



AMERICA'S ESSENTIAL HOSPITALS

July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Ref: CMS-2390-P: Medicaid and Children's Health Insurance Program (CHIP);
Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP
Comprehensive Quality Strategies, and Revisions Related to Third Party
Liability

Dear Mr. Slavitt:

America's Essential Hospitals appreciates the opportunity to submit these comments on the above-captioned proposed rule. The association supports the Centers for Medicare & Medicaid Services' (CMS') work to modernize Medicaid managed care and better align the regulations with existing standards for commercial, health insurance marketplace, and Medicare Advantage plans. However, America's Essential Hospitals is concerned about a number of provisions in the proposed regulation that would harm essential hospitals.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our more than 250 members provide a disproportionate share of the nation's uncompensated care and devote roughly half of their inpatient and outpatient care to Medicaid or uninsured patients; 32 percent of inpatient care and 27 percent of outpatient care at our member hospitals is provided to Medicaid beneficiaries, while 15 percent of inpatient and 24 percent of

outpatient care is provided to the uninsured.¹ (This compares with only 23 percent of inpatient care and 21 percent of outpatient care to Medicare beneficiaries, significantly below the industry average.) Our members provide this care while operating on margins substantially lower than the rest of the hospital industry: an aggregate operating margin of negative 3.2 percent, compared with positive 5.7 percent for all hospitals nationwide.²

In addition, as essential hospitals, our members serve as cornerstones of care in their communities, providing specialized inpatient, outpatient, and emergency services, such as trauma, burn care, and inpatient psychiatric care, which often are unavailable elsewhere in their communities. In the 10 largest U.S. cities, our members operate 34 percent of all level I trauma centers, 69 percent of all burn-care beds, and 33 percent of psychiatric beds.³ Members of America's Essential Hospitals also play a vital role in providing ambulatory care to their communities. The average member operates a network of 20 or more ambulatory care sites. And they deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Essential hospitals play a unique and critical role in the Medicaid delivery system. Given our low-income, vulnerable patient populations, we also have unique potential to make a real and lasting impact on the lives and well-being of some of the most disadvantaged among us. We have the expertise, passion, and commitment to apply and adapt proven models of care to the benefit of our patients, and to pioneer new models to meet their specialized needs. Consistently, members of America's Essential Hospitals find increasingly innovative and efficient strategies for providing high-quality, complex care to their patients, all while facing high costs and limited resources. But the reality is that with their patient mix and margins, our members are utterly dependent on Medicaid funding to carry out their missions and even just to remain viable.

In short, our members are at the very heart of the Medicaid delivery system, providing access where none exists, innovating with populations others ignore, and depending on Medicaid support to stay afloat. As CMS engages in policymaking of the scope reflected in these proposed regulations, it is

¹Reid K, Roberson B, Landry C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential Hospitals. March 2015. <http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf>. Accessed July 2, 2015. (hereinafter, "Vital Data 2013")

²Ibid.

³Ibid.

imperative that the impact on essential hospitals—and more important, on the patients who rely on essential hospitals—be thoughtfully considered. CMS’ goal of providing meaningful access to care for Medicaid patients cannot be achieved without our members. In that spirit, we urge the agency to consider the following comments.

1. The managed care regulations should reflect that states can and should be encouraged to achieve broader policy goals through the Medicaid program.

It is critical that as CMS overhauls its Medicaid managed care regulations, it does so with an understanding that Medicaid is unique. Medicaid as a purchaser is not like an employer simply looking for the best value plan for its employees (though Medicaid certainly should ensure value when purchasing health plan coverage). Medicaid’s role goes much further. State Medicaid programs have always been used as the primary lever through which a state can shape the health care delivery system within its borders—particularly for the poorest residents. States use their Medicaid programs to achieve population health goals, promote health equity and access to quality care for all, support training for the next generation of health care professionals, and protect consumers, among other things. These are vital public policy roles that other purchasers simply do not fill. Indeed, CMS suggests in the preamble that the provisions of the proposed rule need “to recognize and accommodate the unique aspects of the Medicaid program”⁴ and acknowledges the “unique aspects of delivering services through Medicaid managed care;”⁵ such recognition and accommodation must be reflected in policy on provider payment under Medicaid managed care as well.

As such, Medicaid has become a primary source of support for a small but diverse nationwide network of essential providers offering a health care safety net where market forces prove inadequate. A high proportion of essential hospitals’ Medicaid funding is derived not from claims payments, but from a patchwork of policy-based supplemental payments that represent the lifeblood of their existence. For a variety of reasons, that critical safety net support, which is needed to preserve access for beneficiaries, is unraveling—and without identification of a realistic alternative to maintain the viability of these crucial providers. Federal policies related to waiver-based uncompensated care funding, looming cuts to Medicaid disproportionate share hospital (DSH) payments, providers’ inability to access the courts to enforce states’ obligation to pay

⁴ 80 Fed. Reg. 31098, 31251 (June 1, 2015) (hereinafter, “Proposed Rule”).

