July 1, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

SUBJECT: CMS-2439-P, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; Proposed Rule, Federal Register (Vol. 88, No. 85), May 3, 2023

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on access, finance, and quality in managed care for Medicaid and Children's Health Insurance Program (CHIP) enrollees.

As noted in the overview of the rule, as of September 2022, the Medicaid program provides essential health care coverage to more than 83 million individuals nationwide, and, in 2021, accounted for 17 percent of national health expenditures. In California, the staggering size of the Medicaid program (Medi-Cal) makes it a critical component of California's overall health care delivery system. As of November 2022, Medi-Cal covered roughly 15.5 million individuals — nearly 40% of all California residents.[1] This includes over 5.7 million children, nearly 1.5 million individuals over 65, and over 10 million enrollees who are people of color.[2] Furthermore, Medi-Cal funds over half of the births in the state, and in 2022-23 is projected to spend nearly $142 billion across the program. This makes it the largest program in terms of budget in the state and the second-largest programmatic budget in terms of state General Fund dollars behind education.[3] California's Medi-Cal program is by far the largest in the country in terms of enrollment[4] and expenditures.[5] Furthermore, California's Medi-Cal program is primarily delivered through the managed care delivery system with over 13 million Medi-Cal members

[1] U.S. Census Bureau QuickFacts: California
[2] Medi-Cal Monthly Enrollment Fast Facts
[3] DHCS FY 2023-24 GB Highlights_1.10.23.pdf (ca.gov)
[4] Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID-19 Pandemic | KFF
[5] Federal and State Share of Medicaid Spending | KFF

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enrolled in a health plan in November 2022[6] or roughly 85% of the total Medi-Cal population. This number and percentage are only expected to grow in the next couple of years.

CHA shares CMS' goals of the Managed Care Access, Finance, and Quality proposed rule, which would increase the transparency and monitoring of access to services and improve the quality of care delivered in Medicaid managed care delivery systems. With these goals in mind, CHA feels these provisions could be further expanded or modified to include additional areas of analysis and improve the line of sight into managed care access and quality. CHA appreciates CMS acknowledging the inextricable link between access to care and payment sufficiency and are supportive of some of the proposed regulatory changes related to the use of state-directed payments (SDPs). However, CHA is very concerned and opposed to some of the proposed regulatory changes regarding SDPs that would limit a state's flexibility. In addition, the proposed regulatory changes – would divert resources from patient care to administrative processes and impose unreasonable timelines, ultimately making certain SDPs untenable. This would likely have the opposite effect of reducing overall provider payment and impeding access to Medi-Cal services, which is counter to CMS' stated objectives. Below, we further detail these concerns and provide comments and suggestions that we feel would improve the regulatory changes being proposed under this rule.

Enrollee Experience Surveys

Under Section 438.66(b), CMS proposes adding the requirement that enrollee experience surveys be added to the performance monitoring process for Medicaid managed care plans. CMS states its belief that these survey results would provide direct and candid enrollee input. The input could be used by states and managed care plans to evaluate whether their networks offer an appropriate range of services and access and include a sufficient number, mix, and geographic distribution of providers to meet enrollee needs.

CHA supports the use of enrollee experience surveys as a mechanism to create a feedback loop to inform states and managed care plans on how to improve the delivery of services and how they engage with the members they serve. CHA believes a similar feedback loop from health care providers would be similarly valuable in informing states and their contracted managed care plans on ways to improve the delivery of health care services and ultimately improve access.

A recent report released by the American Hospital Association[7] found that 78% of hospitals and health systems' experience working with commercial insurers is getting worse, not better. The report details that many managed care plans are increasingly adopting policies and practices that add unnecessary prior authorization processes and are increasingly delaying or denying payment for services. All these factors contribute to delays in patient care and place undue burdens on both enrollees and health care providers. Many of these practices also add unnecessary administrative costs to providers and the health care system and contribute to provider dissatisfaction. This results in a reluctance to work with Medicaid managed care plans and ultimately decreases access to Medicaid members. Therefore, CHA recommends that CMS also consider adding a requirement that states add provider experience surveys to the managed care performance monitoring process. This would provide policymakers with a better understanding of how Medicaid services are being delivered. In addition, it would provide insight into

[6] https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report/resource/95358a7a-2c9d-41c6-a0e0-405a7e5c5f18
[7] https://www.aha.org/guidesreports/2022-11-01-addressing-commercial-health-plan-challenges-ensure-fair-coverage-patients-and-providers

whether the states' contracted managed care plans are effectively partnering with their network providers in the efficient delivery of quality health care services to their members.

CMS is also proposing consumer satisfaction surveys be performed annually as part of health plan evaluations starting three years after the effective date of the final regulations. CHA agrees these assessments should be performed annually, including provider satisfaction surveys, but the implementation timeline should be shortened to two years after the effective date of the final regulations.

