June/July XX, 2023

The Honorable Chiquita Brooks-LaSure

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attn: CMS-2439-P

P.O. Box 8016

Baltimore, MD 21244-8016

*Submitted electronically via* [*http://www.regulations.gov*](http://www.regulations.gov)

Dear Administrator Brooks-LaSure:

On behalf of [hospital/health system name] and the patients we serve, we write to urge you to withdraw several proposals in the proposed rule **CMS-2439-P Medicaid Program:** **Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality** that would be damaging to patient access and the health care safety net across the state of Texas.

[Insert information about your hospital: Bed size, type, percentage of Medicaid and uninsured, essential services provided to Medicaid clients].

State Directed Payments (SDPs) have been a crucial funding source for our hospital/system, especially after the state’s Delivery System Reform Incentive Payment (DSRIP) program was discontinued in 2021. Existing and new SDPs were essential for hospitals to transition from DSRIP and, at the same time, weather the financial stress the COVID-19 pandemic placed on the hospital industry. The growth of SDPs has enabled us to continue providing comprehensive access to critical health care services to Medicaid enrollees during the public health emergency when our state’s Medicaid enrollment grew to nearly 6 million individuals.

We believe CMS’s proposals to restrict nonfederal share financing and apply strict limits on aggregate SDP expenditures are incompatible with CMS’s stated goal of preserving access to care for Medicaid managed care enrollees. [Insert detail about what your hospital and community would lose if directed payments were reduced or eliminated – reductions or terminations in service lines, scale back plans for growth, closures, anticipated negative effects on access and outcomes, etc.] Ultimately, these proposals could deal a fatal blow to the Texas health care safety net if adopted.

We urge CMS to abandon three proposals made in this rule:

1. **Setting aggregate total payment limits in SDPs at either the Medicare rate, the average commercial rate only in value-based payment arrangements, or at a set percentage between 10-25% of total state Medicaid expenditures.** These measures would dramatically cut current program payments and reduce or eliminate existing opportunities to earn payments benchmarked to the average commercial rate, a population that reflects our state’s Medicaid population more closely than Medicare. These proposals also disproportionately punish states like Texas with low Medicaid base rates, who rely more heavily on supplemental payment programs to make up larger gaps in state funding. In Texas, base payments cover just 72% of inpatient and 75% of outpatient hospital costs on average. Under the strictest of caps CMS proposes, Texas hospitals could lose up to $5 billion annually in Medicaid SDP payments that bring low base reimbursements closer to cost.
2. **Allowing CMS discretion to withhold or retroactively deny SDP approvals based on nonfederal share financing objections that overstep the plain language of statute, and requiring providers who participate in SDPs to attest to anything beyond an affirmation that they are following federal law and regulation.** The financing provisions of the proposed rule are the latest in a series of actions CMS has taken to embed into SDPs financing constraints like those proposed in the withdrawn Medicaid Fiscal Accountability Regulation (MFAR). These proposals apply a faulty, overly broad interpretation of impermissible hold harmless arrangements in federal provider tax law and restrict Medicaid financing that is plainly permissible. As with MFAR, we believe these proposals leave a wide-open door for CMS to interrupt enormous sums of Medicaid payments based on unsupported objections. The consequences to Texas hospitals would be steep. Operating margins would decrease for SDP participants, Medicaid services would be reduced or eliminated, and many hospitals would be faced with closure. Low-income Texans would bear the ultimate cost of this misguided proposal, with dramatically reduced access to care.
3. **Routing all appeals of SDP denials based on financing or other concerns to federal administrative bodies, potentially creating untimely delays and interruptions in SDPs and limiting states’ access to courts for dispute resolution.** From August 2021 to March 2022, Texas hospitals already experienced the pain of a major lapse in SDP payments due to CMS withholding approval of programs. CMS withheld three program approvals for seven months based on an objection to Texas’ financing that was unsupported by statute or regulation. Texas hospitals lost $7 million per day for each day the delay persisted, and many were pushed to the brink. Further losses were only averted by a federal court compelling CMS to act after it described CMS’s objections as “distanced” from the text of the governing statute. Providers caught in the middle of extended SDP approval disputes are forced to either accept possibly indefinite risk of not receiving payments covering costs of care to their low-income patients, or simply withdraw from full participation in the Medicaid program. The effect to provider networks and safety net access would be devastating if the dispute resolution process CMS established leads to untimely resolutions by limiting states’ access to courts.

We appreciate CMS’s consideration of these grave concerns. We are committed, as are all Texas hospitals, to protecting our role in sustaining a high-quality health care safety net. These proposals are not consistent with CMS’s goals to preserve access, and we encourage CMS not to move forward with actions that would decimate hospitals’ ability to continue providing comprehensive care for low-income Texans.

Sincerely,

[Name

Title

Hospital/Health System Name]