⁵ Ibid, p. 31108.

adequate rates, and CMS' apparent reluctance to enforce payment adequacy through regulations, all are cumulatively eroding the support that enables essential hospital to keep their doors open.

Similarly, CMS' policies related to supplemental support for key Medicaid providers have become an increasingly difficult obstacle for our members as states steadily expand their use of managed care. Given the unique and critical role that essential hospitals play in the Medicaid delivery system, as described above, the consequences if not reversed, will be dire.

For that reason, we repeatedly reached out to key CMS staff over the past year as you developed these regulations to urge you to preserve the ability for states to provide supplemental support in the managed care environment. America's Essential Hospitals agrees with CMS, as expressed in the preamble, that we "want states to be able, at their discretion, to incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries under a managed care arrangement."⁶ **CMS should use the opportunity in issuing the first major revisions to the managed care regulations in more than a decade to support, not undermine, this goal—introducing new flexibility in the managed care program so states may continue to rely on Medicaid to ensure an accessible, high-quality health care delivery system for all.** Our more specific recommendations for introducing this flexibility appear below.

- a. CMS should modify the direct pay prohibition in § 438.60 so that states and providers have the ability to support vital missions through direct supplemental payments.

The "direct pay prohibition" embodied in both the current and slightly refined version of 42 C.F.R. § 438.60 is a case in point of how attempts to implement Medicaid managed care without accounting for the Medicaid program's unique nature can seriously impact the health care safety net and beneficiary access. The provision prohibits additional payments for services covered under managed care contracts, with exceptions for payments specifically required to be made by the State in statute or regulation (such as DSH or federally qualified health center (FQHC) payments) or for graduate medical education payments (provided the state has adjusted the capitation rates to account for such direct payments). **America's Essential Hospitals urges CMS to modify the direct pay prohibition to permit certain policy-based direct payments that are part of a state's approved State Plan.** Particularly given the role of states in

⁶ Ibid, p. 31124.

financing the Medicaid program, states should not be forced to cede their role in making public policy to private health plans.

Since its adoption in 2002, the direct pay prohibition has prevented states from making supplemental payments to providers for services furnished to managed care enrollees. This rule ignores the role Medicaid does and should play in achieving policy goals beyond simply purchasing a benefits package for eligible individuals. Under the rule, states are forced to incorporate funding intended to support particular providers and achieve specific state policy goals into capitation rates paid to plans, with little to no control over how the plans spend that funding. This policy strips states of a critical role of government—that of addressing any gaps in the market to ensure the needs of their citizens are met. The market is not structured to value the vital roles played by essential providers. Yet, CMS’ direct pay policy requires states to place their faith in private health plans to act against their economic self-interest and support these providers, nonetheless. As a result, some states have chosen to delay implementation and/or expansion of managed care within their programs—in effect, they are forced to forgo the related potential to improve coordination and care efficiency to ensure providers at the program’s core are able to continue serving beneficiaries.⁷

Requiring states to hand supplemental funding over to the plans also distorts the market-based incentives under which the plans should ideally operate. If states were allowed to address their policy concerns through direct payments to particular providers outside of managed care rates, the plans would be free to negotiate and pay essential providers a market-based rate that would put them on an equal competitive footing with other network providers. Plans would not have perverse incentives to direct utilization away from essential providers, realizing unintended windfalls from funding meant to bolster targeted segments of the health care delivery system.

Congress recognized the wisdom of allowing states to make wrap-around payments outside of managed care when it gave states the option of making such direct payments to FQHCs outside of the capitation rates. Like essential hospitals, FQHCs are a key part of the Medicaid and low-income delivery system that the market would not necessarily support if left to its own devices. Similarly, CMS itself has recognized the urgent need for states to be able to support

⁷ See, e.g., Medicaid and CHIP Payment and Access Commission MACfacts, November 2012 (noting Texas’ delay in implementing managed care, and initial carve-out of inpatient hospital services from managed care contracts prior to implementation of its demonstration waiver payment pool to preserve hospital support).

graduate medical education (GME) through direct payments outside of capitation rates, as the market is not likely to fully support the costs of training the future professional workforce.⁸ GME and FQHCs are not the only important policy goals that states may have the need to support outside of capitation rates.

States' increased use of managed care for Medicaid populations—recent data indicate that more than half of all Medicaid beneficiaries are enrolled in managed care⁹—is having a measurable impact on states' ability to support their essential Medicaid providers. Because contracted health plans do not necessarily share the state's broader goals, CMS should allow states the flexibility to achieve their policy goals outside of managed care.