Appointment Wait Time Standards and Distance Standards for Emergency Services

CMS proposes a new network adequacy standard that requires states to establish appointment wait time standards for Medicaid and CHIP programs. Under the proposal, states would be required to develop and enforce wait time standards for routine appointments for four types of services covered under the managed care organization (MCO) contract:

- Outpatient mental health and substance use disorder
- Primary care
- Obstetrics and gynecology
- One additional type of service determined by the state in an evidence-based manner

CHA supports the use of tracking appointment wait times as one indicator of network adequacy and timely access. CHA commends CMS' proposed appointment wait time standards and the effort to align them with the standards for marketplace plans in an effort to demonstrate compliance with Section 1902(a)(30)(A) of the Social Security Act (SSA). The SSA requires states to "assure that payments are consistent with efficiency, economy, and quality of care and 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 population in the geographic area." It is an important step in moving the Medicaid program forward and improving access to care for Medicaid beneficiaries. CHA is also generally supportive of CMS' proposed standard of review for exceptions to the appointment wait time standards, which recognize that poor reimbursement could be a contributing factor as to why there is not sufficient and timely access to care.

However, while CHA is supportive of these proposals, we believe they could be further strengthened to improve transparency and should also be expanded to other provider types. For instance, in order for wait times to be a meaningful metric for Medicaid beneficiaries and to demonstrate compliance with the equal access command of Section 1902(a)(30)(A) of the SSA, we believe they should be compared to wait times for commercially insured and Medicare patients for the same specialist and/or service within a defined area. For example, if average wait times for commercially insured patients and Medicare beneficiaries in a certain geographic area would be four weeks for a non-urgent appointment with a primary care provider or specialist, then Medicaid wait times should be aligned to demonstrate access is equal to or exceeds other payers.

Furthermore, CHA believes CMS should consider requiring standards of timely access to long-term care, notably placement in a skilled-nursing facility, and inpatient mental health services. California hospitals are facing severe challenges with patient throughput and the ability to discharge patients into lower levels of post-acute care or transfer those with severe behavioral health needs into a more appropriate setting. One of the primary drivers of these challenges is the lack of post-acute services or an inpatient mental health network in Medi-Cal managed care plans and county behavioral health plans. As evidenced

in a recent Kaufman Hall report[8] on the state of California hospitals, lengths of stay have been increasing annually and one factor contributing to this is the inability to discharge patients into a more appropriate setting such as a long-term care facility or inpatient mental health bed. This results in poor patient outcomes, care not being delivered in the most appropriate settings, additional costs to hospitals (that are often not reimbursed), decreased access to hospital beds, and overcrowding in hospital emergency departments.

CHA recommends adding a timely access standard for skilled-nursing placement and if a network provider cannot be identified timely, managed care plans should be required to authorize and fund out-of-network placements in order to ensure Medicaid beneficiaries receive timely care in the most appropriate setting. Additionally, managed care plans should be required to pay hospitals at least the prevailing fee-for-service administrative day rate to cover the additional costs incurred when inadequate networks result in discharge delays. CHA also recommends shorter timely access standards for patients who are being discharged and/or transferred from a hospital. Timely care post-discharge or transfer to a more appropriate setting, such as in inpatient mental health bed, is even more critical in improving patient health outcomes and preventing unnecessary readmissions.

CHA also recommends that CMS establish a distance standard for emergency services. Under the Emergency Medical Treatment and Labor Act (EMTALA; Section 1867 of the SSA), hospitals are required to provide access to emergency services regardless of a patient's ability to pay; therefore, the notion of timely access in an emergency situation is directly correlated to the distance an individual has to travel for emergency care. Establishing a reasonable distance standard for emergency services would be a way to measure whether a health plan has meaningful and appropriate access to those services and whether the reimbursement rates paid by a health plan are sufficient to ensure access to emergency and inpatient care. Lastly, we also encourage CMS to consider adding language that makes it clear that these provider access requirements are the responsibility of contracted managed care plans and ultimately the states. Managed care plans must not pass on their responsibility for access standards through imposing any financial or administrative penalties to providers, unless expressly agreed to in contract, when the plan is failing to meet timely access requirements and state mandated network adequacy standards with contracted providers.

Provider Payment Analysis

CMS seeks greater transparency in provider payment rates from plans and states, which it believes are lower than other payer rates and thus contributes to reduced access to services. CHA appreciates CMS' recognition of the correlation between payment and access, and we agree with CMS that greater oversight of plan payments is warranted. Thus, CMS proposes a process in which managed care plans must report — and each state must review and analyze — their payment rates to providers for certain types of services to ensure network adequacy and enrollee access consistent with state and federal standards. CHA supports the proposed provider rate analysis requirements as a good first step in reviewing Medicaid rates for primary care, obstetrical and gynecological and outpatient mental health services versus those for Medicare.

However, we would also note, that while Medicare is a justifiable benchmark to be used for standardizing comparisons, we would argue it should not be seen as adequate as it still does not cover the totality of costs of providing care to the Medi-Cal or Medicare population. Based on CHA analysis of Department of

[8] PowerPoint Presentation (kaufmanhall.com)

Health Care Access and Information data, hospitals in California lose 25 cents per dollar of care provided to Medicare beneficiaries.

