



AMERICA'S ESSENTIAL HOSPITALS

January 14, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-2408-P: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates the Centers for Medicare & Medicaid Services' (CMS') work to streamline Medicaid and CHIP managed care regulations, reduce regulatory burden, and increase state flexibility. As health care delivery in Medicaid continues to move into managed care, we encourage CMS to finalize proposals that support Medicaid's special role of promoting state policy goals that ensure quality care for beneficiaries and support for essential hospitals and other providers that serve a disproportionate share of Medicaid patients.

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 320 members provide a disproportionate share of the nation's uncompensated care and devote roughly half their inpatient and outpatient care to Medicaid or uninsured patients. For our member hospitals, 35 percent of inpatient care and 29 percent of outpatient care is provided to Medicaid beneficiaries, of which 21 percent of inpatient and 20 percent of outpatient care is covered through managed care contracts.¹ Our members provide this care while operating on margins substantially lower than other hospitals—4 percent on average compared with 7.8 percent for all hospitals nationwide. Through their integrated health systems, members of America's Essential Hospitals offer a full spectrum of primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health services, substance abuse treatment, and wraparound services vital to disadvantaged patients.

¹ Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info. Accessed December 12, 2018.

Essential hospitals play a unique and critical role in the Medicaid delivery system. Given our low-income, vulnerable patient populations, we are particularly qualified 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. Essential hospitals find increasingly innovative and efficient strategies for providing high-quality care to their patients. But the reality is that with their patient mix and margins, our members depend substantially on Medicaid funding to carry out their missions and even 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. CMS' goal of providing meaningful access to care for Medicaid patients cannot be achieved without our members. In that spirit, we encourage the agency to consider the following comments.

1. America's Essential Hospitals agrees with CMS' proposal to give states additional flexibility to achieve Medicaid policy goals through support for their essential providers.

America's Essential Hospitals appreciates the agency's work to give states additional flexibility as they advance Medicaid policy goals. States historically have used Medicaid as the primary lever to shape health care delivery within their 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. As states increasingly turn to Medicaid managed care delivery systems, it is important they continue to have flexibility to advance policy goals.

Essential hospitals derive a high proportion of their Medicaid funding from a patchwork of policy-based supplemental payments that represent the lifeblood of their existence and that preserve access for beneficiaries. However, that critical safety-net support is threatened on a variety of fronts. Among others, these include federal policies dictating decreased amounts of 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 adequate rates, and lack of strict enforce of rate adequacy through federal regulation.

The 2016 managed care rules established a set of limited regulatory exceptions allowing states to continue to support policy goals through Medicaid managed care payment policies. CMS' current proposals would increase state flexibility to achieve policy goals through directed payment policy, including by expanding states' ability to make transitional pass-through payments and to incorporate, with less administrative burden, longer-term directed support to providers. We thank CMS for proposing increased flexibility, and we encourage the agency to finalize these proposals with the revisions and clarification outlined below.

- a) CMS should finalize the option to request multiyear directed payment arrangements for any directed payment model.

Consistent with a previously announced policy change, CMS proposes to amend its regulations to allow states to request multiyear approvals for directed payment arrangements. We support this proposal, as it will reduce administrative burden for states and CMS, while also increasing predictability of funding for providers relying on those payments. Otherwise, a directed payment is approved for only a single rate year, and the state must resubmit a preprint and go through the same CMS approval process each year.

To receive approval, CMS proposes that a state must explicitly identify and describe the payment in the contract as multiyear, develop and describe its implementation plan, and affirm that it will not make “changes to the payment methodology, or magnitude of the payment described in the contract for all years of the multi-year payment arrangement without CMS prior approval.”² We request that CMS clarify that a state does not need prior CMS approval to, for example, adjust for inflation or rebase an approved payment threshold. **We urge CMS to adopt proposed 42 CFR § 438.6(c)(3) and provide the requested clarification.**

