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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

Re: CMS-2439-P, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

Dear Administrator Brooks-LaSure:

On behalf of our more than 450 member hospitals and health systems, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for Medicaid and CHIP managed care access, finance, and quality.

Texas hospitals share CMS's goal of preserving access for Medicaid managed care enrollees across a complete continuum of care. While certain proposals made within this rule serve that goal, we identify numerous others that undermine CMS's stated aim of maintaining services, supports, and networks for Medicaid enrollees that are comparable to those available to enrollees with other forms of coverage. Specifically, CMS's proposed limitations on state directed payment programs (SDPs), including aggregate payment amounts and how such payments may be financed, threaten to retrench the health care safety net in Texas into an inadequate state.

We offer comment on the following proposals concerning State Directed Payments (42 CFR 438.6, 438.7, 430.3):

A. Standard for Total Payment Rates for Each SDP, Establishment of Payment Rate Limitations for Certain SDPs and Expenditure Limit for All SDPs
B. Financing
C. Tie to Utilization and Delivery of Services for Fee Schedule Arrangements
D. Value-Based Payments and Delivery System Reform Initiatives
E. Appeals
F. Reporting Requirements to Support Oversight
G. Non-network Providers

Background

SDPs have been a crucial funding source for Texas hospitals, 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.

Currently, Texas operates a suite of five SDPs, four of which pay hospitals, hospital-affiliated provider groups, or hospital-owned facilities like nursing facilities and rural health clinics. Texas hospitals rely on SDPs to make up for low

Medicaid base rates. In Texas, these base rates only cover 72% of inpatient and 75% of outpatient hospital costs on average.[1]

Texas hospitals wholly agree with CMS that SDPs ought to facilitate access to excellent care under a managed care model that operates with integrity and transparency. Over 95% of Texas' 5.5 million Medicaid enrollees are managed care beneficiaries.[2] Texas has made many efforts to operate a fiscally sound Medicaid managed care program that ensures access and quality while appropriately stewarding the taxpayer funds that support it. Recent efforts include numerous expansions of managed care services and the establishment of the Local Funds Monitoring Program to monitor the nonfederal share funds of Medicaid payments provided by local governments.[3] The state has phased in a multifaceted monitoring plan that includes surveying, public reporting, and evaluation of local funds for compliance, permissibility, and risk. This includes a process to seek assistance from CMS on determining permissibility of any funds.

In this proposed rule, CMS solicits comment on proposals that seek balance between rapid program growth and continued sufficiency of payments to safety net providers. Several of CMS's ideas offer reasonable guardrails and flexibility for states, plans, and providers. However, certain payment and financing limitations would severely undermine the role SDPs occupy for advancing the goals of Texas' Medicaid program. We especially believe CMS's proposals to restrict nonfederal share financing and apply strict limits on aggregate expenditures are not reasonable program integrity measures or workable fiscal guardrails. They are incompatible with CMS's stated goal of preserving access to care for Medicaid managed care enrollees and upholding the legal requirement for states to ensure adequate covered services and networks. Ultimately, these proposals could deal a fatal blow to the Texas health care safety net if adopted.

A. Standard for Total Payment Rates for Each SDP, Establishment of Payment Rate Limitations for Certain SDPs and Expenditure Limit for All SDPs

Recommendation: THA believes a total payment limit tied to 100% of the average commercial rate (ACR) is reasonable and supports ACR and Medicare payment limit flexibilities offered to states. However, we urge CMS to discard alternatives that would cap SDP total payment limits to benchmarks below ACR, such as Medicare. THA urges CMS to avoid overcorrecting for growth in SDP spending that may be attributable to inflated Medicaid caseloads during the federal public health emergency (PHE).

CMS contemplates certain limits on total provider payments under SDPs in response to rapid program growth, citing lack of a regulatory payment ceiling as an oversight concern. These proposals would privilege SDPs that tie total payments to Medicare rates by waiving the need for prior approval of a preprint, and would establish the ACR as the upper payment limit for SDPs for inpatient and outpatient hospital services, nursing facility services, and academic medical center services. CMS also solicits comment on alternative, stricter limits it would be willing to consider if the aforementioned limits did not sufficiently rein in growth of payments financed largely by provider taxes, including reducing the upper payment limit to Medicare rates, offering ACR components only for value-based purchasing (VBP) arrangements, and an aggregate expenditure cap.