State-Directed Payments (SDPs)

As evidenced by their widespread use following the 2016 Medicaid managed care final rule (88 Fed. Reg. 27498), SDP programs have become perhaps the most vital and effective mechanism to realizing equal access to care and adequate Medicaid reimbursement for California hospitals and health systems. CHA appreciates CMS' recognition of this importance and its thoughtful approach to strengthening the regulatory framework associated with such arrangements. Given the inextricable link between sufficient payment and access to care, it is imperative to preserve and promote the use of SDPs to further the Medicaid goals of meaningful coverage, quality, and equity.

With this in mind, we offer the following comments on certain key SDP provisions in the proposed rule:

Medicare Exemption, SDP Standards, and Prior Approval

CHA agrees with and supports CMS' continued flexibility and streamlined approval process for SDPs, which establishes a minimum fee schedule tied to state plan rates. We are also supportive of CMS' expanded flexibility to allow for a streamlined approval process for minimum fee schedule directed payments that are based on the total published Medicare fee schedule.

As mentioned below, CHA is strongly opposed to any arbitrary cap on the size or percentage of total payments for SDPs. However, if such a cap is imposed, we believe that any SDP that imposes a minimum or maximum fee schedule should not count toward this arbitrary cap as this would essentially result in all payments for the provider class that are subject to minimum fee schedule to count against the cap.

Average Commercial Rate (ACR)

Since their adoption in 2016, SDPs have not been subject to an express regulatory limit like the one imposed for hospital services reimbursed in the Medicaid fee-for-service system, beyond actuarial soundness for plan capitation rates. CMS proposes to codify at 42 C.F.R. § 438.6(c)(2)(iii) an upper payment limit equal to the ACR for SDPs for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center that require prior CMS approval. CHA strongly supports this proposal and agrees that ACR is the most appropriate benchmark to foster suitable access and networks in Medicaid plans on par with their commercial competitors. Use of ACR in this fashion places states and plans in the best position to meet the baseline obligation in Section 1902(a)(30)(A) and ensure Medicaid enrollees' access to vital services is at least commensurate with that enjoyed by the general population in the geographic area. The ACR represents fair market value for the services provided, and any prohibition on paying market rates for Medicaid beneficiaries would undervalue the services provided to this important and vulnerable patient population. Finally, while implicit in the proposal, CHA encourages CMS to expressly codify that projected payments that do not exceed ACR are generally considered to be reasonable, attainable, and appropriate, and thus actuarially sound for Medicaid purposes. Furthermore, CHA supports the CMS proposal to allow states flexibility to submit ACR demonstrations that are specific to the service covered by the SDP, but not specific to each provider class impacted by the SDP. We appreciate CMS' recognition that facilities that serve a higher share of Medicaid payments, including safety-net hospitals and rural hospitals, often have less market power to negotiate higher commercial rates. We agree, as outlined in the proposed rule, that allowing ACR demonstrations at the service level but not specific to the provider class "would provide States with tools to further the goal of parity with commercial payments, which may have a positive impact on access to care and the quality of care delivered."

In contrast, we strongly urge CMS to not set an alternative limit based on Medicare or other rates that are less than ACR and that do not reflect the actual costs incurred by hospitals and health systems serving Medicaid populations. While Medicare rates are generally more favorable than Medicaid for certain service categories, they still are far less than what is paid commercially, are not developed for Medicaid-specific populations, and as stated above do not account for the totality of costs borne by providers in treating the Medicaid population. Potentially limiting the aggregate total payments a provider class can receive to a Medicare benchmark would run counter to the acknowledgement CMS has made that provider reimbursement has a direct impact on access and would only serve to limit access to services to the Medicaid population compared to commercial payers. This would challenge the notion that Medicaid access is commensurate with the general population. Codifying ACR would also assure continuity with what CMS has already used in practice for SDP preprint and rate approvals to date and avoid the rate shock and destabilization that would result in replacing it with one of the inadequate alternatives such as Medicare.

In terms of the provider classes that would be subject to the proposed ACR standard (or alternative being considered), CMS proposes to define "academic medical center" as a facility that includes a health professional school with an affiliated teaching hospital. CHA is concerned this definition is too narrow and does not account for certain arrangements in use today, namely a facility that is affiliated with but does not include a health professional school. Accordingly, we recommend CMS amend the definition to read: "Academic medical center means a facility that includes a teaching hospital and is affiliated with a health professional school."