As proposed, the multiyear approval is only for delivery system reform and value-based directed payment programs, excluding minimum fee schedules, cost-based/Medicare/market-based rates, and rate increases. This exclusion is arbitrary, given that states might also have multiyear time frames for achieving objectives through rate increases, as well. CMS could apply the same approval criteria currently proposed for multiyear delivery system reform and value-based payment proposals to these other payment policies. This would require a state to explicitly identify the payment arrangement in a contract as multiyear; describe its implementation plan, including multiyear evaluation; and seek CMS approval for changes. **We urge CMS to expand the proposal at 42 CFR § 438.6(c)(3) to include payment arrangements under (c)(1)(iii).**

- b) CMS should finalize its proposal in Section 438.6 (c)(1)(iii)(E) to allow states to develop rates tied to a variety of bases.

As CMS explained in the preamble, the 2016 rule did not explicitly address all payment models that states have submitted as approaches that would best meet their local needs. CMS therefore proposes to amend the regulations to explicitly allow states to direct plans to adopt rates based on cost, a Medicare equivalent, or other market-based rate for the services under the contract. **We support CMS’ proposal and the desire to encourage states to develop models that will produce optimal results for their programs.**

- c) CMS should finalize its proposal to remove 438.6(c)(2)(ii)(C) to allow states to direct the amount and frequency of plan expenditures where needed to achieve the states’ goals.

Section 438.6(c)(2)(ii)(C) of the 2016 rule prohibited payment programs created through directed payment authority under 438.6(c) from directing “the amount or frequency of expenditures by managed care plans.” As CMS gained experience from states working to implement new proposals, the agency found that this provision

² Proposed 42 CFR § 438.6(c)(iii)(3)(C).

created “unintended barriers to states pursuing innovative payment models.”³ We agree with CMS that there might be times when a state determines it must direct the amount of a plan expenditure to achieve the state’s goals or when states seek to build on or align with other payers’ programs. **We encourage CMS to continue to identify and resolve such barriers as the agency gains further experience with state proposals.**

- d) CMS should revise the proposed definitions of “state plan approved rates” and “supplemental payments” to ensure accuracy and acknowledge the legitimacy and importance of “supplemental payments” in Medicaid.

CMS proposes to add the definitions of “state plan approved rates” and “supplemental payments” to § 438.6(a):

“State plan approved rates means amounts calculated as a per unit price of services described under CMS approved rate methodologies in the Medicaid State plan.”

“Supplemental payments means amounts paid by the State in its [fee-for-service (FFS)] FFS Medicaid delivery system to providers that are described and approved in the State plan or under a waiver thereof and are in addition to the amounts calculated through an approved State plan rate methodology.”

Furthermore, the preamble to the rule explains:

“[...]supplemental payments contained in a state plan are not, and do not constitute, state plan approved rates as provided in 438.6(a)... Supplemental payments are not calculated or paid based on the number of services rendered, and therefore, are separate and distinct from state plan approved rates under this proposed rule.”⁴

The proposed definition of supplemental payments, in particular, and the related preamble are inaccurate. CMS should correct them in the final rule.

First, if a payment methodology has been outlined and approved in the state Medicaid plan, it is a “state plan approved rate.” The state has determined, and CMS has confirmed, that payment of the rates, including a base rate and any add-ons or adjustments, however defined, is consistent with economy and efficiency and designed to meet the state’s Medicaid goals. The definition of supplemental payment as proposed and the explicit exclusion of supplemental payments from state plan rates in the preamble⁵ is misleading and suggests that supplemental payments are somehow not as legitimate a portion of the approved state plans as other types of Medicaid payments.

Second, supplemental payments are by their very nature tied to utilization of services, contrary to CMS’ assertion in the preamble that they “are not calculated or paid based

³ 83 Fed. Reg. 57271 (November 14, 2018).

⁴ 83 Fed. Reg. 57270 (November 14, 2018).

