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June 29, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

RE: Comments on CMS-2439-P

Dear Administrator Brooks-LaSure:

On behalf of its 140 member hospitals, the Missouri Hospital Association offers the following comments in response to Centers for Medicare and Medicaid Services' Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality proposed rules which were published in the *Federal Register* on May 3, 2023.

CMS lacks the statutory authority to impose the provisions of §§438.6 (c)(2)(ii)(G) and (H). MHA opposes §§438.6 (c)(2)(ii)(G) and (H) of the proposed rule. Through the preamble of the rule and imposition of the cited regulations, CMS intends to extend the definition of an unallowable health care provider tax hold harmless arrangement to include redistribution arrangements of private providers. The long-standing and plainly worded provisions of the law at 42 U.S.C. §1396b and CMS' regulations at Subpart B of 42 CFR 433 define unallowable hold harmless arrangements as those created by the state or unit of government imposing a health care provider tax. If CMS wishes to regulate the actions of private entities with respect to health care provider taxes, Congress must establish CMS' authority to do so by amending the law.

Even if the law allowed CMS to regulate private redistribution arrangements, the proposed regulation is inadequate. The plain words of the proposed rule are not necessarily inconsistent with the current law and CMS' past practice. However, CMS declares in the rule's preamble it intends to interpret the existing law in a new way. Inasmuch as CMS intends to reinterpret the law or its own regulations, it should do so with unambiguous amendments in its regulations and not by eisegesis presented in the preamble of a proposed regulation. CMS' approach in the proposed regulation deprives interested parties of the proper notice and the fair opportunity to comment on what would be a profound change in public policy.

CMS should require states to use provider surveys to augment and contextualize the data obtained from enrollee experience surveys. In the preamble to the regulation, CMS says it encourages states to utilize provider surveys, but it does not include a requirement that states do so in the proposed regulation. The enrollee's experience may not fully reflect the circumstances

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in which the care they received was rendered. Hospitals often provide care the enrollee needs, despite managed care plan denials or down-coding. The enrollee may be the beneficiary of excellent care, but completely unaware their managed care plan refused to reimburse their provider for it. The enrollee's experiential data is necessary, but not sufficient to fully understand the adequacy of managed care plan performance. Provider's experiential data is needed for a complete and accurate assessment.

Proposed regulations at §438.68(e)(1)(i) should include prohibitions on plans penalizing providers for plans' failure to meet wait time standards. As CMS notes in the preamble to the regulation, the accurate assessment of network adequacy must consider providers' willingness and ability to serve Medicaid patients. The regulations must clarify that plans must establish adequate networks that provide timely access to the care Medicaid patients need by contracting with a sufficient number of providers to meet the need. Plans should not be permitted to penalize providers with reimbursement reductions for properly exercising their right to not accept new Medicaid patients or to meet the appointment timeliness standards required of the plan by the regulation.

The proposed provider payment analysis regulations at §§438.207(b) and 457.1230(b) should require states to consider providers' cost to comply with managed care plan reimbursement submission and review practices. MHA agrees with CMS' assertion that greater transparency is needed to mitigate payment-related barriers to access to care for Medicaid enrollees. Adequacy of reimbursement cannot accurately be measured by simply comparing a plans contracted rates with known benchmarks like Medicaid fee-for-service rates or Medicare rate schedules. Providers incur substantial costs to be paid for care they provide to Medicaid managed care plan enrollees. These costs effectively reduce the value of the plan's reimbursement and therefore must be considered as a factor for how a plan's reimbursement schema may create barriers to access. Prior authorization documentation, payment denials, down-coding, requests for medical records and request for peer-to-peer reviews add to providers' costs and diminish the value of any reimbursement that is eventually received. CMS should require states to gather actual data on the actual reimbursement practices of Medicaid managed care plans and account for how they diminish provider reimbursement as an explicit element of the analysis CMS requires under the aforementioned regulations.

The average commercial rate is the appropriate benchmark to establish in the proposed regulations at §438.6(c)(2) for state directed payments for inpatient and outpatient hospital care, nursing facility services and for qualified practitioner services at academic medical centers. CMS should not use Medicare as the benchmark for these services. As noted in the preamble, CMS has an established the practice of using ACR as a benchmark for SDP and it is MHA's position that this standard should be maintained and further, that states be allowed flexibility to define ACR for the SDPs they establish. CMS rightfully states that ACR is an appropriate benchmark because managed care plans compete with commercial plans for providers to participate in their networks. Inasmuch as Medicaid primarily covers children and pregnant women (and this especially is true for Medicaid managed care programs), Medicare

covers very few pregnant women and children. For this reason, the ACR is more appropriate than Medicare as a benchmark for SDP expenditures.

Finally, CMS should not predicate its decision on SDP benchmarks on its ability or inability to regulate private redistribution arrangements through the regulation it proposed at §§438.6 (c)(2)(ii)(G) and (H). The non federal share of state spending and the level of SDP expenditures are related, but only by the mechanisms by which the Medicaid program is financed. It would be inappropriate for CMS to limit SDPs by adopting a lower expenditure benchmark like Medicare simply because it cannot regulate private redistribution arrangements as it wishes. Doing so would compromise the stated purpose of the proposed rule, which is, as stated in the preamble, "to make high-quality health care accessible and affordable to every American" and "to continue to expand the availability of affordable health coverage, to improve the quality of coverage, to strengthen benefits, and to help more Americans enroll in quality health coverage."

Thank you for the consideration of our comments to the proposed regulations.

Sincerely,

Brian Kinkade
Vice President of Children's Health and
Medicaid Advocacy

bk/dd