AMERICA'S ESSENTIAL HOSPITALS

April 14, 2025

Mehmet Oz, MD
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: Reducing Regulations that Impose Undue Burden on Essential Hospitals

Dear Administrator Oz:

On behalf of our more than 350 member hospitals, we write to share suggestions for how the Centers for Medicare & Medicaid Services (CMS) can reduce unnecessary regulatory burdens for hospitals that serve a safety net role. As CMS works to responds to President Trump's Executive Order 14219, implementing the president's deregulatory initiatives, we hope to continue to partner with you and your team to ensure that these changes are implemented in ways that do not undermine access to care for the patients our members serve.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to keeping all Americans healthy, including people who cannot afford other options for care. Since 1981, America's Essential Hospitals has advanced policies and programs that ensure access to critical services that meet the needs of the patients our members serve. We support our more than 350 members with advocacy, policy development, research, education, and leadership development.

Although essential hospitals account for only 5 percent of acute-care hospitals nationwide, they provided 28 percent of the nation's charity care in 2022. About three-quarters of the patients our members serve are uninsured or enrolled in Medicare or Medicaid. Essential hospitals do all this and more at a financial loss because much of the care they provide goes uncompensated or is under-reimbursed by government payers. In 2022, members of America's Essential Hospitals had an aggregate operating margin of -9.0 percent, which was far worse than the aggregate operating margins for all other hospitals (-2.8 percent).[1]

Because of the financial challenges that our members face, it is difficult for our members to take on additional costs from unnecessary regulations. As a result, we support the administration's efforts to identify regulations that impose undue burdens on businesses that do not have clear public benefits.

[1] Miu R, Kelly K, Nelb R, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed April 3, 2025.

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In health care, we encourage CMS to focus its deregulatory efforts on reducing overly complex and burdensome regulations that divert staff time and resources away from direct patient care. We encourage CMS to consider policies to simplify the administration of Medicaid state directed payments (SDPs), streamline quality measurement, and remove unnecessary conditions of participation.

We also encourage CMS to ensure that its deregulatory initiatives do not undermine access to care for Medicare and Medicaid beneficiaries. For example, as CMS considers regulatory changes to improve the administration of SDPs, it is important to preserve the ability of states to use this payment authority to ensure access to quality care for Medicaid beneficiaries.

Efforts to make federal regulations more efficient and effective work best if the stakeholders affected by the policies are involved in the policymaking process. We remain willing to work with CMS to identify ways to further streamline these federal regulations, and we encourage CMS to solicit feedback from other stakeholders to avoid potential unintended consequences.

Improving the Administration of Medicaid SDPs

SDPs are a vital tool many states use to offset low Medicaid payment rates and ensure access to quality care for Medicaid beneficiaries. Without SDPs, Medicaid managed care payments to hospitals would be less than half of the rate paid by other payers, which is not enough to sustain access to the essential services that hospitals provide, such as maternity, trauma, and behavioral health care.

During the first Trump administration, the president recognized the importance of providing states with the flexibility to implement SDPs in ways that advance state policy priorities. For example, in 2018, the Trump administration allowed states to use SDPs to close the gaps in hospital payments between Medicaid and the average commercial rate (ACR) paid by other payers. Many states have adopted this policy to keep rural hospitals open; reduce infant and maternal mortality; and improve care quality, value, and access in other ways.[2]

To promote the efficient and effective administration of SDPs, most states use separate payment terms and interim payments based on historic utilization. Unfortunately, the 2024 Medicaid managed care rule requires states to phase out the use of these authorities—42 CFR 438.6(c)(2)(vii)(B) and 42 CFR 436.6(c)(6))

We urge CMS to repeal these two provisions of the final regulation because 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 make it more difficult to ensure that SDPs are advancing their intended goals.

By simplifying the administration of SDPs, CMS can better focus on monitoring policies that matter for patients. For example, we encourage CMS to consider ways to accelerate the

[2] Kozminski J. State Directed Payments: Closing Medicaid Payment Gaps for Essential Hospitals. *America's Essential Hospitals*. September 2024. https://essentialhospitals.org/state-directed-payments-closing-the-medicaid-payment-gap-for-essential-hospitals/. Accessed April 4, 2025.

approval of state directed payment applications to advance the agency's goals of improving federal and state program administration, which are part of the Medicaid and CHIP Scorecard.[3]

i. Separate payment terms (42 CFR 436.6(c)(6))

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."[4]

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, 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."[5]

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.