Proportional Expenditure Limits for Total SDP Expenditures
While not proposed in the regulatory text itself, CMS solicits comment on imposing an aggregate limit for total SDP expenditures, either as a percentage of overall managed care spending or of expenditures within a specific service or provider class category, at a suggested range of 10% to 25%. CHA strongly opposes adoption of any aggregate limit on SDP expenditures as it is inconsistent with core Medicaid tenets and would significantly lessen SDPs' ability to ensure equal access and reduce health outcomes disparities for vulnerable populations. Limiting SDP expenditures based on an arbitrary comparison to total expenditures within managed care or a specific service category would impede realization of equal access for Medicaid enrollees and result in profound disruptions in care. We are deeply concerned that an expenditure limit on SDPs would indeed impact access.

In California, the base payment rates from managed care plans are well below cost, and the additional funding provided through SDPs is critical to ensuring an actuarially sound rate, as CMS itself acknowledges in the preamble. Further, under a percentage-based expenditure limit, states with low base rates, and therefore more of a need to improve rates through SDPs, would have less capacity to use SDPs to improve payments resulting in a race to the bottom. An aggregate limit would also inevitably force states to ration the availability of such payments within service categories and provider classes, frustrating the attainment of Medicaid goals more comprehensively across broader segments of the program. We are also concerned with the preamble's justification for a proportional limit based on the trend of SDPs being financed by provider taxes. If finalized, this would undermine the statutorily mandated flexibility for states in financing the nonfederal share of Medicaid expenditures through this permissible source. It is also unnecessary given already existing actuarial constraints and limits on the use of health care-related taxes up to specified levels pursuant to Section 1903(w) of the SSA. We urge CMS to not adopt any proportional expenditure limit on SDPs so as not to undermine the proven results these arrangements offer and threaten the financial viability of hospitals and health systems. However, in the event CMS moves forward on this front, it is imperative this change be formally proposed via a

subsequent notice-and-comment rulemaking. This would allow stakeholders to respond to proposed regulatory language and meaningful fiscal and impact analyses, rather than the relatively sparse discussion contained in this rule's preamble. This is particularly warranted when considering the relatively limited experience with SDPs — they were first introduced in the 2016 managed care final rule — and their vital importance in ensuring access to and the financial viability of hospitals and health systems serving Medicaid enrollees.

Non-Network Provider Eligibility for Fee Schedule or Uniform Increment SDPs
CHA supports the proposed removal of network provider status as an eligibility condition for receipt of fee schedule or uniform increment SDPs under 42 C.F.R. § 438.6(c)(1)(iii). Our concerns with this limitation stemming from the 2016 final rule include:

- It is overly narrow
- It has led to the exclusion of certain provider arrangements that would have otherwise been eligible for SDP participation
- It has proved to be an unnecessary and burdensome constraint to realizing various programmatic goals within Medicaid managed care
- It has unintentionally provided health plans an unfair advantage in base rate negotiations and other terms with providers and does not support well understood principles associated with good faith negotiations
- It has unintentionally created access issues for this at-risk population that is already access challenged

We are particularly concerned with how this network restriction has been used and would continue to be used in the future to tilt the balance in downstream contract negotiations to the disadvantage of providers. This is crucial given the increasing prevalence and value of SDPs and the importance of such payments in providing adequate access and quality of services. For instance, there is ample evidence Medi-Cal managed care plans know that for a provider to receive a directed payment that provides a uniform dollar increase for a particular service that service must be contracted. Furthermore, health plans also know that because of EMTALA, hospitals in particular do not have the ability to deny care to individuals for emergency services and that the rate paid for out-of-network services is the fee-for-service (FFS) base rate.

In California, FFS base rates are based on the all-patient refined diagnosis related groups (APR-DRGs) methodology, but aggregate spending in FFS APR-DRG rates have been frozen since 2012. Therefore, hospitals have very little leverage as remaining out-of-network would result in an abysmal payment based on FFS. Given the meaningful value of SDPs, health plans can essentially force hospitals to take less than APR-DRG through contract negotiation because they know there is little a hospital can do in order to access the SDP. This uneven bargaining position for hospitals only further exacerbates the losses for California hospitals that treat Medi-Cal patients. These low levels of reimbursement are forcing some hospitals to reduce services or even close, impacting not just Medi-Cal patients but entire communities. Additionally, removal of this limitation is particularly warranted because it does not apply for the other categories of approvable SDPs (namely value based purchasing and delivery system reform payments). This change would bring a welcomed consistency to the SDP provider eligibility framework and CHA encourages CMS to finalize this rule change to take effect at the earliest possible date.

Contract Term Requirements for SDPs
CHA is supportive of the increased flexibility being proposed by CMS that would allow states to submit SDP preprints for approval 90 days prior to the end of the managed care rating period for which the SDP

applies or amendments to the preprint up to the last day of the rating period. However, the proposed rule at 42 C.F.R. § 438.6(c)(5) would require all SDPs to be documented in plan contracts, and depending on the type of SDP, with an expanded level of detail already addressed in the underlying SDP preprint approval. All SDPs would have to be sufficiently documented and finalized in plan contract amendments no later than 120 days after the start date of the approved SDP or 120 days after the date of CMS written approval, whichever is later.

