AMERICA'S ESSENTIAL HOSPITALS

Sept. 16, 2024

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

Re: Need to Consider Unintended Consequences of Structural Barriers on State Directed Payments that Disproportionately Harm Essential Hospitals

Dear Administrator Brooks-LaSure:

On April 22, the Centers for Medicare & Medicaid Services (CMS) issued two final rules that seek to ensure access to care in Medicaid managed care and fee-for-service (FFS) delivery systems. America's Essential Hospitals appreciates your administration's commitment to correcting long-standing inequities and ensuring Medicaid beneficiaries can have the same access to care as patients covered by other payers. In particular, we appreciate that CMS codified the state option to require managed care plans to pay hospitals the same rate as commercial payers, which is an important first step to achieving the administration's health equity goals.

However, **we write to emphasize our deep concerns about the unintended consequences of two unnecessary structural barriers imposed by the final rule that are likely to undermine the effectiveness of Medicaid state directed payments (SDPs):** (1) the elimination of separate payment terms; and (2) the prohibition on interim payments based on historical utilization. These provisions do not change the amount of SDPs providers are eligible to receive, but they will add substantial administrative costs to states, health plans, and providers with no meaningful benefit for patients. Moreover, these provisions reduce payment transparency and could potentially undermine the permissible Medicaid financing mechanisms states have long used to stretch scarce resources to benefit more Medicaid patients.

This letter summarizes concerns shared by our member hospitals about how the proposed changes are inefficient, ineffective, and ultimately unworkable for many states. Most of the comments CMS received on these provisions in the proposed rule highlighted similar concerns, and so we also have serious concerns CMS is ignoring the evidence provided during the comment process and imposing its own arbitrary standards that are unwarranted by the facts and disproportionately harm safety net providers. As a result, **we recommend that CMS reconsider its decision on these provisions and delay enforcement until a more workable alternative is developed.**

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Essential Hospitals' Role in Advancing Health Equity

America's Essential Hospitals is the leading association and champion for hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health, health care access, and equity. We support our more than 300 members with advocacy, policy development, research, education, and leadership development. Our members 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 with an average loss of −8.6 percent, compared with −1.4 percent at other U.S. hospitals.[1]

Essential hospitals are at the forefront of efforts to address health equity because of their complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospitals' patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. To meet the needs of these populations, members of America's Essential Hospitals constantly engage in robust quality improvement initiatives and have created programs to break down language barriers, address social determinants, and engage patients and families to improve the quality and equity of care.

Unfortunately, **essential hospitals' ability to continue to close the health equity gap is threatened by payers that undervalue the care they provide.** Because Medicaid payment rates are so much lower than other payers, essential hospitals have lower operating margins than other hospitals. Over time, this systemic underinvestment can lead to reductions in essential services and limit the capital available to these hospitals to invest in delivery system reforms. As the Institute of Medicine (IOM) acknowledged in its landmark report more than two decades ago, America's safety net is "intact but endangered."[2]

SDPs Have Become a Critical Tool for Advancing Payment Equity

Essential hospitals have long relied on a patchwork of funding to offset low Medicaid payment rates. The Medicaid statute permits states to target a variety of payment types to specific hospitals, but it has historically been difficult for states to offset low Medicaid payment rates in Medicaid managed care because of a lack of state control in how managed care plans pay providers. SDPs help address this problem by giving states authority to set payment rates to providers in ways that advance state access and quality goals.

When states are given the tools to address payment inequities, they can enable essential hospitals to provide even more exceptional care to their communities. For example, in some of our member hospitals whose states have chosen to value care provided to Medicaid patients at the average commercial rate (ACR) in the area, access to maternal and behavioral health care now exceeds that available to patients with commercial insurance. In addition, SDPs have been a lifeline for helping our hospitals keep their doors open and respond to access challenges in

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[1] Taylor, J, Ramiah, K, et al., *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey.* America's Essential Hospitals. October 2023. https://essentialdata.info. Accessed May 8, 2024.

