to the Proposed Rule. CMS overreaches its authority by trying to include this

¹⁹ Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,777-78 (November 18, 2019).

²⁰ Dan Tsai Comment Letter (Jan. 27, 2020).

²¹ 86 Fed. Reg. 5,105 (Jan. 19, 2021).

language in dicta in the preamble commentary instead of altering the underlying regulatory framework. CMS knows it does not have the authority to regulate private arrangements in the absence of state action, which is why it attempted to change the regulations under MFAR. If it seeks that authority now it should go through a similar notice and comment process on that specific rule change, not add substantial confusion through preamble commentary.

Even the examples of indirect payments cited by CMS in the 2023 Proposed Rule preamble commentary resulted from state action. CMS cites a nursing home case that led to the 2008 rule change where *the state* was taxing nursing homes, the nursing homes passed through the tax to the patients, so the nursing home was held harmless, and then a *state agency* awarded grants to the patients of those facilities to hold the patients harmless.²² CMS also cites an Alaska DAB opinion where *the state* “entered into proportionate share payment agreements with several private hospitals and began to make payments to the hospitals based on the agreements.”²³ These examples do not support CMS’s claim in the preamble commentary that an indirect payment constituting a hold harmless can exist in the absence of state action; in fact, these examples only support the requirement of state action in a hold harmless scenario.

E. Effects of Redefining a Hold Harmless on Provider Liability

If CMS leaves the preamble commentary to the Proposed Rule in place that falsely describes a hold harmless without changing the language of the actual rules, it could subject thousands of providers to potential False Claims Act charges for decades of actions previously reviewed and commented on by CMS and the OIG. Altering the regulatory structure through preamble commentary in the absence of supporting language creates uncertainty for states and providers, undermining the use of health care-related taxes as a form of financing for Medicaid payments, and subjects providers to unnecessary risks of liability. CMS should remove the commentary from the preamble to the Proposed Rule attempting to rewrite the history of hold harmless definitions and either enforce the rules as they are written or propose new rules.

II. MAJOR PROPOSALS FOR WHICH CMS IS REQUESTING COMMENTS BUT IS NOT PROPOSING TO ADOPT RULES

The equal access provision of the Social Security Act (SSA) requires that payment rates “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general

²² 88 Fed. Reg. 28,129 (May 3, 2023); see also *Hawaii Dep’t of Human Servs. Bd. et al., DAB No. 1981 (June 24, 2005), reconsideration denied DAB No. 2006-1 (2006)*.

²³ *Alaska Dept. of Health, DAB No. 2103 (July 31, 2007)*.

population.”²⁴ CMS recognizes the critical role SDPs play in ensuring payment rates promote access.²⁵ Unfortunately, CMS is considering potential proposals that are intended to reduce SDP expenditure levels and limit the sources of non-federal share for SDPs. Because CMS is elevating other objectives above equal access, many of the proposals undermine the goals of the SDPs that are essential to the ability of California hospitals to ensure equal access for Medicaid beneficiaries. This is inconsistent with precedent providing that “equal access is—literally and figuratively—the bottom line of Section 30(A), and the measuring point for compliance with the statute.”²⁶ Equal access is intended to be the “objective benchmark” against which other SSA objectives (e.g., efficiency and economy) are considered,²⁷ but CMS has tossed that aside in favor of the proposals considered in this Section.

A. Average Commercial Rate (ACR) as the Maximum Total Payment Rate

CMS should codify ACR as the total payment rate limit as proposed at 42 C.F.R. § 438.6(c)(2)(iii) and discard the alternatives under CMS consideration that would set the limit for hospital, physician, and nursing facility services at Medicare or another payment level that is less than ACR and does not actually cover the cost of treatment due to the many unallowed charges under Medicare payment principles. Permitting SDPs payment rates at 100% of the ACR is fundamental to ensure access to care for Medicaid managed care enrollees, as CMS has expressly acknowledged in the below excerpts from the Proposed Rule.