CHA is concerned with the implication that an SDP that receives timely approval from CMS in the robust preprint process could nonetheless be discarded due to a state's failure to adhere to what we view as redundant administrative requirements. Due to the volume of contract amendments processed in the ordinary course of administration, and the historical and ongoing delays experienced in contract, rate, and SDP approvals, we fear this proposal will be impossible to implement in California. CHA encourages CMS to reconsider the previously accepted practice of states incorporating approved SDP preprints by reference in the managed care contract. We do not believe it is necessary nor efficient to subject SDPs to an additional approval process on top of preprints and rate certifications. SDPs should become binding upon states and plans at the point of obtaining CMS written approval, in the same manner applicable to amendments to a state's Medicaid plan. As an alternative, we recommend CMS streamline the level of SDP detail to be memorialized in plan contracts and remove any durational limit for finalization of the follow-up contract amendment.

Nonfederal Share Financing and Hold Harmless Attestation
CHA urges CMS to abandon the proposed requirement at § 438.6(c)(2)(ii)(H) for each provider receiving an SDP funded by a health care related tax to attest they do not participate in any hold harmless arrangement. While the attestation requirement refers to existing statute and regulation governing hold harmless, we are nonetheless concerned given the preamble clearly incorporates the highly problematic interpretation communicated in the CMS Feb. 2, 2023, Informational Bulletin, which is currently subject to litigation on both substantive and procedural grounds. Specifically, we are concerned that the "or indirectly" language contained in section 1903(w)(4)(A) of the SSA and 42 C.F.R. § 433.68(f)(3) allows CMS — on a sub-regulatory basis — to find an impermissible hold harmless when the state itself does not direct nor has any involvement with downstream arrangements between private entities. We believe a plain-language reading of the controlling statute, and CMS' own regulation, clearly forecloses such a result since it only constrains the tax-imposing entity (the state or local government unit) from providing a direct or indirect offset of tax liability. Put another way, we believe CMS lacks the authority to further restrict sources of nonfederal share by regulating purely private transactions.

It is also impermissible for CMS to effectuate a legally binding change to hold harmless rules outside of the notice-and-comment process mandated when imposing a substantive legal standard. This is indisputably the case for the expansive hold harmless interpretation communicated in the rule's preamble and previously via the Feb. 2, 2023, bulletin. Further, and notwithstanding the statute only restricting state or local taxing entity action, any change to the underlying hold harmless rules should be sought via notice-and-comment rulemaking addressing Subpart B of Part 433 governing health care related taxes and not within the immediate Part 438 governing managed care. We are particularly concerned that CMS is attempting a sub-regulatory end-run to enforce the same hold harmless interpretation that it proposed in the 2019 Medicaid Fiscal Accountability Regulation (84 Fed. Reg. 63722) and subsequently withdrew in 2021 (86 Fed. Reg. 5105). Ultimately, it is our view that extending hold harmless restrictions to private transactions without any involvement from a state or local government requires congressional action.

If the attestation requirement is finalized in concert with the troublesome preamble commentary, we believe far-reaching negative effects are inevitable. In California, use of provider taxes is vitally important and a bedrock component of adequately funding the nonfederal share of SDP expenditures in accordance with Medicaid commands. Going beyond the existing mechanism for disallowing federal financial participation associated with impermissible tax-financed payments under Section 1903(w) of the Act, the proposal would also establish a basis to deny or rescind approval or renewal of an SDP and potentially more large-scale disallowances and recoupments. This seemingly could be accomplished upon a single provider failing to timely provide the requisite attestation. This all would bring massive uncertainty for providers, who are already facing significant financial challenges, and threatens to destabilize state-driven financing arrangements at a fiscally perilous time.

Given the significant legal and fiscal concerns, and in light of the pending litigation on this exact issue, we feel it is premature to adopt any hold harmless changes, including the provider-based attestation requirement, in the derivative context of managed care and SDPs.

Separate Payment Terms

CHA appreciates the rule preserving the ability of states to use "separate payment terms" for certain categories of SDPs at 42 C.F.R. § 438.6(c)(6). This is despite CMS' concerns about the risk-based nature of Medicaid managed care and strong preference that SDPs are included as an adjustment to the plan's capitation rate. Separate payment terms or fixed pools have proven to be a valuable tool for states to target funds toward their chosen policy goals, particularly as a lever in responding to access concerns or deficiencies within a certain service or provider category and to effectively implement specific legislative mandates. With either uniform increment increases or performance-based SDPs, these arrangements have emerged as an effective solution to many of the challenges in including such payments in the capitation rate. They have also provided much needed administrative simplicity while promoting the type of payment transparency that is an overarching goal of CMS in this rulemaking and elsewhere. Furthermore, the separate payment terms help to negate the health plan incentive to deny services or steer utilization to a particular provider in order to retain a portion of the directed payment.

