July 3, 2023

Chiquita Brooks-LaSure
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: Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality CMS-2439-P

Dear Administrator Brooks-LaSure:

America’s Essential Hospitals appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicaid and CHIP Managed Care Access, Finance and Quality. This rule takes another step in assuring meaningful access to Medicaid beneficiaries while promoting financial stability for essential hospitals.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins two-fifths that of other hospitals—3.2 percent on average compared with 7.7 percent for all hospitals nationwide. Essential hospitals’ commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face socioeconomic and sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven and a half million people in communities served by essential hospitals have limited access to healthy food, and nearly 16 million live below the poverty line.

Managed care is increasingly important to the Medicaid program, enabling essential hospitals to treat medically complex patients and meet health-related social needs. We appreciate CMS’ efforts in this rule to improve quality of coverage, strengthen benefits, and advance health equity in Medicaid managed care while balancing the need for state flexibility. We also

2 Ibid.
appreciate CMS’ thoughtfulness in targeting challenges facing essential hospitals, specifically the difficulty in negotiating adequate payment rates.

As CMS has acknowledged, rate adequacy is tied to access and equity. We are pleased CMS maintained the average commercial rate (ACR) as an appropriate rate for Medicaid services without imposing other restrictions that would affect access, such as an expenditure cap on state directed payments (SDPs). However, we are concerned hospital and specialty services are excluded from managed care provider payment analyses. Our members are at the very heart of the Medicaid delivery system, providing access where none exists and innovating with populations others ignore, and depend on Medicaid support. In that spirit, we encourage the agency to consider the following comments.

1. **CMS should leverage directed payment programs to ensure sufficient payment rates to promote meaningful access to care.**

Since CMS adopted formal rules in 2016 governing when and how states may direct managed care plans’ payments to providers, SDPs have grown steadily in both size and importance to essential hospitals.

For many essential hospitals, SDPs have become an important means of financial support, enabling them to invest in access, quality, equity, and innovation—initiatives that align precisely with CMS’ own Medicaid program goals.

We appreciate CMS’ understanding of SDPs’ role in promoting payment adequacy and the role of payment adequacy in supporting equitable care. Preserving states’ ability to pursue their respective programmatic goals by directing payments to defined classes of providers is critical to our members. Particularly, CMS’ support for state initiatives that ensure that safety net providers will be paid at a level equivalent to commercial payer rates is consistent with the goal of equity—equitable care is not possible without equitable payment.

Below, we offer detailed comments on the proposed changes to the SDP provisions of the rule.

a. **Any limit imposed on state directed payments must be no lower than the ACR.**

Unlike fee-for-service supplemental payments, SDPs to date have not been subject to an explicit payment limit. CMS proposes to establish such limits for (1) inpatient hospital services, (2) outpatient hospital services, (3) qualified practitioner services at academic medical centers, and (4) nursing facility services, equal to the ACR. CMS notes that these four services represent the vast majority of SDPs that are currently paying up to the ACR, and that the ACR is an appropriate limit to allow managed care plans to compete with commercial plans for providers to participate in-network.

We strongly support allowing states to require managed care plans to pay at commercial-equivalent rates. 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.

At the same time, we are cognizant that, in other contexts, Medicaid payment limits have led to retrospective audits and surprise recoupments, often years after the fact, that impose extreme...
burdens on essential hospitals in particular. For that reason, CMS must use the ACR as a benchmark for measuring the reasonableness of SDP rates, rather than a limit on the payments.

i. CMS should not consider the Medicare upper payment limit (UPL), as it is not an appropriate payment limit.

In the preamble, CMS notes that permitting SDPs to increase payments up to the ACR could encourage states to implement additional payment arrangements for reasons beyond advancing access to care and enhancing quality. Therefore, CMS is considering limiting total payments for these services at the Medicare rate instead of the ACR, either for all such SDPs or for fee schedule arrangements under 438.6(c)(1)(iii)(C) through (E).

However, CMS acknowledges several concerns about imposing a Medicare UPL, and we agree. While Medicare generally pays more than Medicaid, it still typically does not cover costs and is generally well below commercial rates. Imposing a Medicare UPL would represent a significant payment cut in those states that already pay up to the ACR, causing instability and disruption to ongoing initiatives. As CMS observes, Medicare payments are developed for a different population than Medicaid payments, so Medicare rates are not always appropriate. Moreover, a Medicare UPL would, on its face, be inequitable, as it would prohibit states from reimbursing providers for services to Medicaid beneficiaries at rates paid for commercially insured patients. CMS must not impose a Medicare UPL as a payment limit on any directed payments.

ii. CMS should clarify that the ACR limit applies to SDPs for professional services for a class not defined by their link to an academic medical center.

Among the services CMS proposes be subject to the ACR limit are “qualified practitioner services at academic medical centers.” While some states have established directed payments available exclusively for such practitioner services, other SDPs define the eligible class more broadly, including not only academic medical center services but also other professionals serving a safety net population. It is not clear whether such a class would be subject to the limit or subject to CMS’ current policy of using the ACR as a benchmark. We request that CMS clarify how it intends to treat classes of practitioners that may include but are not defined by their connection to an academic medical center.

b. CMS should finalize its proposal to allow states flexibility to utilize ACR demonstrations that are specific to services under an SDP, rather than specific to a provider class.

To ensure payments do not exceed the ACR in an SDP, CMS will require states to submit (1) an ACR demonstration and (2) a total payment rate comparison to the ACR for the four services subject to the ACR limit. The ACR demonstration would be submitted with the initial preprint submission and updated at least every three years. CMS has chosen not to require a specific template or data source for this demonstration. We support both the submission and update timeline as well as the absence of specific data sources or template requirements for this reporting. This will allow for state flexibility and lessen the administrative burden to implement and report on ACR demonstrations.

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.

Significantly, CMS proposes to allow states to submit ACR demonstrations that are specific to the service covered by the SDP but not specific to each provider class. For example, an SDP that pays a class of safety net hospitals for inpatient hospital services up to the ACR could measure the ACR using commercial payer data that includes data from hospitals not in the safety net provider class, as long as they are within the state. CMS proposes this flexibility recognizing 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.” We appreciate CMS’ recognition of and sensitivity to the frequent disparity in payer rates that disproportionately affects essential hospitals. **We strongly urge CMS to finalize the proposal to allow ACR demonstrations that are specific to the service covered under the SDP, but not specific to each provider class**, providing essential hospitals the opportunity to ensure access to care for Medicaid beneficiaries.

c. **CMS must not impose SDP expenditure limits.**

CMS indicates that it is considering limiting the SDP expenditures to 10 to 25 percent of total costs. The limit intends to improve program and fiscal protections to target oversight risks, ensure risk-based contracts are used as intended and that managed care plans that are ‘at risk’ can truly manage how their revenue is used to cover all reasonable, appropriate, and attainable costs under the terms of the contract. However, CMS acknowledges that a limit could negatively affect access to care.

We are deeply concerned that an expenditure limit on SDPs would indeed affect access. In many states, 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. Unless CMS is willing to impose a firm payment adequacy standard on base provider payment rates, which historically it has not been willing to do, an arbitrary SDP expenditure limit could result in total payment rates that are not adequate to meet the full needs of the managed care population, especially beneficiaries with complex health and social needs. Further, under a percentage-based expenditure limit, states with low base rates, and therefore a greater need to improve rates through SDPs, would have less capacity to use SDPs to improve payments than a state with high base rates.

An expenditure limit also would discourage states from adopting directed payments benefiting all providers of a service type, such as an across-the-board increase for all hospitals, which would promote a broader distribution of utilization across providers. While some states appropriately choose to target SDPs on small classes of providers, other states may be concerned that doing so will result in a concentration of Medicaid patients served by a handful of providers. Capping SDP expenditures at an arbitrary amount would limit access to care. **We urge CMS not to impose SDP expenditure limits and allow states the flexibility to design their Medicaid managed care programs to best serve beneficiaries.**
d. CMS must allow managed care organization (MCO) directed payments for non-network providers.

Under current rules, CMS authorizes fee schedule and uniform rate increases for network providers providing services under the MCO contract. CMS notes this has precluded states from implementing directed payments for non-network providers. We support the new proposal to permit states to direct payments under their managed care contracts for both network and certain non-network providers. This modification will allow states to require MCOs to pay non-network providers at a minimum level to avoid access to care issues, such as access to specialty services and out-of-state providers, and allowing plans and providers time to negotiate provider agreements. Many essential hospitals have patient catchment areas across state lines and provide specialty services, such as level I trauma services and burn care, regionally. **CMS must finalize the proposal to allow MCO directed payment for non-network providers to maintain access to care at essential hospitals.**

e. CMS must not prohibit payments based on historical utilization.