[2] Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *America's Health Care Safety Net, Intact but Endangered.* 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 15, 2024.

rural areas. The enclosed issue brief details additional success stories of how essential hospitals are using SDPs to advance state and federal goals of access, quality, equity, and innovation.

Although states can use state general funds to increase Medicaid base payment rates, this option isn't available to many states with limited state budgets. The Medicaid statute recognizes this challenge and has long allowed states to use multiple sources of funding to finance the non-federal share of Medicaid payments, including intergovernmental transfers (IGTs) from public entities and health care–related taxes. However, states' ability to rely on provider financing depends on the extent to which the state can transparently ensure this funding is efficiently used to advance payment equity goals. States and local governments also want to make sure the funding they provide is used to support the intended providers. Because SDPs provide states more control over how payments to managed care organizations are spent, they have been an invaluable tool in allowing states to use all permissible Medicaid financing sources to ensure adequate payment for care provided to Medicaid beneficiaries.

Even with SDPs and provider financing, some states still fall short of truly equitable payments between Medicaid and other payers. In these circumstances, state legislators often choose to target limited resources to providers that need them most—including essential hospitals, which play a safety net role in their communities. Policymakers who have run Medicaid programs know that this economical and efficient use of available funding is an important step on the journey to achieving state and federal health equity goals.

Separate Payment Terms and Interim Payments Are Effective and Efficient Ways to Make SDPs to Essential Hospitals

One of the keys to the success of SDPs has been the flexibility CMS has given states to administer these programs in the most efficient way possible. Two important tools states and actuaries developed to achieve these goals are separate payment terms and interim payments based on historical utilization.

SEPARATE PAYMENT TERMS

Separate payment terms allow states to distinguish between funding provided through SDPs and other payments to the health plan. This transparency is important for ensuring that additional funding is directed to providers as the state intends. Separate payment terms were initially developed to ensure payments to health plans are actuarially sound by making sure health plans are not overpaid or underpaid for the costs of SDPs.

In the final rule, CMS noted that the use of separate payment terms has grown in recent years as more stakeholders realize the benefit of this payment flexibility. In 2021, more than half (55 percent) of SDPs used separate payment terms, and CMS noted that commenters reported that these arrangements "provide greater transparency, ensure that payments flow to providers as intended, minimize administrative burden for states, and make it easier for states to track SDPs."[3]

In our own analysis, we have found that separate payment terms are particularly helpful tools for states that target SDPs to essential hospitals because they reduce the risk that health plans would have an incentive to steer patients away from the providers the state intended to help. The American Academy of Actuaries highlighted similar findings in its comments on the rule,

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[3] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Final Rule. *Federal Register*. May 10, 2024. p. 41109. https://www.federalregister.gov/d/2024-08085. Accessed Aug. 14, 2024.

noting that "prohibiting these separate payment terms could result in access issues or steerage away from certain providers, including some who may be essential safety net providers."[4]

INTERIM PAYMENTS BASED ON HISTORIC UTILIZATION

Interim payments based on historic utilization help states make more timely and predictable payments to providers. Although these interim payments are ultimately reconciled to actual utilization during the rating period, interim payments allow providers to be paid more quickly before the claims runout process is complete. This process also reduces the administrative burden of needing to recalculate directed payment amounts throughout the year, which adds costs to states and health plans without having any meaningful impact on the amount providers ultimately receive. Historical data is commonly used throughout the Medicaid managed care capitation process to estimate future costs, and so it is the most appropriate estimate to use to ensure payments are consistent with actuarial projections.

Timely payment of SDPs is important for maintaining cash for essential hospitals, which often are financially vulnerable. In the final rule, CMS noted that the claims run-out process can be as long as 16 months in some states, which means that without interim payments based on historic utilization, a hospital might need to wait more than a year to get fully paid for services rendered to Medicaid beneficiaries.[5] Although states can make interim payments based on actual utilization, this is not a good substitute, because it is subject to the same claims runout challenges. Moreover, the additional administrative burden of re-running claims data is unnecessary, since in either scenario any interim payments a state makes are ultimately reconciled to actual utilization.