The continued use of separate payment terms becomes even more necessary when considering the proposal to prohibit interim payments that are subsequently reconciled to actual utilization, based on similar concern around the risk-based nature of managed care. With consideration of requested changes that are noted below, we feel retention of separate payment terms with appropriate guardrails and adequate documentation in the rate certification strikes the right balance between the above-mentioned concerns and the utility these arrangements bring. CHA strongly encourages CMS to not eliminate the use of separate payment terms, as discussed as an alternative in the preamble but not proposed in the text itself, or overly constrain state flexibility in this realm to avoid stifling a state's pursuit of its programmatic goals and maintenance of beneficiary access.

We support codifying the current practice that separate payment terms are reviewed and approved as part of the SDP preprint and that during post-approval the general parameters are sufficiently documented within plan contracts. That said, for the reasons discussed above regarding SDPs in contracts, CHA encourages CMS to streamline what must be documented in the contract and to rescind the 120-day time limit for accomplishing that documentation (at least insofar as a failure to adhere to that time frame negates a state's authority to implement and enforce that separate payment term against contracted plans). As stated above, we believe that approval obtained through the robust SDP preprint should control and become binding on states and plans at the point of initial written approval by CMS. This would prevent the loss of time and resources put into obtaining CMS preprint approval, and

bring certainty to hospitals and health systems that they can expect to receive these critical payments, notwithstanding any failure to comply with post-approval ministerial tasks.
In furtherance of flexibility, CHA suggests that CMS withdraw the definitional limitation that a separate payment term must be a fixed and predetermined amount and allow states to provide either the aggregate pool amount or the per-unit/per-percentage increase for purposes of obtaining preprint approval. If not adopted, we encourage CMS to at least adopt the narrower policy allowing amendments to separate payment terms due to changes in federal law and when there is no change to the associated nonfederal share amount.

The total payment rate comparison would be submitted with the preprint as part of the request for approval of each SDP and updated with each subsequent preprint submission. The comparison would be done separately for each provider class. CMS proposes to require states in the preprint to compare total payments to the provider class —including the base payments, all SDPs, and any pass-through payments — to the ACR, with each component being expressed as a percentage of the ACR.

Quality and Evaluation
CMS proposes several changes to support more robust SDP evaluations, including strengthening the requirements for SDP evaluation plans, and specifying when and how states must conduct and submit evaluation results. CMS is also seeking to tie the use of SDPs more explicitly to a state's quality strategy and increase the oversight and reporting states must meet as part of the SDP approval in order to demonstrate an SDP is furthering the goals and improving quality in the Medicaid program. CMS believes these changes will increase accountability for managed care programs and promote access to care.

While we have no issue with CMS' long-standing policy requiring directed payments be tied to the state's quality goals and objectives, we encourage CMS to be thoughtful in how it implements and measures these quality requirements so they are relevant and achievable for providers. In addition, we encourage CMS to ensure that failure to meet quality benchmarks does not result in actions that are overly punitive and would not result in significant financial hardship and ultimately a reduction in access.

We agree and support CMS' proposal for measures to be applicable to the provider-specific SDP. Hospitals should be assessed on hospital inpatient and outpatient care delivered to patients. We appreciate CMS' focus on further aligning states through a national quality strategy as outlined in the proposed rule. However, this population-based strategy focused on HEDIS measures applicable to health plans identifies only one measure specific to hospital care — a 30 day all cause readmission measure. While this is an important measure, the size and scope of SDPs applicable to hospitals require hospital-specific actionable measures that hospitals can report, be held accountable for, and are reflective of the quality of care provided in the inpatient and outpatient setting.

We urge the agency to consider either articulating an additional domain specific to hospital care — perhaps one that also aligns with CMS' broader national quality strategy and allows states to augment their quality strategies to more fully reflect the measurement needed to align with provider-specific SDPs. For CMS to appropriately evaluate SDPs as outlined in the proposed rule, states must have the ability to select measures applicable to the type of provider. For example, due to the nature of the care provided, CMS has different reporting programs for acute inpatient and outpatient facilities, inpatient psychiatric hospitals, inpatient rehabilitation facilities, and long-term care hospitals. Each of the Medicare programs includes measures applicable and actionable by those providers and the improvement of care can be measured over time in each of those settings. Medicaid should align with Medicare's hospital

measures where appropriate to further focus providers' attention on areas for improvement while reducing reporting burden and administrative costs to both the states and providers. We do not support hospitals' SDPs being based on HEDIS-specified measures.

CMS proposes one of the selected measures to be pay for performance and applicable to care provided to Medicaid managed care (MMC) enrollees. We have several concerns with these two proposals. CHA believes CMS should continue to support pay for reporting of measures in the initial years of a program, giving states and providers time to establish the data infrastructure for reporting if it is not readily available, and allow for experience with new measures before they are moved into a value-based arrangement. The Medicare program will first publicly report on a measure included in the inpatient quality reporting program prior to its inclusion in a value-based purchasing program. This allows for provider experience and understanding of the measure. Most importantly, it allows time to make the necessary changes in care delivery that will have a measurable impact on the care provided to patients. We similarly urge CMS to allow for similar flexibility as part of Medicaid quality reporting.