*CMS believes that using the ACR as a limit is likely appropriate as it is generally consistent with the need for managed care plans to compete with commercial plans for providers to participate in their networks to furnish comparable access to care for inpatient hospital services, outpatient hospital services, qualified practitioner services at an academic medical center and nursing facility services.*²⁸

²⁴ 42 U.S.C. § 1396a(a)(30)(A).

²⁵ Proposed Rule at 28104 (“There is considerable evidence that Medicaid payment rates, on average, are lower than Medicare and commercial rates for the same services and that provider payment influences access, with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who participate in Medicaid, and investments in emerging technology among providers that serve large numbers of Medicaid beneficiaries.”).

²⁶ *Am. Soc’y of Consultant Pharmacists v. Garner*, 180 F. Supp. 2d 953, 972 (N.D. Ill. 2001).

²⁷ *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 931 (5th Cir. 2000); *Hoag Mem’l Hosp. Presbyterian v. Price*, 866 F.3d 1072, 1079 (9th Cir. 2017); *see also* H.R. REP. 101-247, 391, 1989 U.S.C.C.A.N. 1906, 2117 (The question which the Secretary must ask is “whether Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area.”).

²⁸ 88 Fed. Reg. at 28121.

In our view, utilizing the ACR in a managed care delivery system is appropriate and acknowledges the market dynamics at play to ensure that managed care plans can build provider networks that are comparable to the provider networks in commercial health insurance and ensure access to care for managed care enrollees.²⁹

CMS's acknowledgement is underscored by the fact that payment rates are inextricably linked to access in several important ways. First, providers are more willing to contract with Medicaid managed care plans and be part of those provider networks when the payment rates are commensurate with commercial insurance. By incentivizing provider networks that have both breadth and depth, enrollees will necessarily have more access to care. This allows enrollees to proactively seek preventative care and other important medical interventions necessary for positive health outcomes. Unsurprisingly, the National Bureau of Economic Research found that reimbursement rates are an important determinant of access to care, health care utilization, and health status for Medicaid recipients, especially when comparing Medicaid reimbursement to private insurance.³⁰

Second, providers are more willing to take on new Medicaid patients when payment rates are commensurate with commercial insurance. For example, one study showed that physicians were significantly less likely to accept new patients insured by Medicaid (74.3%) compared to those with private insurance (96.1%).³¹ Lower payment rates result in fewer providers willing to treat enrollees resulting in less access to care. In contrast, higher rates have been shown to have a positive correlation with physician acceptance of Medicaid patients.³²

Third, higher payment rates allow providers to maintain a broad array of services. The service lines offered by providers, particularly hospitals, are a function of both community needs and financial considerations. Certain service lines that have high Medicaid utilization are typically some of the first to be reduced or closed by providers due to the unreimbursed costs for those services. Obstetrics is a service line with significant Medicaid utilization, and federal policy has tied Medicaid DSH funding to the maintenance of that service line in recognition of that fact. Higher payment rates through ACR-based SDPs play an important role in improving access to care by making it financially feasible for providers to maintain a broad array of services.

²⁹ 88 Fed. Reg. at 28123.

³⁰ National Bureau of Economic Research Bulletin of Health, Increased Medicaid Reimbursement Rates Expand Access to Care (Oct. 2019), <https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care>.

³¹ MACPAC, Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey (June 2021), (“[P]hysicians were significantly less likely to accept new patients covered by Medicaid than those with Medicare or private insurance.”).

³² Holgash and Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters And What Doesn't*, Health Affairs (Apr. 2019).

Fourth, higher payment rates support provider investments in infrastructure, technology, workforce development, and quality interventions that promote access to quality care. Health care providers continue to struggle financially, and numerous studies show that most providers have razor thin (or negative) operating margins.³³ Higher payment rates for Medicaid services free up resources for providers to make the investments necessary for access to care. Also, higher payment rates help to stave off hospital closures that result from significant unreimbursed costs for services to Medicaid patients. Without the financial stability of providers that serve low-income communities, there cannot be sustained access to care.