CMS proposes a new prohibition on paying SDPs using historical utilization with a subsequent reconciliation. We oppose this proposal.

As CMS notes, “[a] fundamental requirement of SDPs is that they are payments related to the delivery of services under the contract.” Many states fulfill this requirement by making periodic interim payments to plans during the year (e.g., quarterly) based on their utilization from earlier years. For example, if in an earlier year, Hospital A provided 20 percent of the discharges of all hospitals in the directed payment class of providers, the state might establish interim directed payments to Hospital A equal to 20 percent of total payments to all hospitals in the class. After the end of the year, the state would review the encounter data for the year in which the payments were made and reconcile the payments to actual utilization. If, through reconciliation, Hospital A provided only 18 percent of the discharges, some of the interim payments would be recouped. If the hospital provided 25 percent of the discharges, it would receive an additional payment to ensure that overall payments equal 25 percent of the total. The use of interim payments with reconciliation ensures that, after all payments are reconciled, the payments are based on the delivery of services during the year.

CMS now proposes, however, to prohibit states from using this interim payment plus reconciliation process on the grounds that it is inconsistent with the requirement that payments be based on utilization and delivery of services during the year. In support of this proposal, CMS points to an example of a state that required managed care plans to make monthly SDP payments to hospitals throughout 2020 based on utilization from the corresponding month in 2019. After the end of the year when the claims have run out, the state reconciles the interim payments to the amount that should have been paid using 2020 data. The state then submits an amendment to its rate certification to revise the total dollar amount paid. CMS contends that this arrangement makes the managed care plans “whole” for the cost of the SDP, removing the risk. As an alternative, CMS suggests states should adopt minimum fee schedules or uniform increases, which CMS contends would allow actuaries to incorporate the SDP into the capitation rates.

The arrangements that CMS seeks to prohibit are used in SDPs to balance a desire to maintain a steady cash flow for providers with the need for accuracy in payment amounts. Historical data is more mature than real-time encounter data provided by managed care plans and so is more
likely a better interim proxy for actual utilization than immature data. In many states, managed care plans are notoriously slow in submitting accurate encounter data to states.

Moreover, the use of interim payments is far easier to implement for some states, as the interim payments are identical from period to period. For many states, it is much simpler from an administrative perspective to make predetermined interim payments than to determine actual amounts owed to each plan and each provider every payment period during the year. In any case, the eventual reconciliation to actual utilization results in payments that in fact are based on utilization and delivery of services during the rating period, which is, as CMS emphasizes, a “fundamental requirement of SDPs.”

CMS asserts that the use of interim payments with reconciliation eliminates risk for managed care plans. But requiring payments based on actual utilization during the year would not necessarily impose more risk on plans. In both cases, assuming the state is using a separate payment term to provide funding to the managed care plans outside of capitation payments, the risk is removed from the plans. CMS acknowledges that separate payment terms remove risk from the providers but proposes to allow them because they are a “useful tool for States.” Interim payments, for the reasons outlined above, are also “useful tools” for states, and CMS’ rationale for prohibiting them does not make sense. CMS should allow states to structure their SDPs in the manner that best meets their programmatic and administrative needs, including through interim payments and year-end reconciliations.

f. Separate payment terms are critical in Medicaid managed care.

States use separate payment terms as an alternative means of providing SDP funding to managed care plans to pay providers. Instead of incorporating the cost of the SDP into capitation rates, some states use separate payment terms to provide funding to plans separate and apart from the capitation payments. As CMS notes, separate payment terms are unique to Medicaid managed care SDPs.

i. CMS should allow payments from separate payment term SDPs to fluctuate with utilization.

CMS proposes to adopt a regulatory definition of a separate payment term as a “pre-determined and finite funding pool that the state establishes and documents in the managed care contract for a specific SDP for which the state has received written approval.” It also proposes prohibiting separate payment terms from exceeding the amount documented in the written prior approval. Both proposals effectively would preclude states from using separate payment terms for SDPs that establish a fixed rate increase amount (i.e., a fixed dollar amount per unit of service or percentage increase in payment rates). Because it is impossible to know the total amount of such a directed payment program in advance of the program year, the arrangement would not be predetermined and finite, and it is quite possible that it could exceed even the best estimates projected at the start of the year.

To comply with the proposal to limit payments to amounts included in the approved preprint, states desiring to establish a per unit or percentage increase arrangement would need to monitor payments throughout the year and simply stop paying the increase at whatever point they reach the cap. Alternatively, they would have to forego their desire to set the rates at the beginning of the year and instead set the SDP payment rate retroactively and modify it for each payment period. Both alternatives are contrary to normal rate setting practices.
While we agree that the amount of the separate payment term should be fixed in advance or appropriately amended with CMS approval, we do not agree that the only way to fix the amount in advance is through fixing the total dollar amount spent. CMS should allow states the flexibility either to fix in advance the total dollars paid out (adjusting the unit price after the actual utilization is determined) or fix in advance the per unit amount (adjusting the total dollars paid out based on the actual utilization). The latter approach would not be used to manipulate outcomes or remove risk for the providers, as CMS suggests. In fact, it would place providers at risk for their utilization during the rating period—as their utilization declines, so would their payments, consistent with the regulatory requirement that the SDP be based on utilization and delivery of services during the year. An SDP with a fixed unit price or percentage increase promotes the regulatory requirement that the SDP be based on utilization and delivery of services during the year.

Further, it should be unnecessary for a state or CMS to expend administrative resources submitting and reviewing a preprint amendment when actual utilization during the year is higher than projected, causing the total dollars to increase. As long as the providers were paid the price or percentage approved by CMS, it should not matter that the total amount varied from the estimate based on volume. Preprint amendments should be reserved for true changes to the SDP terms. The final payment amount could be reported to CMS as part of the subsequent post-year-end reporting of the SDP on a rate cell basis that CMS proposes to require in section 438.7(f)(3).

We urge CMS to modify its definition of a separate payment term to remove the requirements that payment amounts be fixed and predetermined. CMS also should modify its proposed limit on separate payment terms to require states not to exceed either the aggregate dollar amount or the per unit/percentage increase amount specified in the written prior approval.

ii. CMS should review and approve separate payment terms as part of the SDP approval process.

CMS also proposes to require separate payment terms to be reviewed and approved as part of the SDP approval process and to require separate payment terms to be documented in the managed care contracts. We agree that it is appropriate for CMS to review separate payment terms as part of the SDP approval. We also agree that it is appropriate to include them in managed care contracts. However, for the reasons discussed above, we believe it would suffice to specify either the total dollars to be paid or the unit price or percentage increase in the contracts.

If CMS does not agree to allow separate payment term amounts to fluctuate with volume, it should, at a minimum, allow amendments to separate payment terms where there is no change in non-federal share amount. Such action would account for changes in precise federal matching rates that unavoidably vary depending on the eligibility categories of the beneficiaries receiving the services.

iii. CMS must allow separate payment terms to continue.

We oppose any alternative that would eliminate the use of separate payment terms and require all SDPs (or all SDPs with fee schedule arrangements under paragraphs (c)(1)(iii)) to be included through adjustments to capitation rates. In the preamble, CMS recites numerous challenges with this approach, including the disruption it
would cause to current programs, the challenges of including value-based arrangements in
capitation rates, the need to streamline the administration of SDPs, the difficulty of tracking
and monitoring SDPs provided through capitation adjustments, and the additional burden it
would impose on managed care plans.

g. CMS should ensure that SDP evaluation plans and quality metrics strengthen the Medicaid program.

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 believes these changes will increase
accountability for managed care programs and promote access to care.

i. CMS should continue to allow for flexibility in Medicaid managed care quality
   metrics.

We support CMS’ long-standing policy requiring that directed payments be tied to the state’s
quality goals and objectives. CMS’ requirement to track and report on specific quality metrics
has focused our members on achieving the specified targets and has helped to deepen our
members’ partnerships with states on quality initiatives as they consider appropriate measures
and targets. We appreciate CMS’ acknowledgement that it is not always “practical
and relevant” for states to isolate and monitor performance of Medicaid managed
care populations only and urge ongoing CMS flexibility on this front.

ii. CMS should finalize the proposed evaluation and reporting timeline.

We support the proposed requirements for evaluation plans and reporting. We appreciate CMS’
acknowledgment that reporting every three years on the evaluation plan will be sufficient
to gauge the program’s outcomes, and that states will not be required to submit the reports to
CMS for smaller SDPs. CMS should finalize these provisions as proposed, as these
policies will help limit administrative burden for both states and providers.

iii. CMS should allow remediation before disapproving SDPs that fail to meet plan
goals and objectives.

CMS proposes to add to SDP standards that plans 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. We encourage CMS, before
disapproving SDPs that fail to meet these goals, to work with states to address
underlying reasons for missing quality goals and provide opportunities for
revisions. Essential hospitals depend on SDPs to maintain access to care. Withdrawing SDPs
could lead to diminished capacity or closure of the very service lines to which this rule attempts
to expand access.

h. CMS should reconsider the proposed appeal process.

CMS proposes a formal appeal process for disapproved directed payments. Similar to
disallowances, disputes over disapproved SDPs would be heard by the Department of Health
and Human Services Departmental Appeals Board (DAB). We support the establishment of a
process to take final agency action on directed payments that CMS will not approve. However,
we are concerned about funneling appeals through an administrative process before final
agency action occurs, which can be appealed in federal court. In particular, we understand there is a significant backlog of cases pending before the DAB, and many have languished for several years. CMS justifies its proposal to use the DAB for appeals based on the board’s goal of resolving appeals within six to nine months and the effect that delayed resolutions can have on managed care programs. But it is for precisely these reasons that we are concerned about the choice of using the DAB when the practice, as opposed to the goal, so often results in lengthy delays. **We urge CMS to reconsider the proposal to require DAB review of appeals of SDP denials in light of this backlog.**

2. **CMS should not require attestations of private mitigation arrangements.**

We oppose CMS’ new interpretation of the provider tax hold harmless requirements, as articulated in the February 2023 Center for Medicaid and CHIP Services Informational Bulletin (CIB) and reiterated in the introduction to this proposed rule. A federal district court has preliminarily enjoined implementation of the CIB, finding that the policy “conflicts with the statutory definition of ‘hold harmless provision’ found in [the provider tax statute]” and “will likely be set aside.” Additionally, CMS has not undergone notice and comment rulemaking to adopt the policy. CMS cannot now finalize the proposed attestation requirements in violation of both the preliminary injunction and federal law.

CMS contends that 42 CFR 433.68(f)(3), implementing Section 1903(w)(4)(C) of the Social Security Act, prohibits providers from participating in redistribution or pooling arrangements in which they agree, without the involvement of the state, to mitigate the effect of a provider tax through private payments among themselves. Under Section 1903(w)(4)(C), a hold harmless provision is in effect if:

“The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.”

CMS contends that “the State itself need not be involved in the actual redistribution of Medicaid funds” for the arrangement to constitute a hold harmless. Yet, under the plain language quoted above, a hold harmless exists when the state or other unit of government imposing the tax provides the payment, offset, or waiver that is the hold harmless. As the district court noted, the statute includes a “‘tight grammatical link between the government, as the actor providing for something, and a guarantee, as the thing provided for.” When the state is not involved in the redistribution of funds, the state cannot possibly, under the statute, have provided a hold harmless.

CMS argues that the regulation supports its interpretation. The regulation subtly modifies the statutory text by describing a hold harmless as when:

“The State (or other unit of government) provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset or waiver directly or

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4 Social Security Act § 1903(w)(4).
indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.”

The regulation eliminates the direct connection in the statute between the action of the state in providing a payment that guarantees to hold taxpayers harmless and instead focuses on the state providing a payment such that the payment itself directly or indirectly holds taxpayers harmless. CMS concludes that the regulation thus supports an interpretation that does not require state participation in the arrangement. But CMS cannot on its own enlarge the definition of a prohibited hold harmless that has been established by Congress.

Moreover, CMS’ attempts to characterize its interpretation as long-standing fall short. CMS cites language from the preamble to a 2008 rule in which the agency responded to a court ruling about an arrangement in which states were providing tax credits or grants to nursing home residents to offset the higher costs of a provider tax that were being passed onto them. The 2008 language CMS quotes to support its current interpretation asserts that a hold harmless exists “[w]hen a State payment is made available to a taxpayer or a party related to the taxpayer (for example, a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax.” But the fact pattern clearly involved is the active participation of the state, and the “reasonable expectation” referenced was the state’s reasonable expectation that its payment to nursing home residents would hold the nursing home harmless. In fact, the district court found this preamble language to be evidence of CMS’ “shared interpretation” that the state would need to be involved in providing a direct guarantee for there to be a hold harmless violation.

The 2008 preamble language is thus a far cry from the arrangements CMS now purports to prohibit, which involve private providers and private providers’ expectations, with no involvement from the state. CMS’ current interpretation goes too far.

CMS does not have the authority to prohibit private redistribution arrangements as a hold harmless under the provider tax laws. **We oppose the proposed requirement that states obtain attestations from all providers receiving SDPs that they are not participating in a hold harmless arrangement.**

3. **CMS must ensure that access requirements include hospital and specialty services.**

CMS proposes new standards to improve state monitoring of access to care through MCOs. In the preamble to the proposed rule, CMS notes significant evidence that Medicaid payment rates are lower on average than Medicare and commercial rates. CMS also notes that provider payment rates influence access, due to the limited number of providers willing to accept Medicaid patients and the limited capacity of those who do participate. Yet there are no data sources to assess payment rates across states.

CMS therefore proposes to require managed care plans to conduct a payment analysis to submit to the state, which would review it and submit it to CMS. The annual report would analyze the MCOs’ level of payment for services using paid claims data from the immediate prior rating period in comparison with Medicare rates. The report would be required for evaluation and management codes for primary care, obstetrics and gynecology (OB/GYN), mental health, and

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6 42 CFR §433.68(f)(3).
substance use disorder services. However, there is no proposed requirement with respect to analyzing hospital rates.

**We urge CMS to include hospital and specialty services beyond OB/GYN and behavioral health services in MCO provider payment analyses to ensure access to care for these services.** Low Medicaid managed care rates for hospital and specialty services long have hampered provider participation and access to care, and the need to monitor and evaluate these rates is no less important for these services. The outright exclusion of oversight of these rates sends a strong message to states and plans that payment adequacy for hospitals and specialty services is not of concern. **CMS should correct that impression and require oversight of these payment rates.**

Further, should the payment analysis prove that rates are insufficient, the remedy is unclear. Will CMS require states to increase capitation rates to enable MCOs to increase provider payments? To what level will they need to be increased? What will CMS do if states refuse? **We urge CMS to clarify the remedy for low payment rates that affect access to care.**

**4. CMS must not finalize capitation limits on In Lieu of Services and Settings (ILOSs).**

In the 2016 final rule, CMS specified that managed care plans have flexibility under risk contracts to provide a substitute service or setting for a service or setting under the state plan, when medically appropriate and cost effective, to enrollees. ILOSs are used to strengthen access to and availability of covered services and settings or reduce or prevent the need for covered services or settings. **We strongly support the use of ILOSs, particularly to target health-related social needs (HRSNs).** Essential hospitals work tirelessly to address HRSNs that affect their patients and their health outcomes. The majority of our members participate in state initiatives to target HRSNs, such as health literacy, food insecurity, and healthy behaviors. These services often go unfunded or are underfunded but are critical to essential hospital patients. We appreciate CMS’ promotion of ILOSs to respond to HRSNs.

**We also support the use of ILOSs as immediate or longer-term substitutes for state plan-covered services and settings.** This flexibility would allow states to adopt ILOSs for which cost savings might not be immediately felt. CMS offers an example of housing transition navigation services for populations with chronic health conditions who are determined to be at risk of homelessness or medically tailored meals to individuals with diabetes and poorly managed hemoglobin A1C levels. Over time, these interventions might lead to fewer complications and reduced demand for services. This is particularly true of patients at essential hospitals, who often are medically complex and face socioeconomic barriers to health.

We are concerned, however, about CMS’ proposal to limit allowable ILOS costs to a portion of the total costs for each managed care program (the ILOS cost percentage). CMS proposes a 5 percent limit (i.e., the total portion of capitation payments for ILOSs may not exceed 5 percent of the total capitation payments and SDPs). The 5 percent limit is random, as CMS simply asserts its belief that 5 percent would be a reasonable limit. The agency does not clearly articulate why any limit is necessary if, by definition, ILOSs are cost effective. **We urge CMS**

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not to finalize any limit on the extent to which states may adopt ILOSs to help achieve their program objectives.

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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,

Bruce Siegel, MD, MPH
President and CEO