CMS should not limit the measures specified for selection to the MMC population. If states are to hold providers accountable for improved quality and drive toward value-based payments, then the measures selected must be actionable, reliable, and valid for the patient population being measured. Currently, there are no measures specified for hospital data collection and reporting in the inpatient or outpatient setting that are applicable to a MMC population. The process and outcome measures currently in use are specified for either all payers or Medicare FFS. Many states have taken a measure specified and risk-adjusted for a Medicare population and applied the same methodology to a narrower MMC population. In doing so, that measure is no longer reliable or valid. The risk adjustment appropriate for a patient population over the age of 65 versus an adult under the age of 65 is different. Depending on how the state applies a Medicare-specific risk adjustment may also lead to variation in state to state in reporting on the measure. In addition, it is highly likely that in many organizations, limiting an all-payer measure to a MMC population would not only result in an invalid measure from a reliability standard but for many, there would be an insufficient denominator of patients for measurement.

Finally, CMS proposes that measures be selected annually. As noted above, measures selected for value-based SDPs should start with a pay-for-reporting year before moving to a risk-based methodology. In order to see meaningful improvement, those measures should be in place for a minimum of three years. Adding and or changing measures on an annual basis does not allow for care transformation to take place and meaningful improvements to be made. Further, it's important to note that even when a measure may be topped out, continued focus and attention will ensure that we do not see erosion of the improvements over time and states should have that flexibility. Value-based methodologies that continue to reward achievement, as well as improvement to account for this focus, should be encouraged and supported by CMS.

Lastly, CMS proposes to add to the standards applicable to SDPs, that they must result in achievement of the state goals and objectives in the evaluation plan. CMS states that adopting this standard would allow it to disapprove SDPs that do not achieve these goals and objectives. CHA believes such a denial would be overly punitive and would not allow states and providers the opportunity for remediation before facing a severe financial penalty that a denial would bring. Therefore, before disapproving SDPs that fail to meet these goals, we encourage CMS to work with states to address underlying reasons for missing quality goals and provide opportunities for revisions. While we are grateful and supportive of CMS' attempts to offer a path for due process through a formal appeal process using the Department

Appeals Board, we are concerned that such a process could result in extensive delays and create uncertainty and financial challenges for providers as they await adjudication of the appeal.

Medical Loss Ratio

Medical loss ratios (MLR) are one way that states and CMS can assess whether adequate amounts of the capitation payments are spent on services for enrollees. Under the proposed rule, CMS is seeking to include MLR reporting requirements as they relate to clinical or quality improvement standards for provider incentive arrangements, prohibited administrative costs in quality improvement activity) reporting, and additional requirements for expense allocation methodology reporting. Other changes include specifying the timing of updates to credibility adjustment factors, establishing deadlines for the submission of MLR reports to the state, specifying the level of data aggregation required for state MLR summary reports to CMS, clarifying contract requirements for reporting overpayments, and establishing new reporting requirements for SDPs.

CHA does not have any fundamental concerns with the proposed rule regarding MLR calculation and reporting requirements, however, we believe CMS should consider having states and health plans report their MLR both with and without SDPs. CMS already is proposing that managed care plans would have to include SDPs and associated revenue as separate lines in their MLR reports. CHA recommends this goes one step further and have managed care plans separately report their MLR percentage with and without SDPs. SDPs, particularly those that are paid through separate payment terms for which health plans are not at risk, create distortions in the MLR results as non-risk SDPs artificially inflate a health plan's spending. Viewing a health plan MLR based on what it is actually at risk for would provide a more accurate picture as to what health plans are actually spending on health care services that are within their control.

Quality Assessment and Performance Improvement Program, State Quality Strategies and Extended Quality Review

In accordance with section 1932 of the SSA and 42 CFR Part 438, states that contract with MMC plans (MCOs, PIHPs, and PAHPs) must be in compliance with quality assessment and performance improvement requirements. This includes requiring such plans to have a quality assessment and performance improvement program, a managed care quality strategy for assessing the quality of services furnished by such plans, external quality review of the quality of and access to services under managed care contracts, and accreditation reporting. CMS is proposing regulatory changes that it believes will further improve transparency, monitoring, and accountability with the ultimate goal of improving the overall quality of services provided to the Medicaid population.

While still in their early stages, we believe there are some guiding principles and best practices that should inform CMS policy proposals related to quality going forward. Specifically, we urge CMS to encourage states to work directly with hospitals and health systems to more fully understand the opportunity for quality measurement, reporting, and opportunity for improvement at the provider level. This would strengthen our shared goals of improved quality of care for Medicaid patients while limiting the increasing costs of administering these programs for both providers and the state.

Medicaid Quality Strategy

Currently, states must have a written quality strategy for assessing and improving the quality of health care furnished by MMC plans. States are required to review and update their strategy at least once every three years.