Finally, setting the total payment rate limit at less than the ACR would exacerbate the disparities between Medicaid and other payers due to the costs many providers assume to support those payments. As former Director at the Center for Medicaid and CHIP Services, Cindy Mann, recently noted, hospitals are acutely sensitive to low Medicaid payment rates because the net value of revenue is considerably less when the non-federal share costs are born through provider taxes and/or IGTs.³⁴

B. SDP Proportional Expenditure Limits

CMS is considering whether to limit SDP expenditures to a proportion of Medicaid managed care program expenditures. CMS is also considering several ways to impose such a proportional expenditure limit, such as setting it based on specific services (e.g., hospital SDPs may not exceed more than 10% of the total Medicaid managed care program expenditures for hospital services). CMS should not impose the SDP proportional expenditure limit as contemplated in section I.B.2.f of the Proposed Rule. The SDP proportional expenditure limit CMS is considering: (1) violates the SSA's equal access provision and constitutes an arbitrary and capricious agency action; and (2) violates the SSA's explicit provisions allowing states to use intergovernmental transfers (IGTs) and provider taxes to finance payments.

- (1) Through the SSA, Congress tasked CMS with the important responsibility of ensuring that Medicaid payments for services promote equal access to care comparable to the “care and services [that] are available to the general population.”³⁵ Consistent with this, CMS explicitly states in the Proposed Rule that allowing payments up to ACR would “ensure that Medicaid managed care enrollees have

³³ For example, hospitals have had a negative operating margin in 8 of the last 12 months and—cumulatively—have not had a positive year-to-date operating margin at any point in the last 12 months. KaufmanHall, “National Hospital Flash Report,” 6 (May 2023).

³⁴ Cindy Mann and Adam Striar, “How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost,” Commonwealth Fund (Aug. 17, 2022), <https://doi.org/10.26099/c71g-3225>.

³⁵ 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

access to care that is comparable to access for the broader general public.”³⁶ CMS thus acknowledges that ACR payment rates are integral to access in several important ways, including that the payment rates ensure sufficient provider networks, capacity and investments in technology.³⁷

Despite the acknowledgement that ACR payment rates are integral for equal access, CMS is considering proportional expenditure limits that reduce SDP expenditure levels solely based on their proportion relative to other Medicaid managed care expenditures, rather than based on the payment level needed to ensure equal access. The proportional expenditure limits—by design—thus curtail SDP payment rates significantly below comparable commercial rates.

In addition to violating the SSA’s equal access provisions, CMS failed to properly consider how the SDP proportional expenditure limit would impact Medicaid payments and access for Medicaid beneficiaries.³⁸ CMS acknowledges its authority to collect data to conduct this analysis but has not collected or requested such data to provide stakeholders with an appropriate impact analysis for the proportional expenditure limit. The SDP proportional expenditure limit reduces access for Medicaid enrollees as compared to the general population and significantly changes current law without any analytical justification. Therefore, the SDP proportional expenditure limit violates the SSA’s equal access provision and constitutes arbitrary and capricious rulemaking.

- (2) The SDP proportional expenditure limit is motivated by CMS’s scrutiny of legitimate state sources of financing. Instead of addressing whether rates are sufficient for equal access, CMS is concerned with the fact that SDPs are usually financed by IGTs and provider taxes.³⁹ This is evidenced by CMS comments and the fact that the proportional expenditure limit only reduces overall payment expenditures if a state makes those expenditures through an SDP. CMS recognizes that base payments are typically financed by state funds, and—unsurprisingly—the expenditure limit does not apply if base payments are increased without an SDP to the maximum payment level. However, if that same maximum payment level is

³⁶ Proposed Rule at 28121.