Texas' Medicaid population does not closely resemble a Medicare population. Roughly eight in 10 Medicaid enrollees in Texas are children, pregnant women, or low-income parents and caretakers, while just two in 10 are aged and disabled.[4] Average commercial rates are a better benchmark to establish reasonable payments than Medicare rates for the same state plan services. For this reason, the ability to operate an ACR component in SDPs is essential to ensuring payment amounts are sufficient to bring providers' reimbursements closer to cost. We appreciate and agree with CMS

[1] Texas Health and Human Services Commission. (2023). 2024-2025 PFD Hospitals Rate Tables. https://pfd.hhs.texas.gov/sites/rad/files/documents/hospital-svcs/2024/2024-2025-pfd-hosp-rate-table.pdf
[2] Texas Health and Human Services Commission. (2022 Dec.). 1115 Waiver Texas Healthcare Transformation and Quality Improvement Program Monitoring Report. https://www.hhs.texas.gov/sites/default/files/documents/2022-q4-1115-report.pdf
[3] Texas Health and Human Services Commission. (2023). Local funds monitoring. https://pfd.hhs.texas.gov/local-funds-monitoring
[4] Texas Health and Human Services Commission. (2022). Texas Medicaid and CHIP Reference Guide, Fourteenth Ed. https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf

acknowledging misalignment of Medicare and Medicaid populations as a limitation of its proposals. THA opposes CMS revoking the opportunity to earn up to the ACR in some form.

Most hospitals enrolled as Texas Medicaid providers currently participate in the Comprehensive Hospital Increase Reimbursement Program (CHIRP), an SDP that contains a required Medicare upper payment limit (UPL) and a voluntary ACR component.[5] For hospitals to earn payment up to 90% of ACR they must participate in more extensive quality reporting activities, furthering the state's ability to measure system-wide progress toward quality goals. Nearly all CHIRP-participating hospitals opt in to the ACR component and take on the additional administrative burden to do so, indicating how essential hospitals regard the opportunity to earn up to a portion of ACR.

We note that Texas' SDPs are not fixed pools. As a feature of risk-based capitation, total payments to managed care organizations (MCOs) fluctuate based on caseload. Payments that reach providers depend on enrollees' utilization. CMS's observations about SDP expenditure growth from 2016 to 2022 inlcudes a period in which Texas' Medicaid caseload grew from 3.9 million to nearly 6 million individuals due to the continuous coverage provisions of the federal public health emergency.[2,6] We are concerned that CMS's stricter alternative proposals may be overcorrecting for a growth trend driven by abnormally high caseloads during the PHE. We are also concerned CMS may be overlooking that even when SDP sizes increased due to high caseloads, net payments reaching providers did not approach the total value of the ACR because of aberrant low utilization during the PHE.

We find reasonable and support CMS's proposal to cap total payment rates at 100% of ACR and making a preprint exemption available for states that want to tie their SDPs to 100% of the Medicare minimum fee schedule. **We do not find reasonable** CMS's proposed alternative limits. We urge CMS to discard its proposals to set:

(1) **A total payment limit in SDPs at the Medicare rate.** This measure would be devastating to hospitals that currently participate in Texas' SDPs. It would reduce the size of CHIRP by approximately one-third, and eliminate an opportunity for hospitals to earn payments benchmarked to a like-population that reasonably reflects their costs of care.

(2) **A total payment limit up to the ACR available in value-based arrangements only.** Earning ACR payments solely on quality-based models does not offer enough flexibility to states establishing new programs or moving gradually toward paying for quality in existing programs without threatening the total dollar value available. It forecloses on hybrid value-based and utilization-based models that could be more appropriate for states with legitimate concerns about tying 100% of SDP payments to value-based care.

(3) **An aggregate payment limit capping total SDP payments at between 10-25% of total state Medicaid costs**. This proposal disproportionately punishes states like Texas with low Medicaid base rates, that rely more heavily on supplemental payment programs to make up larger gaps in state funding. Aggregate cap scenarios in this range all threaten to decimate the hospital safety net in Texas, potentially reducing annual payments by as much as $5 billion. It is unwise for CMS to set an artificial limit that withdraws resources and flexibility from states whose SDPs are large because Medicaid base rates are augmented infrequently and inadequately.