⁵ CMS also excludes supplemental payments from the definition of base rates in proposed 42 CFR § 438.6(c)(1)(A), which we recommend amending in section (1)(b) of our comments.

on the number of services rendered.” Supplemental payments are included in the state plan pages for the particular service to which they apply (e.g., Attachment 4.19A defining payment for hospital services) and are subject to defined upper limits calculated based on the underlying service provided. CMS has recognized in previous rulemaking that such “supplemental payments made by a state under its Medicaid state plan that are based on the upper payment limit (UPL) are always identifiable with specific services furnished to individuals.”⁶

CMS might be trying to distinguish how a state plan treats different types of provider payments—e.g., whether an add-on is paid concurrent with an underlying base rate or whether an add-on is paid separately at regular intervals for a set of services in the aggregate. Given the complexity of payment rates, adjustments, add-ons, and other aspects of provider payments, trying to distinguish how different payments are made increasingly seems to be a distinction without a difference. There might be various reasons, including administrative efficiency, why a state might choose to pay supplemental payments separately rather than as part of the initial claims payment. Regardless, it does not change the state’s determination that the full rate provided under the state plan is required to support its goals and CMS’ agreement that the payment is economic and efficient.

To ensure accuracy in these definitions while attempting to retain a distinction in payments to align with CMS’ calculation of pass-through payment limits, we offer the following revisions to proposed § 438.6(a):

State plan approved base rates means amounts paid on a per-claim basis by the State in its FFS Medicaid delivery system to providers ~~calculated as a per unit price of for services as~~ described under CMS-approved rate methodologies in the Medicaid State plan.

State plan approved supplemental payments means amounts paid separately by the State in its FFS Medicaid delivery system to providers that are described and approved in the State plan or under a waiver thereof and are in addition to State plan–approved base rates. ~~the amounts calculated through an approved State plan rate methodology.~~

We urge CMS to adopt these revisions and correct the inaccurate preamble statements to ensure clear and accurate interpretation of the regulations governing special contract provisions.

- e) CMS should provide a streamlined process for states to implement directed payments adopting Medicaid state plan methodologies.

Under the 2016 changes to the Medicaid managed care regulations, CMS established strict criteria and a prior approval process for states seeking to direct plans to participate in certain provider payment arrangements (e.g. minimum fee schedules, rate increases, value-based payments and delivery system reform initiatives). As a result of its experience with implementation of the 2016 rule, CMS found that several states have pursued the approval process for minimum rates based on state plan methodologies the agency already reviewed and approved as meeting requirements

⁶ 78 Fed. Reg. 19918, 19930 (April 2, 2013).

substantially the same as those for the directed payments. As CMS notes in the proposed rule, additional review of payments based on approved state plan methodologies are rendered “unnecessary given that a state would have already justified the rate methodology associated with particular services in the Medicaid state plan (or a state plan amendment) to receive approval by CMS that the rates are efficient, economical, and assure quality of care.”⁷

We are pleased the agency recognizes the burden the current approval process places on states and wants to improve and streamline the process. **We urge CMS to finalize a proposal to require states to obtain written approval for minimum fee schedules based on Medicaid state plan rates.**

CMS’ current proposal would require the full approval process for minimum rate proposals that incorporate both base rates and supplemental rates as defined under the state plan. There is no reasonable basis for making such a distinction. Two states might choose under their respective FFS programs to pay professionals up to the average commercial rate. State A might implement this policy through a payment up to average commercial rate (ACR) for each claim, while State B might choose a payment equal to the difference between the paid rate and ACR at the end of the quarter, aggregated with all other such claims. Both methodologies would have been subject to the CMS state plan review process and confirmed by CMS as consistent with economy and efficiency, as required by statute. If State B wants to implement the same minimum rate requirement for professional services under managed care, there is no additional gain to be had by requiring the state to repeat the approval process. **CMS should further reduce administrative burden on states and the agency by streamlining the review and approval process for all payments based on Medicaid state plan approved payments** with the following revisions to proposed § 438.6(c)(1)(iii)(A):

Adopt a minimum fee schedule for network providers that provide a particular service under the contract use State plan approved base rates and/or State plan approved supplemental payments as defined in paragraph (a) of this section. ~~Supplemental payments contained in a State plan are not, and do not constitute, State plan approved rates.~~

CMS also should clarify what it means for proposals in which CMS does not require a written submission to “meet the criteria in paragraphs (c)(2)(ii)(A) through (F),” and specifically whether a preprint is required.