To increase transparency and opportunity for ongoing public engagement, CMS proposes to require:

- States to make their quality strategy available for public comment at the three-year renewal, regardless of whether or not there are significant changes, in addition to whenever significant changes are proposed to be made
- The state Medicaid agency to post on its website the results of its three-year review, including its full evaluation of the effectiveness of the strategy
- States (prior to finalizing a revised or renewed quality strategy) to submit a copy of the revised strategy to CMS at least every three years, following the state Medicaid agency review and evaluation, in addition to when significant changes are proposed to be made.

CHA supports these recommendations. CMS should continue to encourage states to make changes to their quality strategies to align with the proposed changes for the evaluation of SDPs as noted above. As new SDP programs are developed, the quality strategy must remain in alignment and reflect the care provided so that it can be appropriately evaluated.

Medicaid and CHIP Managed Care Quality Rating Strategy (MAC QRS)
CMS proposes a MAC QRS framework with three components:

1. Mandatory measures (which states must use in the CMS framework or a CMS-approved alternative framework)
2. A rating methodology (either the CMS-developed methodology or an alternative methodology approved by CMS)
3. A mandatory website display format. States may implement additional measures without implementing an alternative QRS. Also, CMS proposes a sub-regulatory process for engaging regularly with interested parties before making updates to the components of the MAC QRS framework.

CHA supports a national framework that standardizes quality measurement requirements that help strengthen the Medicaid program while reducing provider burden and improving the lives of Medicaid beneficiaries. In addition, we applaud CMS' efforts to put forward a meaningful set of mandatory measures across all states and we appreciate the alignment to a core set of measures that are used in the CMS MSSP program. With that said, we believe this list could be further narrowed to focus improvement efforts and limit provider burden but expanded in meaningful ways over time.

According to the Georgetown University Health Policy Institute for Children and Families,[9] five companies owned 112 of the 281 Medicaid managed care organizations (MCOs) that states contracted as of September 2020. They include Aetna/CVS Health, Anthem, Centene, Molina, and UnitedHealthcare. Each company had subsidiaries in over 12 different states. And as of the end of 2020, according to parent company data, these MCOs were responsible for the delivery of needed health services to over 35 million Medicaid beneficiaries. Each company experienced an increase in Medicaid enrollment between December 2019 and December 2020; in total, their Medicaid enrollment grew by 32%.

MMC plans continue to consolidate and as such, we believe that CMS should recognize this consolidation and significantly limit the state variation in quality measures used and the rating methodologies developed. While we understand that CMS wishes to allow for some state variation, the time has come for more standardization if we are to be successful in our shared goals of improving quality. CMS is in a unique position to focus on a set of meaningful measures that will further drive

[9] Medicaid Managed Care: 2020 Results for the "Big Five" – Center For Children and Families (georgetown.edu)

quality improvement efforts across the health care system and improve the health and well-being of patients nationwide.

Process and Cost Concerns

The volume and scope of changes being proposed under this rule (particularly in conjunction with the Ensuring Access to Medicaid Services proposed rule) — if adopted — would result in significant changes to the Medicaid program and would require adequate time and resources to implement. Furthermore, CMS has requested feedback on issues or policy options in the preamble but did not make any proposed changes to the regulations themselves nor conduct the necessary level of impact and fiscal analyses. CHA is concerned that these policies alluded to in the preamble would be finalized within new regulatory language that was not subject to traditional notice-and-comment rulemaking and thus not vetted in accordance with the requirements of the federal Administrative Procedure Act. Therefore, CHA strongly suggests that any new regulatory text changes not noticed in the immediate rule should be subject to subsequent rulemaking so the public may respond to full fiscal and impact analyses and there will be meaningful opportunity for public comment as to the actual regulatory language prior to finalizing.
If finalized the volume and scope of these changes, across both this proposed rule and the companion Ensuring Access to Medicaid Services proposed rule, will create a significant level of administrative workload and cost for states to implement. For these reasons, we are concerned about some of the proposed timelines for implementation as stated above, but we also are concerned about the administrative costs these new requirements will have on states. As mentioned above regarding managed care rate transparency, CHA has strong concerns about the level of hospital base reimbursement and the lack of any meaningful increase to these rates in California for over a decade. One of the reasons for this lack of investment is due to limited budget resources.

If finalized, these rules would result in considerable additional administrative costs for the state to implement, which further reduces budget resources that we believe would be better invested into providing actual care to Medi-Cal members. If providers are not reasonably compensated for the services they provide to Medicaid enrollees, it only serves to undermine the very goal of improving access to high-quality health care services. Therefore, while CHA supports these overall goals and many of the proposed changes, we would request that CMS consider enhanced federal matching funds to states in order to design, develop, and implement the finalized rules. This would be similar to enhanced federal matching funds that are made available to states for investments made to their information technology systems.

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact me at rducay@calhospital.org or (916) 552-7643, or Chad Mulvany, vice president of federal policy, atcmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Robert Ducay
Vice President, Policy