³⁷ Proposed Rule at 28104 (CMS acknowledges that payment rates below ACR reduce the willingness of providers to accept Medicaid patients and hamper their ability to invest in the workforce, technology, and infrastructure needed for access to quality care).

³⁸ Proposed Rule at 28727 (“[The proposed rule] could have potential negative impacts on access to care that would need to be balanced with the need for improved program and fiscal integrity.”).

³⁹ See Proposed Rule at 28123 (“The majority of SDPs that increase total payment rates up to the average commercial rate are primarily funded by either provider taxes, IGTs, or a combination of these two sources of the non-Federal share. These SDPs represent some of the largest SDPs in terms of total dollars that are required to be paid in addition to base managed care rates. We are concerned about incentivizing States to raise total payment rates up to the ACR based on the source of the non-Federal share.”).

achieved through SDPs which, per CMS's own acknowledgement, are almost always funded by IGTs and provider taxes, the proposed limit severely reduces the level those payments can reach.

This unreasonable SDP proportional expenditure limit violates the SSA's explicit protection of IGTs and provider taxes as legitimate non-federal share sources, which CMS has no authority to overrule. The SSA explicitly allows as much as 60% of the non-federal share of a state's Medicaid expenditures to be funded by non-state sources, such as IGTs. The SSA also explicitly allows health care related taxes up to certain levels defined by regulations.⁴⁰ Accordingly, there is neither a reasonable justification nor authority in the SSA allowing CMS to restrict the use of these statutorily permissible financing sources.

In conclusion, CMS cannot limit SDP expenditures in violation of the SSA's equal access provision and the express protection of IGTs and provider taxes as legitimate financing sources. Further consideration of such a proportional expenditure limit should be addressed in separately proposed rules through which CMS provides complete regulatory impact analysis and should ensure compliance with the legal obligation to provide equal access to care.

C. Separate Payment Terms

CMS solicits public comment regarding whether to eliminate states' ability to use "separate payment terms" to implement SDPs, thereby requiring all SDPs to be effectuated only through risk-based adjustments to capitation rates.⁴¹

Under a separate payment term, a state generally allocates a predetermined, fixed pool of SDP funds to MCOs in periodic installments, separate from the capitation rate payment, based on network providers' actual utilization during the rating period. In the preamble to the Proposed Rule, CMS notes the increase in the number of SDPs that use separate payment terms and discusses the agency's primary concern, which is that separate payment terms result in removing the plans' risk for the SDP portion of provider payments.⁴²

⁴⁰ 42 U.S.C. § 1396b(w)(1)(A).

⁴¹ Proposed Rule at 28149.

⁴² See, e.g., Proposed Rule at 28146 ("As noted earlier, CMS has a strong preference that SDPs be included as adjustments to the capitation rates since that method is most consistent with the nature of risk-based managed care."); ("[W]e continue to believe that, while separate payment terms often retain risk for the providers as opposed to guaranteeing them payment irrespective of the Medicaid services they deliver to Medicaid managed care enrollees, there is often little or no risk for the plans related to separate payment terms under an SDP, which is contrary to the nature of risk-based managed care.")

We strongly oppose any prohibition or limitation on the use of separate payment terms in SDPs. CMS's proposal constitutes 1) a likely violation of the SSA's equal access requirements, 2) a stark departure from the agency's stated purpose for creating the SDP authority in the first instance as a vehicle to promote access to care, and 3) an obstacle to important advantages for all stakeholders, including CMS, that are unique to separate payment terms.

- (1) In reversing over six years of CMS practice, eliminating separate payment terms likely violates the SSA's equal access requirements. CMS's proposal to prohibit separate payment terms represents a seismic about-face relative to the more-than six years of agency approvals of SDPs with separate payment terms. In this time, SDPs have evolved into critical terrain within many states' Medicaid landscapes. As CMS itself notes in the Proposed Rule, 41.5% of all the SDPs that CMS approved as of March 2022 and 55% of all SDPs that began in calendar year 2021 were implemented as separate payment terms.⁴³ We believe reversing this practice would effectively dismantle SDPs that have relied on separate payment terms, thereby leading to catastrophic consequences for access to care by Medicaid beneficiaries.

CMS grounds its rationale on the concern that “there is often little or no risk for the plans related to separate payment terms under an SDP.”⁴⁴ However, the entire purpose of most SDPs is to improve access, not amplify plans' risk exposure. And CMS acknowledges that risk-based payments can be harmful to access. For example, in the companion proposed rule titled *Ensuring Access to Medicaid Services*, CMS supports the adoption of a rule that would ensure at least 80% of the payments (including SDPs) for specific services **are not subject to any risk-based arrangements**.⁴⁵ When focusing on improving access, CMS specifically proposes that most of the payment should be removed from the risk pool because of the “inextricable link” between payment rates and access to care.⁴⁶

Despite CMS's own analysis of the prevalence of SDPs that rely on separate payment terms and recognition of the “inextricable link” between payment rates and access to care, CMS fails to reconcile how a prohibition or restriction of separate payment terms safeguards equal access to care by Medicaid beneficiaries. The SSA requires that CMS ensures Medicaid payments for services promote equal access to care “at least to the extent that such care and

⁴³ Proposed Rule at 28145.

⁴⁴ Proposed Rule at 28146.

⁴⁵ See 88 Fed. Reg. 27960, 27983 (May, 03, 2023) (hereinafter *Access Rule*) (emphasis added).

⁴⁶ Proposed Rule at 27982 (“This proposal is designed to affect the inextricable link between sufficient payments . . . and access to and, ultimately, the quality of [care] received by Medicaid beneficiaries.”)

services are available to the general population in the geographic area.”⁴⁷ CMS clearly understands many SDPs are designed, in order to promote access, to provide the incremental amount of provider reimbursement needed to result in parity with rates up to commercial equivalency.⁴⁸ Yet, CMS proposes to prohibit a fundamental feature on which the agency says 55% of 2021 SDPs relied.⁴⁹ Consequently, we are skeptical that CMS can promulgate a restriction or limitation that would threaten the viability of existing SDPs without running afoul of the agency’s statutory mandate to safeguard equal access.

- (2) CMS’s proposal to eliminate separate payment terms for SDPs, based on the agency’s newfound concern about SDPs that do not expose plans to incremental magnitudes of risk, is inconsistent with the agency’s purpose in creating the authority for SDPs. When a state chooses to delegate its role of managing the Medicaid population to a third-party Medicaid managed care plan (and thereby escapes its own risk for utilization), the state must then, in general, step away from the plans’ negotiation of payment terms with its network providers. Under fundamental principles of Medicaid managed care, shifting the risk to third-party plans through capitation allows the plans the autonomy, flexibility, and incentive structure to contract with providers in a way that results in efficient and effective management of their Medicaid beneficiaries. Or, as CMS proposed to (and ultimately did) codify in its original SDP rulemaking in June 2015, “we propose the **general rule** that the state may not direct the [plans’] expenditures under the contract” on the rationale that “as risk-bearing organizations, [plans must] maintain the ability to fully utilize the payment under [the state] contract for the delivery of services.”⁵⁰ However, CMS proposed a number of **exceptions** to this general rule, including an option for a state to “specify a uniform dollar or percentage increase for all providers that provide a particular service under the contract.”⁵¹ CMS then reiterated in its May 2016,⁵² November 2018,⁵³ and

⁴⁷ 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

⁴⁸ Proposed Rule at 28121 (“ . . . States are increasingly submitting preprints that would push total payment rates up to the ACR. . . . CMS believes that using the ACR as a limit is likely appropriate as it is generally consistent with the need for managed care plans to compete with commercial plans . . .”).

⁴⁹ Proposed Rule at 28145.

⁵⁰ 80 Fed. Reg. 31098 at 31123-31124 (June 1, 2015) (emphasis added).

⁵¹ 80 Fed. Reg. 31098 at 31124 (June 1, 2015).

⁵² “Current CMS policy has interpreted these regulations to mean that the contract with the MCO, PIHP or PAHP defines the comprehensive cost for the delivery of services under the contract, and that the MCO, PIHP or PAHP, as risk-bearing organizations, maintain the ability to fully utilize the payment under that contract for the delivery of services. Therefore, in § 438.6(c)(1), we proposed the **general rule** that the state may not direct the MCO’s, PIHP’s, or PAHP’s expenditures under the contract, **subject to specific exceptions** proposed in paragraphs (c)(1)(i) through (iii).” 81 Fed. Reg. 27498 at 27587-27588 (May 6, 2016) (emphasis added).

⁵³ “As finalized in the 2016 final rule, § 438.6(c)(1) permits states to, **under the circumstances enumerated in § 438.6(c)(1)(i) through (iii)**, direct the managed care plan’s expenditures under the contract.” (implying

November 2020⁵⁴ rulemaking actions, as well as the Proposed Rule that SDPs act as exceptions: “Medicaid managed care plans *generally* have the responsibility *under risk-based contracts* to negotiate with its providers to set payment rates, *except* when a State believes *the use of an SDP* is a necessary tool to support the State’s Medicaid program goals and objectives.”⁵⁵

CMS intended for this new SDP authority to “help ensure that additional funding is directed toward enhancing services and *ensuring access* rather than benefitting particular providers.”⁵⁶ Critically, in subsequent rulemakings, CMS would label these latter payments “benefitting particular providers” as impermissible “pass-through payments” and require states to transition away from them with support, in part, from SDPs.⁵⁷ CMS insisted that unlike many pass-through payment arrangements that existed at the time, SDPs must be “based on utilization and the delivery of high quality services”⁵⁸

CMS explained that the SDP authority operates as an exception to the general rule prohibiting states from directing plans’ expenditures outside of risk-based arrangements. And CMS clearly articulated the purpose of the SDP authority: to provide flexibility to states to support increased payment levels for classes of health care providers on an equitable basis, with the ultimate goal of enhancing access for Medicaid managed care beneficiaries.

We are, on the other hand, unable to identify anywhere in CMS’s previous SDP rulemaking actions any assertion that the SDP authority was to have the effect CMS now argues is necessary by eliminating separate payment terms: unilateral exposure of plans to incremental magnitudes of financial risk by states.

- (3) Separate payment terms offer unique advantages to all stakeholders and are critical in furthering CMS’s new reporting and transparency goals. CMS’s

that *only* under those specific circumstances, or exceptions, may states depart from the general prohibition against states directing plans’ expenditures) 83 Fed. Reg. 57264 at 57270 (Nov. 14, 2018) (emphasis added).

⁵⁴ “As finalized in the 2016 final rule, § 438.6(c)(1) permits states to, *under the circumstances enumerated in § 438.6(c)(1)(i) through (iii)*, direct the managed care plan’s expenditures under the contract.” (implying, again, that only under those specific circumstances, or exceptions, may states depart from the general prohibition against states directing plans’ expenditures) 85 Fed. Reg. 72754 at 72775 (Nov. 13, 2020) (emphasis added).

⁵⁵ Proposed Rule at 28144 (May 3, 2023)

⁵⁶ 80 Fed. Reg. 31098 at 31124 (June 1, 2015).

⁵⁷ See 82 Fed. Reg. 5415 (Jan. 18, 2017).

⁵⁸ 80 Fed. Reg. 31098 at 31124 (June 1, 2015); see also 81 Fed. Reg. 27498 at 27587-27588 (May 6, 2016) (“In our review of managed care capitation rates, we have found pass-through payments being directed to specific providers that are generally not directly linked to delivered services or the outcomes of those services. These pass-through payments are not consistent with actuarially sound rates and do not tie provider payments with the provision of services.”).

proposal would also deprive stakeholders of the benefits of deploying SDPs that include separate payment terms. In the Proposed Rule, CMS explains a number of these advantages states have reported from using separate payment terms, including administrative simplicity, ease of tracking and verification of provider payment information, and complying with state legislative mandates to allot “a specific dollar amount that [legislatures] want to invest in increasing reimbursement for a particular service, potentially to respond to an acute concern around access.”⁵⁹ CMS should not preclude stakeholders from these advantages.

Nor should CMS preclude itself from the benefits it seeks elsewhere in the proposed rule relating to transparency. CMS expresses many concerns about transparency and proposes new requirements for states and Medicaid managed care plans to report much more granular detail regarding SDP expenditures. Separate payment terms offer one of the best ways for CMS to facilitate compliance of these new tracking and reporting requirements.

III. PROPOSALS FOR WHICH CMS IS PROPOSING TO ADOPT RULES

A. Prohibition on Interim Payments Later Reconciled to Actual Utilization

CMS should permit SDPs to be paid through interim payments that are later reconciled to actual utilization. The approach: (1) promotes equal access to care for Medicaid enrollees, (2) ensures that SDPs are tied to actual utilization, (3) allows states to easily track and report SDP payments by MCO/provider, (4) facilitates the payment of SDPs consistent with the funding levels, payment methods, and other structural components approved by CMS, and (5) ensures timely and accurate payments to providers currently experiencing economic hardship.

- (1) CMS is proposing to prohibit interim payments due to concerns that this approach is “removing risk” from SDPs.⁶⁰ However, the entire point of most SDPs is to promote access and CMS has acknowledged that access may be undermined when the payments that providers rely on are subject to risk. SDPs are—by design—the exception to risk-based managed care that CMS has deemed an “important tool” to further a state’s Medicaid goals and objectives, meet legislative directives, and support providers in furthering program goals.⁶¹ Moreover, in the companion proposed rule titled *Ensuring Access to Medicaid Services*, CMS supports the adoption of a rule that would ensure at least 80% of

⁵⁹ Proposed Rule at 28145-28146.

⁶⁰ Proposed Rule at 28133.

⁶¹ Proposed Rule at 28110.

the payments for some services are exempt from risk-based arrangements.⁶² CMS specifically proposes that a large portion of the payments not be at-risk because of the “inextricable link” between payment rates and access to care.⁶³ Similarly, SDPs should be removed from risk when their purpose is creating equal access.

- (2) CMS expresses concerns that the interim payment approach is not consistent with requirements that SDPs be tied to actual utilization.⁶⁴ However, the opposite is true. Interim payments reconciled after all claims run out ensure that every dollar paid through SDPs are tied to utilization. Other contemporaneous payment mechanisms risk SDPs being applied inappropriately to claims for members later found ineligible and SDPs failing to be applied to claims that undergo lengthy adjudication by MCOs (usually the most expensive claims). We agree that Medicaid managed care plans should not make payments based solely on historical utilization and never reconcile to actual utilization.⁶⁵ However, interim payments that are later reconciled to actual utilization ensure SDPs are based on the delivery and utilization of covered services rendered to Medicaid beneficiaries during the rating period.⁶⁶ The Proposed Rule does not refute this assertion, or otherwise explain how interim payments that are reconciled to final claims fail to tie to actual utilization.
- (3) Interim payments allow states to more effectively and efficiently track and report SDP payments. CMS proposes to retain separate payment terms because they play a key role in “promot[ing] the ease of tracking and verification of accurate payment to providers from the managed care plans required under the SDP.”⁶⁷ Similarly, interim payments allow improved tracking and verification of payments because it is necessary to conduct the reconciliation to actual utilization.
- (4) Interim payments facilitate the payment of SDPs consistent with the funding levels, payment methods, and other structural components approved by CMS. For example, states and providers have had challenges verifying that SDP rate increases are properly paid on each claim when paying contemporaneously. Not only are claims subject to multiple re-adjudications, but managed care plan

⁶² Access Rule at 27983 (emphasis added).

⁶³ Access Rule at 27982 (“This proposal is designed to affect the inextricable link between sufficient payments. . . and access to and, ultimately, the quality of [care] received by Medicaid beneficiaries.”)

⁶⁴ Proposed Rule at 28133 (“A fundamental requirement of SDPs is that they are payments related to the delivery of services under the contract.”)

⁶⁵ Proposed Rule at 28133.

⁶⁶ Proposed Rule at 28133.

⁶⁷ Proposed Rule at 28145.

administrative denials, policy amendments, and network status changes can result in inconsistent real-time application of the SDP. This makes it difficult to ensure consistency with the preprint, as approved by CMS. Reconciliation processes correct this issue by allowing a sufficient period for claims runout, policy clarifications, and dispute resolution.

- (5) Interim payments help states ensure timely and accurate payments to providers in times of economic hardship. SDPs are designed to provide states with an important tool to maintain access for Medicaid beneficiaries. The implementation process for SDPs is frequently lengthy due to limitations within states, CMS, and Medicaid managed care plans, so significant delays from the preprint submission to the time when all contract year claims are adjudicated and finally paid are common. These delays are particularly harmful in the current economic conditions when inflation continues to drive significant and persistent hospital cost increases. Interim payments allow states to more quickly deploy SDPs to support provider efforts to keep their doors open and provide access to Medicaid beneficiaries.

B. Requirement to Add Performance Measures to All SDPs

The current rules require that SDPs advance at least one of the goals and objectives in a state's quality strategy, but CMS now proposes to increase this requirement to two metrics, one of which must be a performance measure that is attributable provider performance. While performance measures are aligned with the goals of value-based purchasing, delivery system reform, and performance improvement initiative SDPs, SDPs that provide a uniform dollar or percentage increase are fundamentally intended to ensure equal access for Medicaid beneficiaries⁶⁸ in recognition of the important connection between payment rates and equal access.

CMS should not impose additional quality reporting requirements on SDPs that are designed solely to improve access through uniform dollar or percentage increases. Uniform increases improve Medicaid access by rewarding providers that treat more Medicaid managed care beneficiaries. In contrast, value-based payment models, including pay-for-performance incentives, shared savings arrangements, and other alternative payment models penalize hospitals and physicians that fail to cut costs and/or achieve quality goals.⁶⁹ Requiring additional, onerous performance metrics for SDPs based on uniform increases is counterproductive to ensuring improved access for Medicaid beneficiaries.

⁶⁸ Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27583 (May 6, 2016) (amending 42 C.F.R. § 431, 433, 438, 440, 457 and 495).

⁶⁹ Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid Base and Supplemental Payments to Hospitals Issue Brief, March 2023. <https://www.macpac.gov/wp-content/uploads/2023/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals-Issue-Brief.pdf>.

Research shows that the administrative hurdles providers already encounter when billing Medicaid discourage participation as much as low payment rates and result in access problems experienced by Medicaid patients.⁷⁰

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CONCLUSION

Sutter Health appreciates your consideration of our comments. Should you have questions, please do not hesitate to contact me at Jonathan.Williams@sutterhealth.org.

Sincerely,

Jonathan Williams
Vice President of Government Affairs
Sutter Health

⁷⁰ A Denial a Day Keeps the Doctor Away, Abe Dunn, Joshua D. Gottlieb, Adam Shapiro, Daniel J. Sonnenstuhl, and Pietro Tebaldi, NBER Working Paper No. 29010, July 2021, Revised January 2023. https://www.nber.org/system/files/working_papers/w29010/w29010.pdf. Accessed June 5, 2023.