- f) CMS should finalize its proposal to allow states to make new pass-through payments to providers during transitions to managed care delivery systems.

As part of its 2016 changes to Medicaid managed care regulations, CMS prospectively prohibited states from requiring plans to make new pass-through payments. The agency established a one-time transition period for pre-existing pass-through payments, recognizing that states might rely on such funding to support providers as their traditional FFS-based supplemental payments decline during the transition to managed care. CMS now proposes expanding this pass-through payment authority, allowing new pass-through payments during the period when a state is transitioning

⁷ 83 Fed. Reg. 57264, 57270 (November 14, 2018).

either a patient population or a service from a FFS delivery system to a managed care system. A hospital, nursing facility, or physician is eligible for these transitional pass-through payments for up to three years if certain criteria are met.

CMS was correct in recognizing the challenges states and providers face during periods of transition from FFS to managed care delivery systems. This proposed flexibility allows states to fulfill a critical role of government by addressing gaps in the market to ensure they meet their citizens' needs. Allowing states to provide additional support, through pass-through payments, during these transitions ensures providers have the needed resources to care for their patients. In the past, some states have chosen to delay expanding managed care within their programs to ensure providers at the program's core can continue serving Medicaid beneficiaries. This proposal would help avoid such delay and ease the disruption for providers and states as they work to develop appropriate longer-term solutions for support. **We encourage CMS to finalize its proposal to allow for new pass-through payments to providers during periods of state transition to managed care delivery systems.**

Further, the proposed pass-through payments would be subject to limits based on pre-existing FFS supplemental payments for the transitioning population and/or service. CMS proposes calculating the payment limit for each provider type by dividing FFS rate payments for transitioning inpatient and outpatient services by total FFS rate payments and then multiplying by supplemental payments for inpatient and outpatient hospital services. We urge CMS to finalize this methodology and encourage the agency to work with states during such transitions to create permissible directed payments or alternative long-term solutions to ensure appropriate support for essential providers.

2. In determining network adequacy for managed care plans, CMS should ensure that Medicaid beneficiaries retain access to hospitals with a full range of linguistically and culturally appropriate services, such as essential hospitals.

CMS proposes to allow states to determine and develop quantitative network adequacy standards for providers covered under plan contracts. We are encouraged that this flexibility could better reflect providers in a given area. However, we encourage CMS to provide specific guidance to states for developing quantitative network adequacy standards, and to review the standards adopted to 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. **We urge CMS to require network adequacy standards that preserve access to providers and services on which Medicaid beneficiaries rely.**

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. The average community hospital, for example, does not have the resources to provide complex services, whereas essential hospitals are equipped to provide that care to their communities daily. Thus, each hospital cannot be deemed to contribute equally to adequate access. 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. Essential hospitals have deep experience and a long history of providing culturally competent care, including interpretation, transportation, and other social services, to diverse, low-income populations. These services reach beyond the walls of the hospital to provide comprehensive care to vulnerable populations in locations that work for patients. 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. **We urge CMS to assist states in evaluating whether a network includes hospitals that offer the necessary range of services for complex Medicaid populations, as well as offer appropriate linguistic and cultural competence.**

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

In the 2016 Medicaid managed care final rule, CMS required states to operate a Medicaid managed care QRS. The provision contained in the rule allows states either to adopt the QRS framework that CMS would be adopting (which would include identification of performance measures and methodologies) or, optionally, to establish a state-specific QRS producing "substantially comparable information." CMS believes publication of standardized, reliable, and meaningful quality information would increase transparency of Medicaid managed care health plan performance. As described in the preamble to the proposed rule, CMS has begun the early stages of a stakeholder review process for the CMS-developed framework.⁸

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.⁹ 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.

We urge CMS to consider key aspects of The Partnership for Medicaid'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. As this work evolves, CMS should seek input from stakeholders, including The Partnership for Medicaid.