If CMS is considering an aggregate cap at 10%-25% of total Medicaid costs, we estimate the lower 10% limit of Texas' SDP expenditures could not exceed $3.1 billion-$3.8 billion and the higher 25% limit could not exceed $7.9 billion-$9.5 billion. These estimates are based on prior year SDP approvals, proposed SFY 2024 SDP amounts, and current and budgeted state Medicaid expenditures. The lower 10% limit appears

[5] Texas has never proposed a total CHIRP payment rate above 100% of the ACR, and with CMS approval has capped its hospital SDP at 90% of ACR to ensure payments would not unknowingly exceed the ACR.
[6] Texas Health and Human Services Commission. (2023). Presentation to the House Select Committee on Health Care Reform. https://www.hhs.texas.gov/sites/default/files/documents/presentation-health-care-reform-march-2023.pdf

completely unworkable. It is doubtful Texas could even operate a standalone Medicare UPL component of its CHIRP program, valued at $4.1 billion in the state's preprint for SFY 2024. This is a payment rate structure CMS considers reasonable elsewhere in the rule. At the upper 25% limit Texas likely still would not have adequate room to operate its current suite of five SDPs, which are proposed at $8.1 billion total for SFY 2024. Further, Texas would not retain adequate flexibility to enhance existing programs or add new programs to address future needs without the state having to pick "winners" and "losers" in the safety net.

CMS's preamble states that "utilizing the ACR in a managed care delivery system is appropriate and acknowledges the market dynamics at play to ensure that managed care plans can build provider networks that are comparable to the provider networks in commercial health insurance and ensure access to care for managed care enrollees." Therefore, we question why these alternatives are being considered beyond a desire to artificially limit the federal government's expenditures on SDPs.

We strongly caution CMS to avoid throttling SDPs below ACR based on an overriding desire to limit expenditure growth, even as CMS plainly states ACR is an appropriate basis of payment. At a time when Medicaid caseloads and utilization have not yet normalized, such extreme corrections are not necessary. We urge CMS to allow more time for the PHE unwinding to complete, then re-evaluate the size and growth of SDPs de-linked from underlying PHE-related factors before discussing stricter limits.

B. Financing

Recommendation: THA urges CMS to abandon its proposals to withhold or retroactively deny approvals of SDPs based on nonfederal share financing objections that overstep the plain language of statute. We oppose CMS's proposed use of attestations as a tool to enforce its faulty interpretation of the hold harmless prohibition, and oppose requiring providers to attest to anything beyond an affirmation that they are following federal law and regulation.

CMS discusses a historic trend of states growing their use of provider taxes and intergovernmental transfers (IGTs) instead of state general revenues to fund the nonfederal share of Medicaid payments. While federal law and regulation regard these as equally permissible sources of nonfederal share financing, CMS expresses an oversight concern that states presently have too strong an incentive to rely on funds other than state general revenue to finance payments. Further, CMS asserts its recent belief that impermissible hold harmless arrangements are occurring in provider tax programs that fund SDPs, a practice that would serve as basis for withholding federal matching funds.

While CMS fails to reference in the preamble to this proposed rule either its withdrawn Medicaid Fiscal Accountability Regulation (MFAR) or its Feb. 17, 2023, Informational Bulletin promulgated as subregulatory guidance to states, it reiterates the concepts and interpretations promulgated in MFAR and the Informational Bulletin, at times verbatim. Furthermore, the preamble reiterates statements CMS specifically made to justify withholding approval of Texas' SDPs based on concerns with nonfederal share financing in past negotiations[7] and legal proceedings.[8] We view this proposed rule as the latest in a series of actions CMS has taken to embed MFAR-like constraints into SDPs and restrict financing that is plainly permissible.