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 on 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 new administrative costs that do not benefit patients to the rate.

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

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[3] Centers for Medicare & Medicaid Services (CMS). Medicaid and CHIP Scorecard. https://www.medicaid.gov/state-overviews/scorecard/measure/State-Directed-Payment-Review-Administrative-Data. Accessed April 11, 2025.
[4] 89 Fed. Reg. 41,002, 41,285. (May 10, 2024.)
[5] American Academy of Actuaries. Letter to CMS regarding "Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-P)" on June 30, 2023. https://www.regulations.gov/comment/CMS-2023-0071-0104. Accessed Aug. 14, 2024.

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, and they add substantial administrative costs that do not benefit patients. 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.

ii. Interim payments based on historic utilization (42 CFR 438.6(c)(2)(vii)(B)

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 recalculating 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.[6] 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 must incur added costs months or years before they are paid. This process also can create cash flow challenges for states. 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.

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.

[6] 89 Fed. Reg. 41,002, 41,285. (May 10, 2024).

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 recalculation 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.

Streamlining Quality Measurement

Essential hospitals are committed to delivering high-quality care and improving health outcomes for the communities they serve. However, the current quality measurement landscape is overly complex and often duplicative, and it imposes a significant administrative burden on providers. Rather than supporting improvements in care delivery, many existing measures and reporting requirements pull valuable time and resources away from patient care.

We urge CMS to streamline and better align quality measures across programs, focusing on a targeted set of evidence-based measures that are clearly linked to improved health outcomes. Reducing the volume of overlapping or low-value measures will help hospitals more efficiently direct their resources toward clinical improvements and patient needs.

For example, the Patient Safety Structural Measure finalized in the Inpatient Quality Reporting program in the fiscal year 2025 Inpatient Prospective Payment System final rule illustrates the strain that resource-intensive, attestation-based measures can place on hospitals. The measure requires hospitals to attest to multiple statements across several domains, but the process is time-consuming, lacks clear evidence of impact on patient outcomes, and may not provide meaningful information to patients beyond what is already available through existing public reporting tools. Measures like this, which rely heavily on subjective attestations and labor-intensive data collection, add to the growing administrative burden without demonstrating clear benefits.

We encourage CMS to prioritize simplification of quality reporting and focus on well-tested, actionable measures that promote better care and efficient use of provider resources. This approach will support hospitals in their mission to improve the health of the communities they serve while reducing unnecessary compliance burden.

Removing Unnecessary Conditions of Participation

As major providers of care to Medicaid and Medicare patients, essential hospitals adhere to the regulatory requirements and conditions of participation (CoPs) they must meet to participate in these programs. CoPs were put in place to protect the health and safety of patients, but some of these requirements have become obsolete as the health system has evolved over time. In recent years, policymakers have also attempted to add new CoPs that add additional regulatory burden. These policies add additional regulatory costs on hospitals without meaningful improvements in patient care. Essential hospitals are particularly affected because they have limited resources to invest in additional compliance efforts.

CMS should review and revise obsolete, unnecessary, or burdensome provisions in CoPs to ensure continued patient safety, as well as reduced regulatory burden on essential hospitals. Overall, we urge CMS to provide hospitals the flexibility to shape their programs and policies in

the way that best and most efficiently serves patient needs, particularly as hospitals consider new and innovative ways to deliver care to their communities.

Rather than implementing new CoP requirements, we strongly urge CMS to explore alternative approaches that offer hospitals the flexibility to innovate and improve care in ways that best serve their communities. Technical assistance programs, learning collaboratives, and well-developed, thoroughly tested quality metrics are all potential tools that could help hospitals achieve better outcomes without the punitive implications of new CoPs.

For example, CMS could expand support for hospitals through targeted funding opportunities, evidence-based training, and the development of quality improvement initiatives. By providing hospitals with the resources and guidance they need, CMS can encourage improvements in care while allowing hospitals to maintain the flexibility necessary to address the unique challenges they face.

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If you have questions, please contact Director of Policy Robert Nelb, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Bruce Siegel (Apr 14, 2025 14:43 EDT)

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