Illinois Health and Hospital Association

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn. CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-2439-P
COMMENTS ON MEDICAID AND CHIP, MANAGED CARE ACCESS, FINANCE AND QUALITY PROPOSED RULES – PUBLISHED MAY 3, 2023

Dear Administrator Brooks-LaSure:

On behalf of its over 200 member hospitals and nearly 40 member health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment and provide feedback on the Centers for Medicare & Medicaid Services' (CMS) proposed policies and rules. Overall, IHA finds the proposed rules generally consistent with previous rulemaking and guidance. Our comments primarily focus on the need for potential added clarification. Additionally, we will address items referenced in the preamble of the proposed rule, which were not directly impacted at this time but do raise concerns.

The Medicaid program is a critical thread in the overall healthcare fabric for residents of Illinois, serving almost 3.6 million Illinoisans today. These individuals reside in diverse, vulnerable communities in our state, or suffer from life-altering physical and behavioral healthcare needs. The hospital community is the most invested provider community serving these individuals, not only in Illinois but also, across our country. Hospitals are at the center of care during the most challenging times, which has never been clearer than during the past three years of the COVID-19 pandemic. Many of Illinois' hospitals are still desperately trying to recover from this challenging time. Finances have been weakened, workforce challenges have never been greater, and hospitals face a future which has never been more uncertain.

As noted in the preamble, CMS set the stage for Directed Payments and Pass-Through payments in its 2016 final rule. This rule has been clarified both through additional rulemaking and through State Medicaid Director letters; this guidance more formally defined the landscape of Medicaid payment rules in a managed care environment. Frequently in writings, CMS has acknowledged the importance of proper funding of the program and the critical role that Healthcare Related Taxes (HRT) play. Guidance has

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also properly acknowledged the importance of assuring that those provider payments funded by HRT fully flow through the Managed Care Organizations (MCO) to achieve the proper funding goal of preserving and improving access to quality healthcare.

The rules related to State Directed Payments (SDP), as well as the flexibility given to states over the ten-year phase out of Pass-Through payments, highlight efforts to advance this acknowledged goal. Examples include:

- Where in most cases state Medicaid agencies are **not** permitted to direct specific payment levels or rates to specific providers, for services provided to individuals covered by MCOs, SDPs are specifically designed to provide that state level policy discretion.
- The Pass-Through ten-year phase down clearly acknowledged the fragile nature of many Medicaid program General Revenue Fund (GRF) to HRT financing relationships, and the need to provide a **gradual** transition to one more directly linked to a specific service in a more real time manner.

These HRT financing relationships are often at the heart of the survival of many state Medicaid programs. Without the current Illinois Hospital Assessment Program (HAP), which is financed by an HRT on hospitals, the hospitals would only receive 50 cents for every dollar they spend caring for Illinois Medicaid patients. Even with the HAP, SDPs and the supplemental payments they fund, Illinois hospitals still only receive 80 percent of the cost of care for Medicaid patients. Therefore, the rules applying to SDP and Pass-Through payments are critical, as are the flexibilities afforded states in the administration of their programs. **Further restrictions on a state's use of HRTs to finance Medicaid payments could have unfortunate consequences for coverage and access to quality healthcare for Medicaid beneficiaries, as a direct result of diminished provider viability.**

STATE DIRECTED PAYMENTS

The development of SDPs and the state-level policy authority which they provide was a welcome concept as Illinois transitioned its Medicaid program from a Fee-For-Service (FFS) model to a capitated managed care model. Conceptually, the use of SDPs continued the state flexibility to recognize the need to assure a minimum level of reimbursement for either specific services or specific providers. The Illinois hospital community, in collaboration with the Illinois Medicaid agency, has developed and deployed a very dynamic and robust SDP model, fully funded by the HAP. This model is a stark departure from the historic static supplemental payment model, which was the historic platform for the Illinois hospital Medicaid reimbursement system. These payment models provide a guaranteed minimum **rate of reimbursement** and not a guaranteed level of reimbursement.
While we appreciate that CMS may believe it appropriate for the MCOs to "fully control" the allocation of Medicaid funds or the determination of rates, these guaranteed reimbursement rates provide increased stability in what is often a very challenging relationship between payer (MCO) and provider. The Illinois model is a shining example of how this guarantee can improve

access to care. Over the most recent years, through the conversion of Fixed Supplemental payment models to ones where the money follows the patient, Illinois has seen an improved participation rate by the Illinois hospital community. This improved engagement was strengthened when the hospital community realized that over half of their reimbursement, all of which is funded by a hospital HRT, would not be subject to manipulation or negotiation between the MCOs and themselves. The state directed rate of reimbursement would always prevail and be guaranteed when the service is provided. This assurance has allowed for a more collegial integration of the managed care environment.