Although this rule is written to apply to all states, it appears targeted at Texas and would foreclose on specific solutions offered by Texas in negotiations on three SFY 2022 SDPs for which CMS withheld approval for seven months. During this period, hospitals experienced a lapse in payments of $7 million per day. The delay was perpetuated by CMS maintaining a position on Texas' financing that was unsupported by statute or regulation. Further

[7] Texas Health and Human Services Commission. (2022 Mar 11). Texas & CMS Meeting. Discussion: State Directed Payment Preprint Modifications. https://www.hhs.texas.gov/sites/default/files/documents/cms-feedback-with-state-response-march-2022.pdf
[8] Tex v. Brooks-LaSure, No. 6:21-cv-00191, 2022 WL 741065 (E.D. Tex. 2022).

losses were only averted by a federal court compelling CMS to act after it described CMS's interpretation as "distanced" from the text of the governing statute.[9]

Once again, CMS is asserting an overly broad interpretation of Social Security Act § 1903(w) and implementing regulations at 42 CFR § 433.68(f)(3) by declaring impermissible arrangements between private providers who pay a health care related tax where the state or other unit of government imposing the tax is not a party. Current federal Medicaid law and regulation does not prohibit private hospitals from making payments to each other to mitigate the impact of a provider tax on one of the hospitals. Units of government that are not aware or party to such private arrangements cannot be providing a direct or indirect guarantee that any provider will receive all or part of their tax back. **CMS remains wrong on the law, and oversteps its bounds by translating its faulty interpretation into supposed authority to take adverse action against SDPs, and potentially participating providers.**

We detail two concerns within this rule that arise based on CMS's erroneous policy position:

1. Attestations

First, CMS proposes to require states to collect attestations (directly or through an MCO) from each participating provider in an SDP that they do not participate in any hold harmless arrangement with respect to any health care related tax as specified in § 433.68(f)(3). States would be required to furnish these attestations to CMS upon request.

Here we revisit CMS and Texas' November 2021 - January 2022 discussion of attestations to explain our opposition to this proposal and raise questions about CMS's planned use of attestations as an enforcement tool.

The attestation proposal in this rule is a change from CMS's position in negotiations with Texas over withheld SDPs, where CMS offered attestations as a voluntary and minimally burdensome alternative to intrusive back-end examinations of financing.[10] Here, CMS is proposing to compel attestations from all providers in all SDPs in conjunction with a promise that "CMS will scrutinize the source of the non-Federal share of SDPs during the preprint review process."[11] CMS does not explain its change in position after previously offering attestations as voluntary and acknowledging there is no statutory attestation requirement.[12]

During 2021 SDP negotiations Texas attested on behalf of participating providers as follows:

> *"Texas attests that all units of government and the hospitals within their jurisdictions are in compliance with 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f). Texas attests the units of local government imposing a mandatory payment (a.k.a. Local Provider Participation Fund (LPPF)) do not provide for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Texas attests that neither the state or any unit of local government within the state issue a payment directly or indirectly to any participating hospitals such that the hospital could compel an agreement from another hospital to transfer, redirect, and/or redistribute (including through pooling arrangements) payments supported by LPPF revenues."*

CMS rejected this attestation because:

[9] Tex v. Brooks-LaSure, No. 6:21-cv-00191, 2022 WL 741065 (E.D. Tex. 2022).
[10] Letter from Dan Tsai to Stephanie Stephens. (2021 Nov 15). https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-ltr-state-11152021.pdf
[11] 88 Fed. Reg. 28132
[12] Letter from Dan Tsai to Stephanie Stephens. (2021 Nov 15). https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-ltr-state-11152021.pdf

"…it does not attest that no arrangement exists, through written agreements or otherwise, which involves participating hospitals transferring, redirecting, and/or redistributing (including through pooling arrangements) their payments supported by the tax to other Medicaid providers, directly or indirectly."[13]

In short: Texas attested that the state, all local governments, and all hospitals in their jurisdictions are following federal law and regulation. CMS dismissed Texas' attestation by layering on its own faulty interpretation that impermissible hold harmless agreements extend to private providers, and would not accept any attestation that did not contain this extra, unsupported language. Texas hospitals disagree that CMS is within its authority under §1902(a)(4) to require providers to attest to anything beyond their full compliance with federal law. **Therefore, we oppose CMS's proposal as currently drafted, which includes a requirement for providers to attest they are not participating in arrangements that would be permissible under the plain language of statute and regulation.**

We further note that CMS has not clearly stated how it intends to use the mandatory attestations or where attestations fit into its broader promise to scrutinize financing during preprint review. Does CMS still envision attestations to reduce the burden of demonstrating compliance or are they a potential tool to enable enforcement actions aimed directly at attesting providers? What guardrails apply to CMS's use of attestations collected? If states, local governments, and providers demonstrated that no impermissible hold harmless arrangements existed through other means, would CMS still consider attestations necessary? These questions warrant clarification.

2. Withholding, Conditioning or Retroactively Denying SDP Approvals

Second, CMS proposes to withhold approval, condition approval, or retroactively deny prior written approval for SDPs if CMS determines that taxpayers enter into agreements to redistribute Medicaid payments so that taxpayers have a reasonable expectation that they will receive all or a portion of their tax cost back.

Federal provider tax law only gives CMS authority to reject local funds where a tax is not broad based, is not uniform, or where the unit of government holds a taxpayer harmless from the tax; the law does not authorize CMS to deny nonfederal share funds based upon the existence or non-existence of agreements exclusively between private entities. Such agreements are plainly permissible under current federal Medicaid law and regulation.

CMS's obligation to reduce federal financial participation (FFP) is only applicable when CMS has affirmatively found that a violation has occurred. Such reduction is subject to a defined administrative procedure.[14] Under current disallowance procedures, CMS must affirmatively determine that a claim or a portion of a claim is not allowable. Then CMS must inform the state of precise amounts of FFP claimed and disallowed and findings of fact supporting the disallowance (such as a report, financial review, or audit). For good reason, these are the high standards of proof to which CMS holds itself on recouping FFP already granted. What CMS may *not* do is deny FFP simply because it supposes that a portion of nonfederal share funds were likely impermissible based on private provider-to-provider agreements that could have existed.

Unlike a disallowance, these proposed rules grant CMS broad discretion to withhold or retroactively deny approval for entire programs based on "potential financing concerns." These concerns do not have to be supported with findings of fact during a preprint negotiation, and overstep the circumstances in which CMS has authority to withhold FFP. In the new regulations, CMS:

- Does not subject itself to a burden of proof in preprint review to withhold SDP approval based on financing concerns;

[13] Texas Health and Human Services Commission. (2022 Mar 11). Texas & CMS Meeting. Discussion: State Directed Payment Preprint Modifications. https://www.hhs.texas.gov/sites/default/files/documents/cms-feedback-with-state-response-march-2022.pdf
[14] 42 CFR §433.70; 42 CFR §430.42.

- Does not contend with the severe financial harm of disabling entire SDPs – including all financing CMS deems permissible – based on presuming that an unspecified portion of impermissible financing could exist;
- Does not explain in what circumstances CMS would issue a disallowance of certain funds versus a retroactive denial of an entire program;
- Could cite unsubstantiated concerns to override states' concrete evidence (including provider attestations) that funds are permissible and the law has been followed, as it has done to Texas in the past.[15] This potentially includes alleging hold harmless agreements that CMS cannot possibly prove, nor can states falsify, such as an "implicit meeting of the minds"[16] and;
- Does not limit itself to a time period in which it may apply retroactive SDP denials if a state has historically used a method of finance that CMS later finds to be a concern.

The lack of front-end guardrails for any of these shortcomings during the preprint review phase appears to leave the proposed Departmental Appeals Board (DAB) or Office of Hearings and Inquiries (OHI) appeal process as CMS's only proposed administrative recourse for states and providers. A DAB or OHI appeal is time consuming and could only occur after a program denial is issued.

We believe these proposals leave a wide-open door for CMS to interrupt enormous sums of provider payments based on unsubstantiated presumptions and a faulty, overly broad interpretation of hold harmless arrangements. It will enable retroactive clawbacks of Medicaid payments – potentially tens of billions of dollars in Texas alone – financed by longstanding, CMS-approved mechanisms that CMS may call into question with or without findings of fact. None of these can be a basis for withholding FFP, or withholding approval of otherwise acceptable SDPs.

CMS appears not to have modeled the impact it expects this financing change to have on Medicaid enrollees' access, and which populations would disproportionately bear its impact. Based on a recent analysis, THA estimates that loss of SDPs would[17]:

- Reduce participating hospitals' average adjusted margins by 4%, and drive participants' average adjusted margins into negative territory;
- Result in operating losses for SDP-participating hospitals of all classes;
- Decrease already-negative adjusted margins in small, rural, and critical access hospitals by an additional 1%-2%; and
- Reduce children's hospitals' adjusted patient margins by the greatest magnitude, approximately 11%.
- Reduce critical service lines. In key informant interviews for this analysis, Texas hospitals identified service reduction options to respond to loss of directed payment programs, as existing operations could not continue. Pediatric, OB-GYN, and behavioral health services were commonly cited as service lines that hospitals would likely reduce or eliminate as they are currently supported by a high portion of Medicaid enrollees. Research, education, and outreach efforts would also be negatively impacted.

CMS's proposal is therefore incompatible with the agency's stated goal of preserving equitable access to care for Medicaid managed care enrollees, and for enabling states to uphold their legal requirement to ensure adequate covered services and networks. Medicaid funding issues are a primary driver of the precipitous rise in hospital closures, increased maternal health deserts, and cuts to crucial health services. These hospital cuts directly affect critical access to health care for some of the most vulnerable and underserved Texans, who depend on – and are entitled to – this

[15] CMS took this approach in Texas in 2021 when it was unmoved by Texas' description of actions it took to ensure the attestation the state supplied was accurate, and efforts of its Local Funds Monitoring program to establish permissibility of funds. Texas Health and Human Services Commission. (2022 Mar 11). Texas & CMS Meeting. Discussion: State Directed Payment Preprint Modifications. https://www.hhs.texas.gov/sites/default/files/documents/cms-feedback-with-state-response-march-2022.pdf

[16] Centers for Medicare and Medicaid Services. (2023 Feb 17). CMCS Informational Bulletin: Health-care related taxes and hold harmless arrangements involving the redistribution of Medicaid payments. https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf

[17] Results of analysis performed by Dobson DaVanzo & Associates, LLC. (2022). Commissioned by the Texas Hospital Association.

access to care. When CMS considers the net effect of proposed financing policy changes, CMS must consider not only the financial impact, but also the access impact for more than 5 million Texans.

CMS, Texas, and Medicaid providers all share a key role in upholding Medicaid program integrity, but this proposal as drafted is not a reasonable guardrail that serves a program integrity goal. **This is a solution in search of a problem that would decimate the health care safety net, and we urge CMS in the strongest possible terms to abandon it.**

C. *Tie to Utilization and Delivery of Services for Fee Schedule Arrangements*

Recommendation: We encourage CMS not to adopt its proposal to prohibit states from performing post-payment reconciliations to actual utilization in SDPs.

CMS identifies a concern with SDP arrangements it has historically approved that allow for interim payments based on historical data and final payments based on states later conducting a reconciliation to actual utilization in the rating period. CMS proposes a new §438.6(c)(2)(vii)(B) that would prohibit states from continuing to use this practice. CMS believes this prohibition is needed to ensure participants bear appropriate risk.

Interim payments based on historical utilization provide more predictability for providers. This structure mitigates cash flow instability that can result from MCO payment and claim adjudication delays. CMS suggests in its proposal that states are using reconciliations to remove risk from certain providers; however, providers in such arrangements are bearing risk because they may experience recoupments or receive additional funds based upon historical-to-actual utilization fluctuations. MCOs will also experience downward or upward risk as their capitated payments based on historical utilization will vary as utilization varies or if the recoupments and redistributions are significant enough to lose actuarial soundness.

CMS has not provided a justification that states should not be able to do a post-payment reconciliation to ensure providers who participate in an SDP are receiving what they should be receiving. We encourage CMS not to move forward with this proposal and consider state SDP proposals that include reconciliations on a case-by-case basis.

D. *Value-Based Payments and Delivery System Reform Initiatives*

Recommendation: We encourage CMS to allow for time-limited periods of payment for reporting in VBP directed payments. We recommend CMS consider allowing states to apply differential standards for earning payment in circumstances when a high-performing provider has failed to improve over self in a single program year, such as requiring a multi-year trend of absolute and relative performance decline to occur before failing to reward a high-performing provider.

CMS proposes to codify its interpretation of policy that SDPs structured as value-based payments (VBPs) cannot be based on pay-for-reporting as the act of reporting is not a covered service. Reporting can be a condition of participation but reporting alone, without a tie to utilization, would not be an acceptable basis for payment.

We appreciate CMS's clarification of its intent not to create obstacles for states trying to implement VBP initiatives. It is possible that prohibiting pay-for-reporting arrangements in regulation could potentially deter states that wish to establish new value-based payment SDPs or transition more mature SDPs into a value-based arrangement. There can be value in a brief period of payment for reporting upon the launch of new programs or introduction of new measures, especially when the long-term intent exists to have providers bear full risk on performance.

Under the right circumstances, a payment for quality arrangement can be an ideal way to ensure providers have certainty about what is available to them in SDPs if they meet targets. In programs paid as uniform rate increases per claim, by contrast, abnormal patterns of enrollment and utilization drive payments available to providers more

significantly than health outcomes. The appeal of structures that de-emphasize volume is diminished without a glidepath to performance-based payments that includes payment for reporting. States need to continue to have flexibility to assess the validity of measures before they are tied completely to performance, and providers could be incented to better emphasize the pay-for-performance component they know is coming. This is not incompatible with maintaining a tie to utilization by paying on reporting for a quality outcome for a covered service used by a Medicaid enrollee. **We encourage CMS to broaden its interpretation and allow for time-limited periods of payment for reporting in VBP directed payments.**

CMS also notes an oversight concern that current VBP directed payments, including one in Texas, have rewarded providers whose performance individually declines year over year. This raises the question of whether maintaining high performance over an external baseline – such as a national or state average – ought to be considered a valid basis of payment even when a provider does not improve over self. While we understand CMS's policy preference not to reward providers whose performance individually declines, we believe in certain cases performance decline if a provider always remains high performing can and should be regarded differently than a performance decline among average or low-performing providers. **We recommend CMS consider allowing states to apply differential standards for earning payment in circumstances when a high-performing provider has failed to improve over self in a single program year.** This could include requiring a multi-year trend of absolute and relative performance decline to occur before failing to reward a high-performing provider. Achievement and maintenance of high performance reflects a provider's investment of effort and resources into those outcomes, and we believe there are reasonable ways not to overcorrect for fluctuations when data support the provider's overall high achievement.

E. Appeals

Recommendation: We urge CMS not to finalize its proposal to route all appeals of SDP denials to the DAB or OHI, potentially creating untimely delays and limiting states' access to courts for dispute resolution.

CMS proposes to begin issuing formal written denials of unapprovable SDPs for reasons including but not limited to impermissible financing. For consistency with other written denials, it proposes to establish an appeal process for states by which DAB or OHI would hear disputes over disapproved SDPs. CMS estimates the DAB process would take six to nine months; the OHI process may take a year or more. CMS argues neither would prevent states from seeking redress in courts, but both carry the advantage of being familiar to states and less time consuming than court action.

THA appreciates CMS recognizing that SDP approval interruptions have significant adverse impacts on states' managed care programs, and that a defined process can facilitate resolution of such disputes. However, THA has significant concerns regarding CMS's proposal that appeals be heard by the DAB or OHI. There are several reasons that a DAB or OHI appeal may be inappropriate for this purpose.

1. The current rules do not state that a denial of a preprint must be appealed to DAB or OHI. CMS does not address that the current language of the rule setting apart SDPs from processes used for other denials may be intentional. The preprint is not a part of the state plan and therefore the same appeal process should not necessarily apply.
2. DAB decisions are not always timely, regardless of CMS's goal that DAB would resolve a dispute within six to nine months. DAB has numerous mechanisms to draw out the review process with undetermined timings, such as additional requests for information. This would allow CMS to continue rehashing policy disputes with states regarding nonfederal share financing on which there are well-documented fundamental disagreements. CMS could continue attempts to impose unsupported, MFAR-like demands on states' preprint applications under threat of complete collapse of the state's health care safety net, which CMS has shown itself willing to do in past disputes over SDP approvals in Texas.

Insofar as a DAB or OHI process precludes access to courts if a state has not first exhausted administrative options to appeal its denial, we object to CMS's proposal and urge CMS not to finalize it. While the preamble offers that states could still seek redress in courts, it is likely that not seeking an administrative appeal first would limit states' ability to use this remedy. We do not agree with CMS that a DAB or OHI appeal would be any more efficient than court action. In fact, limiting court action is antithetical to due process and swift resolution of disputes. States should maintain the ability to appeal directly to district court where the state believes CMS has violated the terms of a contract with the state and/or is acting arbitrary and capricious.

We remind CMS that 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 process CMS established leads to untimely resolution of disputes. Medicaid enrollees, ultimately, are the ones who pay the price for that shortcoming.

F. Reporting Requirements to Support Oversight

Recommendation**: **We support CMS's proposal to require MCOs to report separately their SDP expenditures – specifically provider payments – on MLR reports, and for states to report this data to CMS.

CMS is concerned that no reporting requirements exist to assess any differences between SDP payments estimated at time of preprint submission and actual payments during the program year. This concern applies to payments made to MCOs from the state, and in turn, actual payments MCOs made to providers.

We agree it is important to establish a method for CMS and states to obtain this information and ensure providers, states, CMS, and other oversight bodies have complete transparency into the flow of funds through SDPs. There is often an assumption that the entire dollar value of an SDP reaches providers (less the taxes and fees MCOs withhold); Texas hospitals know and have experienced firsthand that in a utilization-dependent risk-based arrangement, that is not necessarily true.

Currently Texas makes no information available on the amount of SDP funds that reach providers because the necessary reporting does not exist. Texas currently includes no terms in its managed care contracts that require Medicaid MCOs to identify and separate on a claim remit the portion of the payment that is attributable to the base payment versus the SDP increase. Texas' MCOs similarly do not separate out the base payments from the SDP payments on Financial Statistical Reports they submit to the state. This not only creates heavy administrative burden for providers to verify their payments, it is difficult for the state to know what portion of aggregate program funds are being disbursed as payments for care.

We support CMS's proposal to require MCOs to report separately their SDP expenditures – specifically provider payments – on MLR reports, and for states to report this data to CMS. We believe this proposal would force positive movement toward provider-level and plan-level transparency in SDP payments.

G. Non-network Providers

Recommendation: We ask CMS to consider a modified version of its non-network proposal with guardrails to protect network adequacy and ensure local or state financed SDP funding is retained as much as possible within the locality or state that supplied it.

CMS proposes to remove the term "network" from the description of providers who may be paid from an SDP, permitting SDPs to be used for non-network providers. Under current regulations, providers must be "network

providers" to benefit from an SDP fee schedule arrangement. CMS solicits comment on potential negative unintended consequences.

We believe this proposal could provide useful flexibility to Texas hospitals by allowing them to make decisions about their participation in an MCO network without the threat of losing payment enhancements provided by SDPs. Some hospitals find this is a leverage point used in contract negotiations with MCOs, who are conscious that Medicaid providers cannot access SDP payments if they remain out of network and lean on providers to accept lower base rates. However, we are conscious that this may create disincentives for providers to remain in managed care networks, and could erode network adequacy if such incentives were too strong. We encourage CMS to explore other iterations of this proposal that would mitigate such disincentives, and give MCOs time to adjust for network fluctuations before moving ahead.

While some Texas hospitals may also benefit from this arrangement if they (1) provide highly specialized care to patients who travel across state lines, or (2) provide the nearest site of care to out-of-state residents living close to state lines, this benefit may be outweighed by concerns that local funds used to support SDPs in Texas would ultimately flow outside the state or locality that supplied the financing. Without a financial model, it is difficult to ascertain the net direction SDP dollars would flow into and out of states, and we encourage CMS to perform a quantitative analysis to this effect before moving ahead. Regardless, any benefit to one state comes at the expense of another. We suggest to CMS that one possible way to address this potential outcome would be to limit the non-network provision to non-network providers within a state.

Thank you for the opportunity to comment. Should you have any questions, please contact John Hawkins at jhawkins@tha.org.

Respectfully submitted,

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