In states that rely on hospitals to finance the nonfederal share of SDPs, hospitals also have to incur added costs months or years before they are paid. This process also can create cash flow challenges for states, as well. When this process is combined with the uncertainty and administrative complexity of eliminating separate payment terms, it creates an added risk that hospital costs and hospital payments will be further misaligned.

Removing Separate Payment Terms Increases the Risk SDPs Will Differ from What the State Intended

Despite the proven benefits of separate payment terms in achieving the statutory goal of efficiency, CMS noted in its preamble to the final rule that it chose to eliminate these provisions because of concerns these policies are inconsistent with "the risk-based nature of managed care." However, the agency does not explain why it prioritizes this goal over the statutory responsibilities of states to safeguard access and ensure managed care payments benefit Medicaid beneficiaries. There is no statutory reason for CMS to restrict the use of separate payment terms.

Section 1903(m)(2)(A) of the Social Security Act does require managed care plans to be paid on a prepaid risk basis, but the statute does not specify how much risk managed care plans should take on. In managed care, states often employ a variety of strategies to help minimize the risk to managed care plans for costs outside their control. For example, because most health plans are

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[4] American Academy of Actuaries. Letter to CMS regarding "Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-P)." June 30, 2023. https://www.regulations.gov/comment/CMS-2023-0071-0104. Accessed Aug. 14, 2024.
[5] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Final Rule. *Federal Register*. May 10, 2024. p. 41084. https://www.federalregister.gov/d/2024-08085. Accessed Aug. 14, 2024.

paid on a per member per month basis, health plans are not at risk for changes in Medicaid enrollment. In addition, many states have established risk corridors and outlier payment policies for high-cost services to reduce the risk that health plans are underpaid for the services they provide.

Section 1903(m)(2)(A)(iii) of the Social Security Act further specifies that prepaid amounts to managed care plans must be actuarially sound. Federal regulations define this term to mean that the capitation rate covers all reasonable, appropriate, and attainable costs of services covered under the contract (42 C.F.R. § 438.4). Ultimately, actuarially sound rates help reduce the risk that health plans are overpaid or underpaid for the care they provide.

Although actuaries are responsible for certifying managed care rates, states are ultimately responsible for setting managed care contracts, including requirements for SDPs to advance state access and quality goals. When a state changes the managed care contract by adding SDPs, it necessarily changes the actuarially sound rate needed to cover the costs of that contract.

Separate payment terms were developed as a tool to make sure that the amount paid through SDPs is equal to the amount states intended to advance the state's quality and access goals. Separate payment terms are particularly useful for ensuring accurate rate setting for SDPs that are targeted to specific safety net providers because other types of rate adjustment (e.g., regional cost benchmarks) cannot fully account for the differences in payments for one provider versus another. Separate payment terms not only help provide more clarity to health plans and providers but also make the MCO payment process more efficient and help state policymakers better budget available resources. Moreover, actuaries have certified and endorsed the use of this practice as actuarially sound.

CMS concerns about separate payment terms appear to be based on a mistaken view that separate payment terms remove health plans' responsibility for managing utilization of services under the contract. However, SDPs continue to be based on actual utilization during the contract period, and plans continue to be at full risk for base payments under the contract. Separate payment terms do reduce incentives for health plans to steer patients away from essential hospitals that receive targeted SDPs, but that is consistent with the state goals to target their limited resources to hospitals that need the funding most.

We recognize that risk is an inherent part of managed care, but CMS must ensure that any risks passed to health plans have the potential to benefit Medicaid patients. Eliminating separate payment terms only adds administrative risk that SDPs will not equal the amount targeted by the state or the amount funded through managed care capitation rates. Ultimately, actuaries will need to account for this risk by adding in new administrative costs to the rate that do not benefit patients.

To mitigate the consequences of eliminating separate payment terms, CMS noted that states can add risk corridors to limit how much the actual SDP amount can deviate from the expected amount and recoup unspent SDP funding. In addition, states can require health plans to contract with essential hospitals to minimize the risk plans would steer patients to other providers. However, these policies do not fully eliminate the possibility health plans will pay providers differently from what the state intended. Moreover, these policies do not mitigate other actions health plans could take to reduce the amount they owe in SDPs, such as delaying or denying claims for care provided at essential hospitals.

Prohibiting Interim Payments Based on Historic Utilization Adds Unnecessary Delays for Providers that Can't Afford it

CMS applied the same amorphous standard of the "risk-based nature of managed care" to justify prohibiting interim payments based on historic utilization. However, in doing so, it ignores the legitimate needs of providers to be paid on a timely and accurate basis. Just because payments to health plans must be prepaid does not mean payments to providers need to be delayed.

To the extent SDPs are otherwise consistent with federal managed care rate regulations and statutory requirements, it is unclear why CMS would preclude states from making interim payments based on historical utilization, especially when they are ultimately reconciled to actual utilization. CMS new policies only add uncertainty that providers will not receive the amount of SDPs the state intended in a timely manner. For safety net providers operating on thin margins, these delays and uncertainties increase the risk of losing access to essential services.

To mitigate the consequences of eliminating interim payments based on historic utilization, CMS noted that states can make interim payments based on utilization during the rating period. However, recalculating payment amounts each month or quarter would require substantial administrative costs to process claims and still would be subject to delays due to the claims runout process. This constant recalculating of claims also adds administrative costs to states and health plans with no benefit to patients, because it does not alter the final payments providers receive once the claims are reconciled.

These Policies Run Counter to CMS Goals of Improving Transparency and Accountability

An unintended consequence of CMS' new policies is that it will undermine the agency's stated goals of improving the transparency and accountability of SDPs. Although CMS does add new requirements for provider-level data on SDPs to be reported in the Transformed Medicaid Statistical Information System (T-MSIS), T-MSIS data are subject to substantial delays. In contrast, separate payment terms and interim payments based on historic utilization make it easy for states, health plans, and providers to immediately know how much providers are paid and when.

Knowing how much providers are paid in SDPs also helps policymakers keep health plans accountable for ensuring SDPs are used for state-defined goals. In CMS' proposed managed care rule, it acknowledged the lack of accountability when SDPs are folded into the large capitation rate: "Incorporating this funding into the State's capitation rates through standard rate development would not ensure that plans did not use this funding, or portions of this funding, for other purposes."[6] In the final rule, we appreciate CMS' efforts to strengthen evaluations of SDPs, but it doesn't take a multiyear evaluation to know that if SDPs are not being made as intended, then they are not likely to achieve their goals.

For value-based SDPs, it is particularly disruptive for providers not to know how much money they can earn for achievement of quality milestones. Ultimately, if the payments providers receive from SDPs become more uncertain, providers are less likely to make the upfront investments needed to reform their delivery systems and achieve these quality goals.

[6] 88 Fed. Reg. 28,092, 28,146 (May 3, 2023).

These Policies Unfairly Penalize States Using Permissible Financing Methods

Without transparency and accountability that health plans will make SDPs as the state intends, it will be particularly challenging for states to finance SDPs with health care–related taxes and IGTs. In addition, state legislators may be less willing to appropriate dedicated state general funding for SDPs. The result may be that some states cut payments to providers or stop making SDPs altogether, threatening the gains they have made so far in payment equity.

CMS' discussion about separate payment terms and interim payments in the final rule does not explicitly acknowledge the disparate impact its policies will have on states that finance these Medicaid programs through these permissible sources. However, in other parts of the rule, CMS criticizes states that use these sources to establish fixed pools of funding for provider rate increases, suggesting that the agency is inappropriately favoring some types of permissible Medicaid financing sources over others.

In our view, this criticism is not helpful for states that must work within the limits of their budgets. Although states do not always have sufficient resources to fully close the gap between Medicaid payment rates and the ACR, it is economical and efficient for them to budget how much they can spend and target available resources to the providers that need them the most.

We understand CMS' role as a steward of the program to ensure effective fiscal oversight, but in doing so, it should not undermine funding authorities established by Congress to help ensure access.

These Policies Create Structural Barriers that Disproportionately Harm Essential Hospitals

Essential hospitals likely will be disproportionately affected by these new barriers CMS created because they are more likely to receive SDPs financed through health care–related taxes and IGTs. Unfortunately, essential hospitals also will be disproportionately harmed because they are particularly reliant on SDPs to maintain access to essential services.

We do not believe that CMS intended to disproportionately harm essential hospitals. One of the key goals of the agency's health equity plan is to support providers of safety net care in underserved communities so they can continue to ensure care is accessible to those who need it.[7] This goal is consistent with President Joe Biden's executive orders for agencies to consider how their policies can better support communities that have endured generations of disinvestment.[8]

Unfortunately, CMS' analysis of the effects of separate payment terms and interim payments missed this equity impact because the agency failed to fully examine the characteristics of providers most affected by the policy. For example, CMS cites the fact that some SDPs do not have separate payment terms as evidence that its new policy is workable. However, CMS does not look closely at which types of providers receive those payments or how they are financed.

A full equity analysis of SDPs should consider the unique role of the Medicaid program and how it is financed. For example, CMS cites other types of health insurers without separate payment

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[7] Centers for Medicare & Medicaid Services. CMS Strategic Plan: Health Equity. 2023. CMS Strategic Plan Health Equity Fact Sheet. Accessed May 15, 2024.
[8] E.O. 13985 and E.O. 14091.

terms as evidence that this option is not needed in Medicaid. However, these other insurance programs are not financed by multiple sources and do not have the same statutory responsibilities to support providers who serve a disproportionate share of low-income patients. State Medicaid agencies have a statutory responsibility to ensure access to care for the most disadvantaged in our communities. To meet this responsibility, states must have the flexibility to administer payments in ways that help meet their access and quality goals.

Ultimately, we believe that policies intended to advance health equity are made stronger by fully listening to the communities policymakers are trying to help. CMS' health equity plan commits to "engagement with and accountability to the communities CMS serves in policy development and the implementation of CMS programs."[9] We remain ready to engage with CMS on these issues and we encourage CMS to consult with essential hospitals to better understand how new SDP policies will work in practice.

There Is an Urgent Need to Develop a More Workable Alternative

Given the evidence that CMS' new barriers on SDPs do not support statutory goals and disproportionately harm safety net providers, the agency should reopen public comments and reconsider these policies from an equity perspective.

At a minimum, CMS should not implement these policies until states evaluate current Medicaid payment rates and the effects of current SDP programs that help close equity gaps. Similar to how CMS delayed the effective date of new restrictions on home and community-based services (HCBS) payments until 2030, after states conduct new rate studies required under the FFS access rule, CMS should delay the effective date of the proposed changes to separate payment terms and interim payments until after states comply with new payment rate transparency requirements and SDP evaluation requirements.[10]

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Thank you for your engagement on this issue, which is of utmost importance to essential hospitals. We remain committed to continuing to work with CMS on these issues. If you have questions, please contact Director of Policy Rob Nelb, MPH, at rnelb@essentialhospitals.org or 202.585.0127.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

[9] Centers for Medicare & Medicaid Services. CMS Strategic Plan: Health Equity. https://www.cms.gov/files/document/health-equity-fact-sheet.pdf. Accessed Aug. 15, 2024.
[10] Centers for Medicare & Medicaid Services. Medicaid Program; Ensuring Access to Medicaid Services. Final Rule. *Federal Register*. p. 40633. https://www.federalregister.gov/d/2024-08363. Accessed Aug. 14, 2024.