Therefore, we applaud CMS for the authorization of SDPs and urge that no further restrictions be placed on their use. We believe that allowing for creativity in the creation of models of reimbursement is fundamental to the state-federal partnership, which has guided the Medicaid program since its creation. Furthermore, we support the change that SDPs to non-network providers are permissible, which will serve to increase access to care for Medicaid patients.

Payment Rate Limitations

Upper Payment Limit: Average Commercial Rate

Our understanding is that CMS' current practice allows for using the average commercial rate (ACR) as the benchmark for payment rates for SDP review. The agency notes that because Medicaid managed care plans must compete with commercial plans for provider participation in their networks in order to provide comparable access to care; benchmarking provider payment rates to the ACR has greater relevance. By allowing such comparisons for rate setting, CMS will greatly improve access to care for Medicaid individuals by reducing the disparities in payment rates between what is now the largest insurer in Illinois (Medicaid) and commercial plans competing for access to necessary providers.

We appreciate and support CMS' codification of current practice in establishing the ACR as the upper payment limit for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center. Additionally, we believe the use of the ACR as the upper payment limit for services provided through Medicaid Fee-For-Service models would further aid in the proper funding of Medicaid services and aid in improving access to quality healthcare for Medicaid beneficiaries.

Modification of the ACR Calculation

Currently, CMS requires states to demonstrate that an SDP does not exceed the ACR for a specific service type (e.g., inpatient or outpatient hospital services) or for providers in a **specific provider class** (e.g., rural or urban hospitals). States are currently required to use ACR data from only providers in the provider class that are receiving the SDP. However, the agency recognizes that certain types of providers could be disadvantaged by this approach and is therefore proposing to provide states with added flexibility in how to calculate the ACR. The

proposed changes will allow states to use ACR data from a broader set of providers, such as all providers in the state. For example, rural hospitals or urban hospitals with historically lower commercial payer mix would likely benefit from the state using ACR data from a broader set of statewide providers, which could have the effect of raising their ACR cap and thus increasing the SDP amount.

As CMS notes, this added flexibility would allow state Medicaid programs to target funding to providers with certain financial needs, such as Safety Net and Critical Access Hospitals, without affecting other hospitals. This added flexibility proposal however is silent on whether states could use ACR data from a subset of providers within a state, such as a certain region of a state, which we believe may be helpful to advancing goals related to quality and access in some circumstances.

IHA supports CMS' proposal to increase state flexibility to use ACR data from a broader set of providers to allow states to improve SDP resources and better target funding for financially vulnerable providers, such as urban or rural hospitals. We encourage CMS to consider adding to that flexibility by allowing states the option to use regional provider ACR data if it would be most beneficial to the providers receiving SDPs or to advancing state access and quality goals.

Expenditure Limit for SDPs

CMS notes in its preamble that SDPs are vital to ensure adequate access to care for Medicaid beneficiaries and provide critical financial support for Safety Net providers and states. CMS also notes though that several oversight bodies have authored reports on the oversight of SDPs. Some of these bodies have raised the concern that SDPs are somehow circumventing the "risk-based" concept of placing Medicaid clients in MCO models. As such, CMS has requested comments on the concept of limiting total spending on SDPs. CMS has identified potential problematic alternatives to address the perceived threat of uncontrolled SDP growth, such as limiting SDPs to 10-25% of total cost, limiting the upper payment limit rate to ACR for only SDPs that are value-based purchasing initiatives, and/or setting the upper payment limit for SDPs to Medicare rates.

IHA strongly opposes such potential alternatives to artificially limit SDP growth as arbitrary and unnecessary. We believe that these alternatives are fundamentally contrary to the founding principle for SDPs—to more closely align these payments to **rates** for specific services and patients, and by linking to actual claims. Creating an artificial **aggregate** limit on SDPs to a percentage of an equally artificial estimate of cost seems to promote the continued use of fixed payment pools. As CMS has often noted, these fixed payment pools ignore the dynamic nature of utilization, neither growing nor shrinking with changes in utilization.

The most recent example of such utilization swings is the COVID-19 pandemic period. If aggregate spending had been capped at pre-pandemic levels, instead of allowing rate-based utilization to dictate total spending, hospital cost coverage would have been even more dramatically diminished. Such diminishment would have most likely caused an even greater negative impact on access to care than the actual financial pressures experienced by hospitals during this period.

Allowing for the use of SDPs has greatly improved participation and access to Medicaid services in the state of Illinois and to retreat from such advances by the application of arbitrary limits seems contrary to the goals of the Medicaid program. Since a significant percentage of SDPs are financed by HRTs, placing such an aggregate SDP spending limit would naturally shift the financial burden of properly funding the program to the individual states, and therefore rely on each states individual financial health. While a fully "state funded" Medicaid program, at levels sufficient to assure access to care, is ideal, history has demonstrated that this is not a practical reality, therefore HRTs will remain a vital financing component, and SDPs will most likely rely on HRTs.

IHA believes that the current spending controls, such as the aforementioned ACR, the six-percent limit on HRTs, and the requirement of actuarially sound rates, provide sufficient controls. **IHA strongly encourages CMS to reject further consideration of the alternative spending limitations, and instead follow the plan in this proposed rule to establish the upper payment limit for SDPs at the ACR.**

Applicable Payment Periods for SDPs

The state of Illinois and the hospital community have taken great strides to properly design utilization-based SDPs and a fully compliant HRT program. SDPs are directly linked to services provided by hospitals to individuals enrolled in one of five current MCO contract arrangements. Funds are released to MCOs for payment to hospital providers for services rendered in a previous period, paid by the MCO, and reported to the state Medicaid agency, per contracted encounter data submission timeline requirements.

Since the Medicaid rules provide for a six-month period for the timely filing of claims for payment, and MCOs are afforded a reasonable time to adjudicate and pay for such claims, followed by a reasonably tight encounter reporting timeline, there is a natural lag between date of service and encounter reporting to the state Medicaid agency. As such, claims can cross MCO contract or reporting periods. To require the state to reconcile across such multiple periods would be extremely onerous and administratively burdensome. The state employs a claims identification process to make sure that claims, which are the basis of SDPs, are accounted for only once. This process creates a uniform rate by class, as required by current rules, which can then be applied and accounted for in the rate certification process.

Unfortunately, the proposed rules appear to create some level of ambiguity that such approaches may not be compliant going forward. This payment approach has been highly effective for the three (3) years in which Illinois has used the approach and has been clearly outlined and discussed with CMS regulators during the approval process. **IHA encourages CMS to clarify that SDPs may be developed based on dates of service paid for or reported by an MCO during a fixed and specified period, assuring that a claim for services is only accounted for once when calculating a SDP.**

Hold Harmless Attestation

In this proposed rule, CMS seeks to reinforce its interpretation of Medicaid provider tax hold harmless arrangements based in statute and regulation by imposing new compliance measures. **CMS' proposal to further restrict state sources of financing and use hospitals to police such financing arrangements through this rule is of great concern to the IHA.**

Specifically, the IHA has serious concerns with subsections 438.6(c)(2)(G) and (H) of the proposed regulations. Taken together, these proposed subsections require providers to attest to the lawfulness of any hold harmless arrangements that they have. To be clear, hospitals and health systems always seek to comply with the law, and the IHA does not have any objection with requiring providers to do so or, in the appropriate circumstances, attest to their compliance. However, the language of this proposed regulation is potentially overly broad in ways that may harm hospitals, patients and their communities. If this attestation is to be adopted, CMS needs to clarify the scope of the attestation requirement, including exactly what parties are attesting to generally and particularly with respect to the hold harmless prohibition.

One example of the confusion that would be created by the proposed rule is that it could be interpreted to apply individually to hospital facilities, within a hospital system. Often large hospital systems own and operate hospitals in vulnerable communities and subsidize their operations and costs, such as the cost of a HRT, from revenues earned by other system hospitals. By sharing revenues and expenses at the system level, the health system is better able to advance health equity and access goals in all of the communities that it serves.

If CMS sought to limit the sharing of revenues and expenses among hospitals in a system, this could prove to have a chilling effect on such investment in health equity initiatives**.** IHA believes that the sharing of revenues and expenses by hospitals within a health system is consistent with the spirit and letter of the statutory hold harmless provision. **IHA recommends that CMS clarify that cross allocation of funds within a system of providers owned by a common legal entity would not violate existing regulations.**

While the text of proposed subsection (G) requires compliance "with all Federal legal requirements for the financing of the non-Federal share," IHA is concerned that HHS will add in sub-regulatory guidance or its own novel interpretations of federal law, such as using the regulatory phrase "including but not limited to." **Consequently, the final rule must make clear that any provider that makes an attestation based on its own good faith belief of compliance with federal statutes or regulations—not sub-regulatory guidance—has satisfied subsections (G) and (H), and the IHA urges CMS to ensure such clarification.**

Put another way, HHS may not seek to elevate sub-regulatory guidance into "Federal legal requirements" via this proposed attestation requirement; the only way sub-regulatory guidance can become a federal legal requirement is through notice-and-comment rulemaking. *See Azar v. Allina Health Services, Inc*., 139 S.Ct. 1804, 1812 (2019) ("Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements. On the contrary, courts have long looked to the contents of the agency's action, not the agency's self-serving label, when deciding whether statutory notice-and-comment demands apply."); *see generally id*. at 1810 (holding that notice and comment rulemaking is required for any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing the payment for services").

Provisions Specific to Value-based SDP Arrangements

CMS proposes several changes intended to reduce barriers for states that are interested in implementing value-based payments (VBP) and delivery system reform initiatives through SDPs. The proposed rule would remove requirements that prohibited states from setting the amount

or frequency of the plan's expenditures. It also would remove requirements that prohibit states from recouping unspent funds allocated for these SDPs. The rule would revise and clarify how performance in these types of arrangements is measured for participating providers, including a prohibition on payment conditioned upon administrative activities such as reporting or learning collaboratives. The regulation would require states to identify a baseline level for all metrics used to measure performance. In addition, it would establish requirements for use of population-based and condition-based payments in these SDP arrangements.

Medicaid has been a leader in promoting VBP and delivery system reform initiatives. Many states and other stakeholders attribute this to the close collaboration that occurs between state Medicaid agencies, providers, and the patients and communities they serve, as well as the program's administrative infrastructure and authority. Historically, states used supplemental payments and Section 1115 demonstration waivers, among other authorities, to implement VBP programs. As Medicaid managed care enrollment has grown, CMS has thoughtfully preserved states' ability to implement these programs through SDPs. More recently, many states and other stakeholders have expressed interest in using delivery system reform initiatives to improve health equity and population health outcomes.

However, delivery system reform initiatives are challenging to establish and implement. In MACPAC's June 2015 Report to Congress, the commission noted that delivery system reform initiatives are often resource intensive. States and other stakeholders reported that they hired additional administrative and clinical staff to implement and monitor them to ensure that they achieve their performance goals. Such initiatives also often require the adoption of new costly technology or modifications to existing technology. States have also reported that finding a source for the non-federal share has been a challenge. These lessons learned should be applied to VBP and delivery system reform initiatives that are implemented through SDPs

In addition, IHA specifically urges CMS to reconsider prohibiting the use of pay-for-reporting metrics in delivery system reform initiatives that are included in SDPs. There are circumstances when this authority and payment would be critical in driving system change, and best viewed as a pathway to accelerating progress toward pay-for-performance measures. These payments could allow a state to develop a baseline for performance measures they have not historically tracked or hire new staff necessary to get an initiative off the ground and running. For example, pay-for-reporting may also be a useful tool to establish baseline performance in the early years of an SDP in priority areas, such as health equity measurement, where there may not be well-established baseline data. Delivery system reform collaborators, including states, plans, and providers have the shared goal of improving value and providing better quality healthcare for our patients and beneficiaries, and no one believes that it can be done with pay-for-reporting metrics alone. However, we believe they are an important tool that can serve as a catalyst to achieve our broader goals.

In addition, we support CMS' proposal to allow states to recoup excess funds from health plans that are allocated for SDPs but not ultimately paid out to providers as intended. This can occur specifically with VBP, delivery system reform or performance improvement initiatives if providers fail to achieve performance targets. These changes would remove possible perverse incentives whereby health plans could profit by retaining unspent funds that were intended to be paid to providers.

In Lieu of Service and Settings

CMS proposes several changes that are intended to provide clarity, protect beneficiaries and ensure that in lieu of services (ILOS) policies are fiscally responsible. The proposed rule limits ILOS to be a service or setting that would be allowed under a state plan or 1915(c) waiver authority. The proposed rule also would limit ILOS spending to a portion of the total managed care costs, although it would exclude certain institutions for mental disease services from this calculation. The rule would require states to provide support for their determination that each ILOS is medically appropriate and a cost-effective substitute for a covered state plan service or setting. The rule would streamline documentation requirements for states with a projected ILOS cost percentage that is less than or equal to 1.5% of capitation payments and require additional reporting for states that exceed this benchmark. The rule also would require that states provide an annual report of the actual cost of delivering ILOS. Overall, the rule both broadens the circumstances in which ILOS can be covered by managed care plans and establishes guardrails for this authority.

The IHA supports these policies. ILOS are an important authority for tailoring coverage and benefits to the needs of a population. Some states are using these policies to provide health-related social needs for Medicaid beneficiaries, including providing short-term housing or medically tailored meals as part of a comprehensive care plan for Medicaid beneficiaries. As such, ILOS policies are an important tool to achieve our shared goal of improved community health outcomes.

The IHA also supports CMS' proposal related to the treatment of short-term institutions for mental disease (IMO) stays. CMS proposes to exclude the cost of short-term IMO stays from the calculation of the ILOS cost percentage. This policy would lessen barriers for states to provide IMO coverage for those in need of these services and, in doing so, increase access to quality behavioral healthcare.

We appreciate your consideration of these issues. If you have any questions or wish to discuss these comments, please contact Joe Holler, Vice President of Healthcare Finance, at jholler@team-iha.org or 217-541-1189.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association