⁸ 83 Fed. Reg. 57280(November 14, 2018).

⁹ The Partnership for Medicaid. The Next Step: Improving Health Care Quality and Reducing Cost in the Medicaid Program. March 2014. <http://www.partnershipformedicaid.org/wp-content/uploads/2016/05/Partnership-for-Medicaid-The-Next-Step.pdf>. Accessed December 12, 2018.

- a) CMS should develop a measure set for the QRS that contains only reliable and valid measures that accurately reflect quality of care and plan performance.

America's Essential Hospitals supports the creation and implementation of performance measures that lead to fair comparisons. However, before including measures in a QRS, CMS must verify that the measures are properly constructed and do not lead to unintended consequences. The sheer number of existing measures on which hospitals report—as well as lack of focus, consistency, and organization—limits their overall effectiveness in improving health system performance. Further, the proliferation of measures combined with a lack of consistency often leads to inaccurate comparisons of providers and, ultimately, patient confusion.

As highlighted by the Institute of Medicine's Committee on Core Metrics for Better Health at Lower Cost, there is a need to reduce the burden of unnecessary and unproductive reporting by requiring fewer, more focused measures that improve comparability.¹⁰ The committee set forth a measure set of "vital signs" for tracking progress toward improved health and health care in the United States. While this starting set might be imperfect, it emphasizes the importance of streamlining measures to promote greater alignment and harmonization and to reduce redundancies and inefficiencies in health system measurement. Last year, CMS launched its Meaningful Measures Initiative to identify high-priority areas for quality measurement and improvement in the Medicare program. **We applaud CMS' efforts to increase measure alignment across programs, including Medicaid, and reduce provider reporting burden. We hope the outputs of this work will be applicable to Medicaid managed care.**

- b) CMS should align the CMS-developed QRS, where appropriate, with existing summary indicators developed for the qualified health plans (QHPs) and include Access to Care as a summary indicator in any future Medicaid QRS.

Current regulation provides that the CMS-developed QRS would align with the summary indicators used by 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 Affordable Care Act health insurance marketplace. America's Essential Hospitals appreciates CMS' proposed flexibility in using a rating system consistent in format and scope with those for QHPs, where appropriate, to ensure any rating system is appropriate for the population it serves.

As noted in a 2014 report by the Department of Health and Human Services Office of the Inspector General, 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).¹¹ Access to health care services for enrollees in Medicaid managed care is essential. Without adequate access, enrollees would not receive preventive care and treatment

¹⁰ Blumenthal D, Malphrus E, McGinnis JM. *Vital Signs: Core Metrics for Health and Health Care Progress*. Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Washington, D.C.: The National Academies Press; 2015.

¹¹ 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.

necessary to achieve positive health outcomes. **America's Essential Hospitals urges CMS to recognize the importance of access to care as a summary indicator when developing a standardized Medicaid QRS.**

- c) CMS should adopt a uniform, state-level reporting mechanism for the Medicaid managed care QRS.

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

- 1) ***Development of federal reporting infrastructure.*** Coinciding with the development of an initial reporting set, CMS also should develop a standardized reporting infrastructure. America's Essential Hospitals supports the development of 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 uniformity across managed care, fee-for-service, and other alternative payment models under Medicaid. 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 use its existing authority to provide incentives, no later than one year after the development of the initial measures reporting set, for states reporting on applicable measures. These incentives would account for the costs of implementing a comprehensive measurement system at the state, plan, and provider levels.
 - 4) ***Mandatory reporting by all states.*** Through mandatory reporting, standardized information may be gathered and made available for policymakers to make informed, evidence-based decisions about how to provide financial and programmatic incentives to improve the Medicaid program based on quality, patient experience, and access to care.
- 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 QRS.

While we support CMS' proposal to eliminate the requirement that a state receive agency approval before implementing an alternative QRS, 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 QRS 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 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. **To ensure equity across states in the application of a Medicaid managed care QRS, we urge CMS to provide robust oversight to states as they work to comply with the components of the system.**

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO