



July 3, 2023

e-comment submitted electronically

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8013
Baltimore, MD 21244-8013

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

Dear Administrator Brooks-LaSure:

The Tennessee Hospital Association (THA), on behalf of its over 150 healthcare facility members, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed policies related to access, finance and quality in Medicaid and Children's Health Insurance Program (CHIP) managed care programs. While we appreciate CMS addressing many of our hospitals' priorities and issues within Medicaid and proposing policies that would improve access to coverage and care if finalized, THA and our members are concerned that certain policies may undercut these efforts by jeopardizing states' access to critical financial resources.

TennCare, the Medicaid agency in Tennessee, provides critical coverage and access to healthcare for more than 1.7 million Tennesseans, many of whom are some of the most at-risk patients hospitals and health systems treat. We commend CMS for its focus on ensuring access is maintained and improved and their acknowledgment that enrollment in Medicaid is not enough to secure care. Providers are a critical factor, and it is vital that an adequate supply of providers are available to care for Medicaid enrollees. Achieving enough access to care has proven to be challenging for TennCare, and the Medicaid program as a whole, as CMS notes, largely because of chronic underpayment of providers.

THA commends CMS for proposing a variety of regulatory changes that aim to address payment-related barriers to care, as well as better monitoring of enrollee access to care. Specifically, we appreciate CMS' proposals to review provider payments for adequacy, as well as proposals to adopt wait time standards, and secret shopper surveys to ensure managed care plans maintain adequate networks.

State Directed Payments

Medicaid's historically low provider reimbursement rates have led to the need for and growth of supplemental payments. These payments help enable providers to participate in the Medicaid program and improve beneficiary access to covered services. To address this, beginning in

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2016, CMS established the option for state directed payments (SDPs) in managed care arrangements to help mitigate concerns regarding payment-related barriers to care. These additional payments have been critical in paying for services provided to Medicaid beneficiaries and help to offset the losses resulting from inadequate base rates.

Payment Limits for State Directed Payments (SDPs)

CMS proposes to establish an upper payment limit of the average commercial rate (ACR) for four categories of SDPs: inpatient hospital services, outpatient hospital services, qualified practitioner services at academic medical centers, and nursing facilities. CMS states that it believes the ACR to be an appropriate limit while still enabling Medicaid managed care plans to provide access to services and a network of providers commensurate with commercial payers, ensuring equitable care for Medicaid beneficiaries. **THA strongly supports allowing payments up to at least the ACR for these services, which not only allows Medicaid managed care plans to compete with commercial payers for network providers, but also provides sufficient payment to ensure access to care for enrollees and appropriately values services provided to Medicaid patient populations by paying market rates.**

For these reasons, THA opposes CMS' alternative proposal that would use the Medicare upper payment limit (UPL) as a payment limit on some or all SDPs. We agree with CMS' reservations regarding this alternative, namely that Medicare generally pays below cost and Medicare payments have been developed for a different population than Medicaid. As a result, using the Medicare UPL as a payment limit for SDPs would result in a significant curtailment of payment flexibility and would jeopardize the gains in access and quality that states have achieved through SDPs.

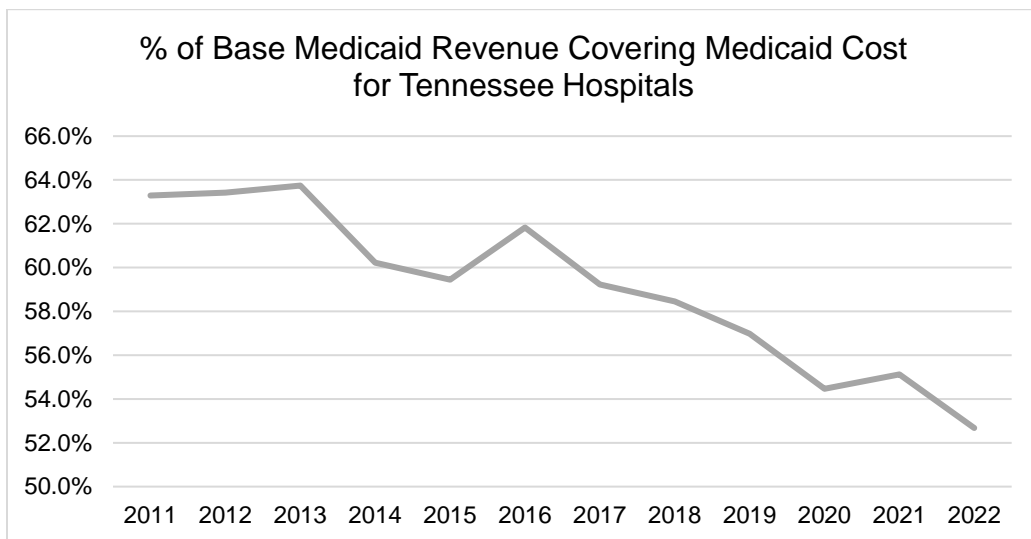
Providers are more willing to contract with Medicaid managed care plans and be part of those provider networks when the payment rates are comparable with commercial insurance. Higher payment rates allow providers to maintain a broad array of services. The service lines offered by providers, particularly 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. Maintaining obstetrics in rural settings is even more important, but also difficult, and ensuring adequate funding for rural providers should be encouraged.

Setting higher payment rates supports provider investments in infrastructure, technology, workforce development, and quality interventions that promote access to quality care. Healthcare providers continue to struggle financially, and numerous studies show that most providers have razor thin (or negative) operating margins.¹ 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

¹ 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. Kaufman Hall, “National Hospital Flash Report,” 6 (May 2023).

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.

As CMS notes, with managed care there is wide variation in negotiated rates but also Medicaid rates are well below the costs incurred to provide care for beneficiaries. Tennessee’s Medicaid program has operated in managed care since 1994, and providers – in particular hospitals – have seen significant stagnation in base rates from managed care organizations. In 2011, Medicaid revenue from hospital base payments (not including supplemental pools) covered 63.3% of costs. However, in 2022 Medicaid base payments only covered 52.7% of costs.² Because base payments have not kept pace with growing cost burdens, Tennessee providers, especially hospitals, rely on supplemental pools including state directed payments to ensure hospitals can provide care to their communities.



Source: Tennessee Joint Annual Reports for Hospitals, 2011 through 2022.
<https://apps.health.tn.gov/publicjars/default.aspx>

CMS also requests comments on a potential overall limit on the proportion of managed care expenditures attributable to SDPs, such as limiting SDPs to 10% to 25% of total costs. Such a limit would be intended to ensure that managed care plans remain at risk for the services they cover and address oversight concerns regarding the growth of SDPs in recent years. **THA strongly opposes an overall expenditure limit on SDPs.** We are concerned that such a limit would have unintended harmful effects on access to care. Managed care-based payment rates are frequently well below cost, and SDPs and other supplemental payments are vital tools to ensure sufficient payment rates to support meaningful access to care in the absence of a firm payment adequacy standard imposed by CMS.

THA believes that the ACR limit for the four proposed categories of services, which currently comprise the majority of payments made up to the ACR, serves as a sufficient limit on the overall size and growth of SDPs and ensures an appropriate level of risk remains with Medicaid

² Source: Tennessee Joint Annual Reports for Hospitals, 2011 through 2022.
<https://apps.health.tn.gov/publicjars/default.aspx>

managed care plans. 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.

Modification of the ACR Calculation

Currently, CMS requires states to demonstrate that an SDP does not exceed the ACR for a specific service type (e.g., inpatient or outpatient hospital services) or for providers in a specific provider class (e.g., rural or urban hospitals). States are currently required to use ACR data from only providers in the provider class that are receiving the SDP. However, the agency recognizes that certain types of providers could be disadvantaged by this approach and is proposing to provide states with added flexibility in how to calculate the ACR. The proposed changes will allow states to use ACR data from a broader set of providers, such as all providers in the state, if that would better align with state access and quality goals. **THA supports CMS' proposal to allow states additional flexibility to use data from a broader group of providers.**

Participation of Non-Network Providers in SDPs

Participation in SDP arrangements, including fee schedule amounts or uniform rate increases, is currently limited to providers who are contracted with Medicaid health plans. **We appreciate and support CMS' proposed change to permit non-network providers to be eligible for participation in SDPs.** We support this proposed change and believe the additional flexibility will enable states and CMS to more equitably shape policy and target payments in a way that promotes access and quality for Medicaid beneficiaries.

Financing Restrictions

THA opposes CMS' proposals to require that states obtain attestations from providers participating in SDPs that they are not participating in a hold harmless arrangement with respect to any healthcare-related tax. CMS has recently published, both in a February 2023 Informational Bulletin and in the preamble to this proposed rule, a new interpretation of the provider tax hold harmless provisions that would prohibit certain private agreements between providers. A district court in Texas has now preliminarily enjoined that widely controversial interpretation, prohibiting CMS “from implementing or enforcing the Bulletin dated February 17, 2023 . . . or from otherwise enforcing an interpretation of the scope of [the provider tax hold harmless statute] found therein,” including through the “review of state payment proposals.”³ CMS cannot lawfully proceed in requiring providers to attest to compliance with the provider tax hold harmless provisions while this litigation is pending. Doing so would preempt the critical legal processes that Congress has preserved for states and providers to challenge policies that may exceed the scope of agency authority, establishing a harmful precedent not just with respect to this particular issue, but more broadly within the Medicaid and other federal programs.

Network Adequacy Metrics and Oversight

Many of our members have expressed concerns about network adequacy and how that may lead to inefficient use of care. We applaud CMS' efforts to enhance requirements for Medicaid managed care programs and believe they will promote better health for beneficiaries.

³ Texas v. Brooks-LaSure, No. 6:23-cv161-JDK, slip op. at 29 (E.D. Tex. June 30, 2023).

Appointment Wait Time Standards and 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.

THA supports CMS' proposal to require states to establish and enforce appointment wait time standards. These standards are meaningful measures of realized access and would hold health plans accountable for constructing provider networks that are available and accessible for their members, and as a result, could reduce delays in care that are harmful for Medicaid beneficiaries' health. We agree with CMS' proposal to allow for exceptions in certain circumstances and that the exceptions process would need to consider the impact of provider payment rates. 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.

THA additionally 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. As CMS notes, states that do not already operate these types of arrangements may find it administratively difficult. THA urges CMS to consider enhanced federal match rates for these services to encourage states to implement these sooner than the proposed time frame of four years after the rule is effective.

Additionally, CMS is proposing to require states to conduct annual enrollee surveys which THA also supports. CMS acknowledges that provider surveys can provide important information, however, the agency is not mandating those. THA requests that CMS reconsider that approach and also mandate that state Medicaid programs conduct provider surveys. Gathering input from both enrollees and providers will only strengthen the agency's knowledge of their program.

Strengthening Network Adequacy for Post-Acute Care Settings

As described above, THA 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.

Insufficient PAC networks within managed care programs result in upstream issues – patients are held in acute care beds longer than medically necessary, care is delayed due to having no appropriate provider to accept the patient, and strains already thin resources in hospitals. Action should be taken to better align MCOs incentives to build stronger networks, and THA believes implementing a per diem payment to acute care hospitals who are housing patients would be appropriate.

THA has additionally heard from member hospitals that ensuring patients can move easily through the continuum of care to appropriate care settings is also hindered by inadequate inpatient psychiatric networks with Medicaid MCOs. With the importance of mental health services, THA also encourages CMS to implement similar provisions to improve access to these providers.

Assurances of Adequate Capacity and Services

The proposed regulation would require Medicaid managed care organizations (MCOs) 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. Absent these data, MACPAC's analysis of Medicaid health plan approaches to hospital payment rate setting shows that states vary in terms of whether they establish payment rate floor requirements. Due to the lack of publicly available data, little is known about how payments compare across Medicaid FFS and Medicaid managed care programs or other benchmarks. **Accordingly, THA supports CMS' efforts to improve transparency among provider payment rates to assure that Medicaid managed care beneficiaries have adequate access to care.**

THA has a few considerations for CMS as it works to finalize this proposal. 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. THA also cautions having MCOs only report aggregate or average rate information. In managed care, negotiations dictate the rates providers receive and MCOs only reporting high level information may not tell the full picture. Alternatively, THA would support having MCOs report common metrics for each provider type, broken down by median rates and lowest rates.

CMS is also requiring states to use claims paid during the immediate prior rating period to ensure all payments are captured before being compared and notes that there is typically a lag of 180 days for all claims to be processed. THA supports the use of the most current claims data, however, additionally cautions that while that will be helpful data, it will not capture the final reimbursement to providers. Typical contracts with MCOs allow the plans between two to three years to review payments, issue denials, and process recoupments, although that does vary depending on each contract. As ProPublica recently reported,⁴ there is little to no data on how claims are reviewed by insurance plans, why they are denied, or how many claims are denied. There are some national reporting guidelines, but the data available is incomplete or only

⁴ How Often Do Health Insurers Say No to Patients? No One Knows. Robin Fields. 28 June 2023. ProPublica. <https://www.propublica.org/article/how-often-do-health-insurers-deny-patients-claims>

applies to small subsets. Even the data CMS collects is only for in-network providers for insurers in the federal marketplace plans. There is even less transparency on Medicaid managed care organizations. THA is concerned that plans may approve claims, report those figures for the purposes of comparing to Medicare, but then increase denials post-payment, lowering overall provider reimbursement but not having to report the final impact. **THA urges CMS to consider additional ways that will require plans to report the amounts of denials for prior reporting periods with updated comparisons to Medicare and provide states enforcement powers to handle denial outliers. THA also encourages CMS to set national standards on how long MCOs have to review claims and issue denials. Providers have 90, 120, or 180 days to submit claims; plans should not have longer time periods.**

Medical Loss Ratio (MLR) Standards

The medical loss ratio (MLR) measures the amount of premium dollars that go toward healthcare 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. We commend CMS for taking steps to strengthen the MLR requirements within the Medicaid program.

We echo the concerns raised by THA members and other stakeholders that vertical integration within some of the largest insurance companies poses significant threats to patients' and providers' experiences. In light of those mergers and integrations between organizations that offer 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. It is problematic 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.

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.

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.

Treatment of SDPs in the Medical Loss Ratio (MLR)

CMS proposes to require Medicaid managed care plans to include SDPs and associated revenues in their reporting of the MLR. While THA appreciates and generally supports the need for transparency with respect to SDPs, we are concerned that CMS' proposal without modification and additional clarification could unintentionally mask low plan MLRs, allowing plans to allocate less money to medical claims and quality initiatives. In many states, including Tennessee, SDPs are intended to supplement—not displace—pre-existing Medicaid managed care plan spending on services furnished to beneficiaries, and the MLR provisions as described in the proposed rule could undermine that goal. The required inclusion of SDPs in the MLR also could skew states' prospective rate setting calculations, which must be set at a level that can reasonably achieve an MLR of at least 85%.

SDPs are, of course, payments for services tied to actual utilization, and so are appropriate to include as a component of plans' medical spending. In establishing MLR minimums and remittance requirements, however, states may appropriately desire to exclude SDPs from consideration in the MLR to ensure that SDPs do not simply divert for other purposes spending that plans would otherwise need to commit to medical services (or remit to the state) to satisfy states' MLR requirements. By definition, plans are not meant to have flexibility or control in directing how funds flow through SDPs. The purpose of having an MLR floor and related remittance requirements is to ensure that plans spend the funding they do have control over on medical claims and quality initiatives, as opposed to administrative expenses or other purposes (e.g., profits).

As CMS acknowledges in the proposed rule, SDPs are “an important tool in furthering the State’s overall Medicaid program goals and objectives.” If Medicaid managed care plans can shift non-directed capitation payments from medical services to administrative and other expenses and still satisfy minimum MLR requirements by virtue of SDPs, the SDPs may not meet their intended quality and access goals. THA urges CMS to finalize an alternative MLR policy that would better balance the need for transparency in SDPs with the overarching purpose of SDPs, which is, as CMS describes, to “ensure that Medicaid managed care enrollees have access to care that is comparable to access for the broader general public.” Requiring MLR reporting both with and without the inclusion of SDPs would achieve this balance, providing transparency while still enabling states to appropriately evaluate those portions of capitation payments over which MCOs have control and discretion. States should be permitted to continue establishing MLR remittance and reinvestment policies without consideration of SDPs.

Quality Provisions

Proposed Updates to Evaluation Plans for SDPs

CMS currently requires that states develop an evaluation plan for SPDs that advances one or more goals in a state’s managed care quality strategy. CMS proposes states must identify two metrics for its SDP evaluation plan, one of which measures access and the other measures performance at the provider class level for SDPs that are population-based or condition-based. **THA urges CMS to provide state Medicaid agencies with meaningful guidance on setting performance measures that are within the control of the hospital receiving the SDP and that improves care for the Medicaid patient population it serves.** CMS should allow states flexibility to select measures applicable to the type of hospital, like current practice in the

Medicare program. The Medicare program includes measures applicable and actionable by different provider types such as acute inpatient and outpatient facilities, inpatient psychiatric hospitals, and inpatient rehabilitation.

Conclusion

THA appreciates the opportunity to share our views on issues that will play a significant role in provider participation and beneficiary access in the Medicaid program going forward. If you or your staff wish to discuss this letter, please contact me or Amanda Newell, VP of Financial Policy at anewell@tha.com.

Sincerely,

A handwritten signature in black ink that reads "Wendy Long MD". The signature is written in a cursive, flowing style.

Wendy Long, M.D., MPH
President and CEO
Tennessee Hospital Association