The direct pay prohibition should be modified to allow states to make direct payments to providers to meet public policy goals states have designated as important to their Medicaid programs. From a practical perspective, this goal could be implemented by allowing states that have received CMS approval for policy-based supplemental payments in their Medicaid state plan to continue to make such payments directly to the intended providers. As with GME payments, states would be required to make corresponding adjustments to the capitated rates to the plans to reflect such direct payments. Through such required adjustments, CMS can be assured that overall payments will be consistent with economy and efficiency, as required by statute,¹⁰ because the underlying state plan supplemental payments would have necessarily met that standard.

To support the critical mission of essential hospitals and the Medicaid patients they serve, it is vital that CMS modify the direct pay prohibition and allow states to make policy-based supplemental payments beyond GME directly to providers for services provided under managed care contracts.

- b. CMS should allow states to direct managed care plan expenditures to achieve state policy goals.

CMS proposes to expand the direct pay prohibition by adding a new section to the regulations (proposed 42 C.F.R. 438.6(c)) explicitly prohibiting states from

⁸ 42 C.F.R. §438.60 allows states to make graduate medical education payments based on services provided to Medicaid managed care patients, as long as capitated rates are adjusted accordingly.

⁹Kaiser Commission on Medicaid and the Uninsured. Medicaid Moving Forward. March 2015. <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward>. Accessed July 2, 2015.

¹⁰ 42 U.S.C. §1396a(a)(30)(A).

directing plan expenditures under contracts, except under certain specified circumstances, which include

- requiring implementation of value-based purchasing models;
- mandating participation in a multipayer delivery system reform or performance improvement initiative; or
- requiring the plan to adopt a minimum fee schedule or uniform rate increase for all providers of a particular service.

This proposal, with its narrow exceptions, would have the effect of shifting authority and discretion over the Medicaid program from the state policymakers to plans—hamstringing states’ ability to ensure that their investments in Medicaid achieve the state’s intended policy goals, and will leaving essential hospitals without the support on which they rely to serve our nation’s most vulnerable.

New § 438.6(c) would now require states to spread their scarce dollars across all providers, rather than targeting support to where it is most needed—diminishing the impact state investments can have on service delivery and access. There are many legitimate and important reasons states target support through directed payments to a subset of providers, not just for the benefit of those providers, but for their patients, including a disproportionate share of the most vulnerable beneficiaries.

For example, faced with fiscal constraints necessitating below-market payment rates, states may seek to focus additional support on providers with the largest Medicaid patient populations, acknowledging the extra burden they bear and their inability to cross-subsidize the low rates. Or, states may seek to direct enhanced payments to providers that offer access to particular essential services, such as trauma, burn care, pediatric, or other specialized or primary care services. Or states may seek to target payments to providers in underserved rural or urban areas. It appears that these forms of targeted payments would no longer be permitted under CMS’ proposed rules. Instead, states would be forced to disperse their limited funding exclusively in across-the-board rate increases that dilute the impact of the additional support.

For these reasons, **CMS should remove proposed 438.6(c) from the final rule.**

- c. If CMS chooses to retain the new prohibition on directed payments, it should add flexibility for states to prioritize the use of Medicaid resources by directing plans to make policy-based payments consistent with a state’s approved state plan.

Specifically, CMS should add a new paragraph (c)(1)(iv) providing that the state may require plans to make enhanced payments to providers to account for CMS-approved, policy-based supplemental payments in their Medicaid state plan. States may have legitimate policy goals beyond the limited goals CMS *would choose for them* in the proposed rule. And CMS can be assured that inclusion of these payments in the capitated rates will be consistent with economy and efficiency, as required by statute,¹¹ because the underlying state plan supplemental payments would necessarily have met that standard to receive CMS approval.

In addition, CMS should revise and/or replace the demonstrations required for approval in proposed (c)(2) with a more flexible review process. Such a process should permit states to 1) make policy-based payments to a subset of identified providers 2) direct payments on a basis that may be linked to measures other than utilization of services, and 3) finance such payments with legally permissible sources of non-federal share funding.

Otherwise, as written, CMS' proposal would necessarily frustrate CMS' stated desire for "states to be able, at their discretion, to incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries under a managed care arrangement."¹²

- d. If CMS retains the new prohibition on directed payments, it should provide flexibility to states in defining "services" for which a minimum fee schedule or uniform increases may be directed.

We are concerned with the proposed requirement that state-mandated minimum fee schedule or rate increases be uniform for all providers of a particular service. It is unclear how CMS intends to define the term "service." If this provision is retained, **we strongly encourage CMS to allow states to define categories of services that align with state policy goals. CMS should not prescribe a broad definition of the term "service" that does not allow states to reflect legitimate distinctions within categories, such as physician services (e.g., increases for primary care services provided by primary care professionals).** In particular, CMS should not equate the term "services" for purposes of this regulation with the broad categories of "medical assistance" in 42 C.F.R. Part 440.

¹¹ See discussion of application of 42 U.S.C. §1396a(a)(30)(A) to managed care rates *infra* page 10.

¹² Ibid, p. 31124.

- e. CMS should clarify that its prohibition on directed payments is not “longstanding policy.”

In proposing to add the new prohibition on directed payments through managed care contracts, CMS states in the preamble to the proposed rule that it is simply “formaliz[ing] our longstanding policy on the extent to which a state may direct the [plans’] expenditures under a risk contract.”¹³ But this has not been CMS’ longstanding policy. It has not been stated in any informal guidance or other policy statements. And CMS has approved contracts that explicitly direct payments to particular providers that the state has sought to support.

In fact, a few days *after* issuing the proposed managed care rule, CMS issued a “Draft 2016 Medicaid Managed Care Rate Development Guide” that notes states’ use of “pass-through payments” that include “[a]ny amount added by the State or any amount required by the State to be added, to the payments from the plans to the providers that is not included in the contracted payment rates between the plans and the providers.”¹⁴ The guide requires states to provide details about such pass-through payments, but nowhere makes mention of any longstanding policy prohibiting them. Similarly, although the finalized 2015 Rate Development Guide does not include a specific discussion of pass-through payments, it does require states to provide information to CMS about “[r]equirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.”¹⁵

CMS’ characterization of the proposed new prohibition on directed expenditures under managed care contracts as “longstanding policy” is inaccurate, unnecessarily calling into question the legal status of currently approved contracts. **CMS should correct its misstatement and clarify that the proposed provision prohibiting directed expenditures does not reflect longstanding policy. If CMS opts to finalize the prohibition in 42 C.F.R. §438.6(c), it should be applied prospectively only. Furthermore, because CMS should**

¹³ 80 Fed. Reg. at 31123.

¹⁴ Centers for Medicare & Medicaid Services. Draft 2016 Medicaid Managed Care Rate Development Guide. June 5, 2015. <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf>. Accessed July 2, 2015.

¹⁵ Centers for Medicare & Medicaid Services. 2015 Managed Care Rate Setting Consultation Guide. September 2014. <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2015-medicare-manged-care-rate-guidance.pdf>. Accessed July 2, 2015.

correctly identify the proposal as a change in law, the agency should conduct the required regulatory impact analysis.

- f. If CMS retains proposed § 438.6(c), it should clarify that requiring participation in *Medicaid* delivery system reform or performance improvements is permissible.

As a more technical point of clarification, the proposed regulation at 42 C.F.R. §438.6(c)(1)(ii) provides that states may require plans “to participate in a multi-payer delivery system reform or performance improvement initiative.” The preamble, however, indicates that CMS intends to allow states to also direct payments for *Medicaid-specific* delivery system reform initiatives.¹⁶ If CMS chooses to finalize some version of §438.6(c)(1), **we encourage CMS to modify the regulatory text itself to make clear that the state may also mandate participation in *Medicaid-specific* delivery system reform or performance improvement initiatives.**

In addition, CMS should revise or clarify its limited exception for “value-based purchasing models” to include a broader set of possible payment reform efforts through which the state seeks to accomplish reforms within its program.

- 2. CMS should ensure flexibility in rate setting by allowing certification of rate ranges and retroactive adjustments to capitation rates.

America’s Essential Hospitals urges CMS to allow states to certify actuarial soundness of a range of rates, rather than requiring states to submit for approval specific rates for each individual rate cell. Under CMS’ proposal, states would no longer be permitted to rely on rate ranges and would have to provide certification to CMS of the actuarial soundness of a specific rate for each rate cell (a category of enrollees defined by one or more characteristics, such as age, gender, or eligibility category). States and their actuaries would have to follow specific steps for each individual rate cell and states would have to demonstrate to CMS compliance with those steps or submit explanations of why certain steps did not apply. Further, CMS would also require states to receive its approval of each of these rate certifications, in addition to approval of the managed care contract, before implementing the rate.

CMS does not provide a coherent rationale for denying states the flexibility inherent in the use of rate ranges and retroactive adjustments, nor for the federal interest in certification of each individual rate cell. If actuaries have

¹⁶ See 80 Fed. Reg. 31124.

certified that any rate within a range is actuarially sound, there is no apparent purpose or additional benefit to be gained by requiring certification and prior approval of each specific rate negotiated for each cell within the range. Nor is it clear why CMS would need to approve retroactive adjustments to the rates, provided the adjusted rate is within the actuarially sound range. By contrast to the lack of apparent benefit, the added burden on states and CMS and the additional bureaucracy imposed would be significant. This administration has committed itself to simplifying government and eliminating burdensome and unnecessary regulation.¹⁷ This proposal, however, is a significant step in the other direction, with no compelling federal interest articulated to support such a move.

CMS should afford states flexibility in the submission and approval of payment rates for managed care plans.

3. CMS should ensure that capitation rates are sufficient to permit plans to pay contracted providers at levels that ensure equal access to care consistent with statutory standards.

CMS must require states to adopt capitation rates that are sufficient to protect beneficiary access to care. CMS builds on the existing definition of actuarially sound rates by defining them as rates “projected to provide for all reasonable, appropriate, and attainable costs under the terms of the contract” and “for the time period and population covered under the terms of the contract.”¹⁸ It would require rates to be adequate to meet requirements for availability of services, capacity, and coordination of care. America’s Essential Hospitals urges CMS to go further to carry out its statutory authority to ensure sufficient provider payment rates—including its role as sole enforcer of the sufficiency of such rates—by ensuring that capitation rates allow for provider payments that meet statutory access standards.

Section 1902(a)(30)(A) of the Social Security Act requires states to adopt payment rates that are sufficient to ensure that Medicaid services are available *at least* to the extent that they are available to the general population.¹⁹ In its 2011 proposed rule implementing Section 1902(a)(30)(A), CMS’ preamble discussion stated that the requirements of (a)(30)(A) “discuss access to care for

¹⁷ Executive Office of the President. Executive Order: Identifying and Reducing Regulatory Burdens. May 10, 2012. <https://www.whitehouse.gov/the-press-office/2012/05/10/executive-order-identifying-and-reducing-regulatory-burdens>. Accessed July 2, 2015.

¹⁸ Proposed 42 C.F.R. § 438.4(a).

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

all Medicaid services paid through a State plan under fee-for-service and do not extend to services provided through managed care arrangements.”

While it may be true that Section (a)(30)(A) does not apply to rates managed care plans pay to providers, it does, nonetheless, cover capitation payments made by states to plans. Section (a)(30)(A) applies to “payment for, care and services available under the [State Medicaid] plan...” Capitation payments, in fact, are payments made for care and services under the state plan, even though they are risk-based rather than fee-for-service. Therefore, the capitation payments themselves, in addition to being actuarially sound, must meet the statutory standard including the equal access requirement.

America’s Essential Hospitals believes CMS should make this connection clear. Capitation rates must be sufficient to allow plans to pay providers in amounts sufficient to ensure access *at least* equivalent to that available to the general population. Too often, current Medicaid managed care rates result in less access to services for beneficiaries.

CMS has neglected to finalize its 2011 proposed regulatory standards to ensure that rates meet the equal access standard.²⁰ We commented on the rule at the time,²¹ and have more recently urged the agency to finalize the rule.²² As our letters have noted, we believe the standards CMS proposed in that rule are wholly inadequate to ensure compliance with the statute because they do not impose any substantive payment benchmarks. Instead the proposed rule focuses on access standards that do not require *equal* access as compared with the general population, and that provide states with maximum flexibility to meet this loose standard. As such, the rule does not have any teeth.

Our concerns about the 2011 proposed rule have been heightened since the Supreme Court, earlier this year, foreclosed all routes to judicial enforcement of

²⁰ 76 Fed. Reg. 26342 (May 6, 2011).

²¹ National Association of Public Hospitals and Health Systems. Letter to CMS Administrator Donald Berwick. July 5, 2011. <http://essentialhospitals.org/wp-content/uploads/2013/11/Association-Comments-on-Medicaid-Equal-Access-Proposed-Rule.pdf>. Accessed July 2, 2015.

²² America’s Essential Hospitals. Letter to CMS Administrator Marilyn Tavenner. September 25, 2014. <http://essentialhospitals.org/wp-content/uploads/2014/09/Equal-Access-letter-to-M.-Tavenner-FINAL.pdf>. Accessed July 2, 2015; America’s Essential Hospitals. Letter to Vikki Wachino, acting deputy administrator and director, Center for Medicaid and CHIP Services. April 28, 2015. <http://essentialhospitals.org/wp-content/uploads/2015/04/Americas-Essential-Hospitals-Medicaid-issues-response-letter-4-28-15.pdf>. Accessed July 2, 2015.

the standard.²³ As a result, CMS is now the *sole* arbiter of the sufficiency of payment rates. For this reason, we believe CMS must take its responsibility seriously and enforce the statutory standard as it was intended. In the managed care context, this responsibility means ensuring that capitation rates paid to plans are sufficient to allow for adequate payment rates from plans to providers.

The vital link between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries cannot be overstated, particularly with the significant expansion of Medicaid coverage under the Affordable Care Act (ACA). When Medicaid rates drop too low, many providers choose not to treat Medicaid patients, and those that do are often forced to shift the unreimbursed Medicaid costs onto other payers. While essential hospitals can continue to be relied on to serve the Medicaid population, their ability to do so when they are compensated well below cost becomes severely compromised, directly impacting the care available to Medicaid patients. In short, through a reduction in either the number or capacity of providers serving Medicaid patients, inadequate Medicaid rates restrict beneficiaries' access to care, particularly as compared with the access available to the general population.

As states continue to increase their use of managed care for their Medicaid populations, it is vital that plans are paid rates that are sufficient to provide not just access to these services, but equal access as the statute requires. **As such, CMS should ensure states accurately account for the costs associated with providing care to guarantee that payment rates are actuarially sound and preserve access to providers. The development of actuarially sound rates should include, as part of the base data, the assumption of provider payment rates that meet the (a)(30)(A) standard.**

4. CMS should ensure that implementation of the medical loss ratio (MLR) accurately captures the services and delivery of care to Medicaid beneficiaries.

America's Essential Hospitals agrees with CMS that health plan MLRs be calculated, reported, and used in the development of actuarially sound capitation rates. We believe it is important not only that rates be set to cover all reasonable, appropriate, and attainable costs in providing covered services, but also that plans actually use those funds to pay for those costs (rather than to support administrative costs, profits, or other items that do not directly benefit members). Moreover, we believe that the additional transparency in the required

²³ *Armstrong v. Exceptional Child Center*, 575 U.S. ____ (2015).

reporting, along with the use of the actual MLRs in future rate setting, will help encourage compliance with the minimum MLR.

Of course, use of the specified MLR in rate setting does not, in and of itself, ensure that capitation rates will be actuarially sound. Again, it is important that states and their actuaries assume adequate provider payment rates (consistent with the statutory equal access standard) when setting capitation rates. We agree with CMS that an MLR that is too high could indicate that payment rates are too low, but caution states and CMS against concluding that an MLR below 85 percent means that the rates are too high; it could also mean the plans are incurring unnecessary administrative costs or realizing surpluses by keeping provider rates too low. **America's Essential Hospitals supports CMS' efforts to institute an MLR for Medicaid managed care plans.**

5. In determining network adequacy for managed care plans, CMS should ensure that Medicaid beneficiaries retain access to their providers of choice.

America's Essential Hospitals urges CMS to require network adequacy standards that preserve access to providers and services on which Medicaid beneficiaries rely. CMS proposes to add a new provision to the regulations requiring states to establish explicit network adequacy requirements for specified provider types. We support the adoption of such provider-specific requirements, but urge CMS to provide guidance to states on specific criteria for developing network adequacy standards, and to review the standards adopted to ensure conformance with these criteria.

CMS should develop its network adequacy requirements to include specific criteria for determining when a state's standards are deemed adequate. Such guidelines should include both quantitative and qualitative criteria that ensure the plans are including providers that offer the full range of primary through quaternary care, including trauma care, public health services, mental health services, substance abuse services, and wrap-around services critical to vulnerable patients.

As CMS develops these criteria, it is imperative to note that simply measuring the number of participating hospital providers in managed care plan networks does not discern whether plan beneficiaries have adequate access to all essential hospital services. Hospitals vary in the services they provide to their communities. A community hospital, for example, does not have the resources to provide complex services, whereas disproportionate share hospitals and

academic medical centers provide that care to their communities daily. Thus, each hospital cannot be deemed to contribute equally to adequate access as, perhaps, each primary care physician in a network could be. Therefore, states should be required to undertake a more qualitative review to ensure patients are able to access vital hospital services within their managed care plan networks.

Another important aspect of network adequacy is linguistic and cultural competency. Members of America's Essential Hospitals have deep experience and a long history of providing culturally sensitive care, including interpretation, transportation, and other social services, to diverse, low-income populations. These services reach beyond the walls of the hospital to provide much more comprehensive care to vulnerable populations. Essential hospitals' experience handling such complex medical and social conditions is invaluable to the health of entire communities.

Merely counting the number of hospitals or other providers in a network plan does not account for the types of specialized services essential hospitals provide. **As such, CMS should ensure that standards states adopt to determine network adequacy ensure access to essential hospitals that are uniquely suited to offer highly complex services to a diverse set of patients. In doing so, CMS will ensure patients have access to the full range of vital hospital services within managed care plan networks.**

6. CMS should finalize its proposal to require managed care plans to establish procedures to prevent duplicate discounts by excluding data for drugs subject to 340B Drug Pricing Program discounts from outpatient drug utilization reports.

CMS is proposing to require plans to establish procedures to exclude outpatient drugs purchased at 340B prices from the drug utilization reports provided to the states.²⁴ The ACA exempted 340B drugs provided to Medicaid managed care enrollees from the manufacturer Medicaid rebate requirement, to avoid the possibility of duplicate discounts. Given that 340B managed care drugs are not subject to rebates, the provisions of the 340B statute imposing liability on covered entities for creation of duplicate discounts do not apply when the underlying drug is provided through managed care plans.

The proposed regulatory requirement and related preamble explanation make clear that the states and their plans, through the proposed reporting procedures, have access to the data needed to avoid duplicate discounts and the

²⁴ Proposed 438.3(s)(2).

responsibility to do so. **America's Essential Hospitals urges CMS to finalize its proposal to require managed care plans to exclude drugs subject to the 340B Drug Pricing Program discounts from utilization reports.**

In addition, we encourage CMS to address the more technical comments expressed in our joint letter with 340B Health and other associations representing covered entities—including to ensure that the methodologies plans use are not overly administratively burdensome for providers (particularly when contracting with multiple plans) and that participation in or the benefit of the 340B program is not limited in the managed care environment.

7. CMS should finalize its proposal to address managed care plan flexibility in the context of patient stays in an institution of mental disease (IMD).

CMS proposes to modify a longstanding exclusion in funding inpatient care for mental health and substance use disorders (MH/SUD) at psychiatric facilities by permitting plans to receive a capitation payment from the state for enrollees ages 21 to 64 that spend no more than 15 days in an IMD. The IMD must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a subacute facility providing psychiatric or SUD crisis residential services.

The IMD exclusion has prevented Medicaid beneficiaries from accessing needed care. By relaxing this inclusion, CMS is taking an active step in ensuring parity for services provided at IMDs. Members of America's Essential Hospitals understand the importance of providing MH/SUD services and have actively responded to patients with these needs. **As such, America's Essential Hospitals supports CMS' proposal to relax the IMD exclusion and allow plans to receive capitation payments for 15-day IMD stays.**

8. CMS should formalize and clarify its rate-setting policy regarding services provided in lieu of covered services.

CMS retains the regulatory provision that allows plans voluntarily to cover services in addition to those covered in the state plan, although the cost of the additional services may not be included when determining payment rates. In the preamble, CMS elaborates on this policy, characterizing it as historical flexibility that plans have had to provide "alternative services or services in alternative settings in lieu of covered services or settings if cost-effective, on an optional basis, and to the extent the managed care plan and enrollee agree that such setting or services would provide medically appropriate care."²⁵ **We support this**

²⁵ 80 Fed. Reg. 31116.

flexibility, as we believe it will ensure that Medicaid beneficiaries receive the most appropriate services in the most effective care settings.

The preamble further discusses how the provision of such alternative services factors into the rate setting process, although we believe that the discussion could be clarified, and should be incorporated into the regulatory language. In general, CMS is clarifying that while the cost of “in lieu of” services may not be included in the rate setting process, the cost of state plan services avoided through the use of these alternative services may be included. In practical terms, CMS appears to be making a distinction between the process for determining the costs avoided when the alternative service is an IMD as opposed to any other alternative service, because of the IMD exclusion in the statute. Specifically, we understand that CMS’ policy is that for most alternative services, states may use the *cost and the utilization* of the alternative service as a proxy for the cost of state plan services avoided. For IMD services, however, only the *utilization* of IMD services may be used in approximating the utilization of state plan (i.e. inpatient psychiatric) services. The *cost* of IMD services may not be used; instead, the state must use the cost of the state plan service, in this case, inpatient psychiatric services. **We request clarification that our understanding is accurate.**

We also recommend that CMS specify in the regulatory language that the cost of state plan services avoided through the use of alternative services may be considered in determining rates.

9. CMS should seek input and guidance in the development of a Medicaid managed care quality rating system through a consensus-building approach that involves the public and interested stakeholders.

In developing a comprehensive quality rating system for Medicaid managed care, CMS should seek input from coalition groups, such as The Partnership for Medicaid. CMS proposes to add a new section setting minimum standards that all states contracting with health plans would use in developing and implementing a Medicaid managed care quality rating system. CMS believes that publication of standardized, reliable, and meaningful quality information would increase transparency of Medicaid managed care health plan performance.

America’s Essential Hospitals supports the development and implementation of a comprehensive, standardized quality measurement and reporting program, to increase transparency and promote improved quality of care for our nation’s

most vulnerable populations. The association has worked with The Partnership for Medicaid to develop a quality reporting framework aimed at improving health care quality and reducing costs in Medicaid.²⁶ The Partnership for Medicaid is a nonpartisan, national coalition of 23 organizations representing physicians, health care providers, safety net health plans, counties, and labor. The goal of the coalition is to preserve and improve the Medicaid program. As outlined in further detail below, America's Essential Hospitals urges CMS to consider key aspects of the Partnership's quality reporting proposal as the agency works to develop a quality rating system that establishes a baseline for the quality of provided care, identifies quality gaps in Medicaid, and institutes a standardized quality measurement method.

- a) CMS should include Access to Care as a summary indicator in any future Medicaid quality rating system.

While America's Essential Hospitals appreciates CMS' rationale in using a rating system consistent in format and scope with those for qualified health plans (QHPs), we believe access to care, as a summary indicator, is required. CMS proposes to use the QHP quality rating system as a model for the Medicaid quality rating system, given that the overall Medicaid population more closely resembles that of the ACA health insurance marketplace. The three summary indicators CMS proposes include (1) clinical quality management; (2) member experience; and (3) plan efficiency. As noted in a 2014 report by the U.S. Department of Health and Human Services Office of the Inspector General (OIG), access to care standards for Medicaid managed care enrollees vary widely by state and often are not specific to providers who are important to the Medicaid population (e.g., pediatricians, obstetricians, and high-demand specialists).²⁷ Access to health care services for enrollees in Medicaid managed care is essential. Without adequate access, enrollees would not receive preventive care and treatment necessary to achieve positive health outcomes. Essential hospitals serve the most vulnerable, those whose health status is often determined by social and economic factors, in addition to the clinical care they receive. **CMS should recognize the importance of access to care as a summary indicator when developing a standardized Medicaid quality rating system.**

²⁶ The Partnership for Medicaid. The Next Step: Improving Health Care Quality and Reducing Cost in the Medicaid Program. March 2014. <http://thepartnershipformedicaid.org/images/upload/Partnership-for-Medicaid-The-Next-Step.pdf>. Accessed July 2, 2015.

²⁷ U.S. Department of Health and Human Services Office of the Inspector General. OEI-02-11-00320, State Standards for Access to Care in Medicaid Managed Care. September 2014. <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>. Accessed July 2, 2015.

- b) CMS should adopt a uniform, state-level reporting mechanism for the Medicaid managed care quality rating system.

As set forth by The Partnership for Medicaid's quality reporting proposal, America's Essential Hospitals urges CMS to adopt a four-step process for comprehensive state reporting and accountability, to include:

- 1) *Development of federal reporting infrastructure.* Coinciding with the development of an initial reporting set, CMS also should develop a standardized reporting infrastructure. CMS proposes to make results and findings of the effectiveness of the quality strategy publicly available on states' respective Medicaid websites. Additionally, CMS proposed that states make their final comprehensive quality strategy available on the same website. America's Essential Hospitals encourages CMS' efforts to develop a mechanism to provide a standard method for states to report to CMS; an infrastructure to collect, house, and analyze data; and the ability of the public to compare results.
- 2) *Establishment of a succinct common reporting set.* The establishment of a common reporting set would allow for assessment of overall program activity, as well as activity by delivery service modality (e.g., managed care, fee-for-service, accountable care organizations, and primary care case management) by using a standardized format, developed by CMS. America's Essential Hospitals believes the phasing in of measures, beginning with a limited number, will reduce administrative burden and guarantee that reporting is manageable for providers, plans, and states. The measures reporting set should be dynamic, and America's Essential Hospitals urges CMS' to engage stakeholders in the measure selection and methodology development process, including measure weighting, every two to three years.
- 3) *Federal incentives to report.* In recognition of the costs of measure development and infrastructure needed to report the measures under a Medicaid quality rating system, CMS should develop a federal incentive to report on applicable measures no later than one year after the development of the initial measures reporting set. These incentives would account for the costs of implementing a comprehensive measurement system at the state, plan, and provider level.

- 4) *Mandatory reporting by all states.* CMS should require all states to report on all applicable measures. Through mandatory reporting, standardized information may be gathered and made available for Congress to make informed, evidence-based decisions about how to provide financial and programmatic incentives to states to improve their Medicaid program based on quality, patient experience, and access to care.
- c) CMS should ensure fairness in its efforts to promote quality of care in the Medicaid program by requiring that a state's comprehensive quality strategy be applied to all state Medicaid programs, including fee-for-service.

America's Essential Hospitals supports CMS' intent to apply a comprehensive quality strategy, developed through a public engagement process and refined over three to five years, to all state Medicaid programs. The association commends CMS for recognizing that, regardless of delivery system, it is important to measure performance across Medicaid programs to develop a comprehensive plan to strengthen and improve care quality for all Medicaid beneficiaries. In uniformly applying a quality strategy across all state Medicaid programs, CMS will avoid the risk of creating quality standards that vary by delivery system, with care for beneficiaries covered by MCOs held to a different standard than beneficiaries in fee-for-service plans.

- d) CMS should provide robust guidance and oversight to ensure states fully comply with any proposed Medicaid managed care quality rating system and to promote uniformity across the quality rating system.

To ensure equity across states in the application of a Medicaid managed care quality rating system, CMS should provide robust oversight to states as they work to comply with the components of the system. CMS proposes to give states the flexibility to change how they weight a measure in their quality rating methodology. While America's Essential Hospitals commends CMS for considering state flexibility, there is concern that too much flexibility could lead to an imbalance among states in the approaches they take in determining compliance with newly developed Medicaid quality rating system requirements. Medicaid is a federal-state partnership and, as the federal partner, CMS should actively verify that any measures in a quality rating system are properly constructed and do not lead to unintended consequences or place a significant administrative burden on states. Any new measures that are added should be reliable, valid, and useful in improving the quality of hospital care. The National

Quality Forum's Measures Application Partnership, development of the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set, and Partnership for Patients are possible process models for measure set development.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Beth Feldpush, DrPH, senior vice president of policy and advocacy, at 202-585-0111.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO