July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Via electronic submission

RE: CMS–2439–P; Medicaid Program: Medicaid and Children' Health Insurance Program Managed Care Access, Finance, and Quality

Administrator Brooks-LaSure:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities – and their more than 45,000 employees – as they strive to provide health care and community services for all Arkansans. On behalf of our member hospitals, I appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed rule update (CMS-2439-P) to the Medicaid and Children's Health Insurance Program (CHIP). We commend CMS for its dedication to advancing access, finance, and quality in the Medicaid and CHIP managed care programs. As enhancements are made, it is critical that implementing these well-intended policies does not undercut beneficiaries' access to care or further diminish financial resources for our member hospitals and other health care providers.

The Medicaid program plays a critical role in granting vital access to health care services for the people of Arkansas. As of May 2023, 1.066 million Arkansans, representing more than one-third of the state's population, rely on health insurance benefits provided

through the State's Medicaid program. This total includes 307,510 adults and 446,171 children who receive benefits through traditional fee-for-service Medicaid coverage; 312,860 beneficiaries who receive coverage through the Arkansas Health and Opportunity for Me (ARHOME) Medicaid Expansion program; and an additional 55,000 Arkansans with complex behavioral health, developmental, or intellectual disabilities who are covered via managed care, known as the Provider-Led Arkansas Shared Savings Entity (PASSE) program.

As is true for most states, Medicaid has historically reimbursed hospitals at significantly lower rates than the cost of providing care. In fact, Arkansas Medicaid rates for fee-for-service inpatient hospital care have not increased since 2007. Arkansas Medicaid rates for outpatient hospital services last changed in 1992, and that rate was a decrease. Those rates have fallen far below the excess costs of labor, supplies, drugs, and other expenses – all of which have been exacerbated by record-setting inflation.

Arkansas's managed-care PASSE program began March 1, 2019. While the state has continued to tweak the program to ensure that patients covered by the program are receiving the care they need in community settings, hospitals have struggled to ensure that reimbursement for hospital services covers the cost of care for these patients with complex needs.

State Directed Payments and Financing Restrictions

Each state operationalizes the Medicaid financing partnership between its federal and state share differently. Historically, CMS has recognized that individual states have variable abilities to pay their own state matching dollars with state revenue and has allowed providers to augment a state's share to draw down critical federal Medicaid payments. In Arkansas's fee-for-service programs, Arkansas hospitals have relied heavily on our supplemental payment program since 2009 to finance the non-federal share to make up a portion Arkansas's low Medicaid base rate. In the Medicaid managed care program, Arkansas has not yet implemented State Directed Payments (SDPs) for the population served through the PASSEs; however, many sister states rely on these types of CMS-approved financing methods to ensure that essential care is accessible to patients assigned to a managed care organization. Arkansas must be afforded the same opportunities to create a financing program that preserves access to care for Medicaid managed-care enrollees in this financial environment.

The proposed rule would grant CMS broad authority to withhold approval of SDPs. We would respectfully ask that the financing restrictions in this rule be withdrawn to allow for maximum flexibility to finance the non-federal share of the SDPs.

Network Adequacy, Performance Metrics, and Oversight

The AHA supports CMS in its efforts to fortify the network requirements for Medicaid managed care programs. Specifically, the AHA applauds measuring appointment wait times, conducting secret shopper surveys, and adding price transparency and payment rate comparison requirements designed to ensure adequate capacity and availability of services. While hospital emergency departments continually follow state and federal laws requiring hospitals to provide care for anyone who seeks it, regardless of their ability to pay, we recognize that an emergency department is not always the most efficient place for patients to receive routine care. Managed care organizations must bear responsibility for their enrollees who have no place to go but to an emergency department, especially if a physician office or outpatient setting could have provided the service to the patient in a more cost-efficient manner. Strengthening network adequacy standards and oversight of the standards can promote better health for managed care enrollees.

As CMS determines reporting requirements, it is imperative that those requirements strike the right balance between regulatory oversight and minimizing the administrative burdens placed upon health care organizations. Providers must be empowered to devote most of their resources to providing high-quality care to Medicaid beneficiaries.

Medical Loss Ratio Standards

The medical loss ratio (MLR) is an important tool used to ensure that sufficient resources are dedicated to patients' access to care and to hold health plans and managed care organizations accountable for how premium dollars are spent. Recognizing that there are legitimate administrative costs in patient case management, the purpose of the premium payment is to ensure that patients receive the care they need – not only to survive but also to have every opportunity to thrive.

We request that CMS take additional measures to safeguard Medicaid beneficiaries against the potential misappropriation of patient premiums, specifically when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that

inappropriately increase health system costs while increasing profit for the plan's parent company.

Conclusion
The AHA appreciates this opportunity to provide comments on the proposed rule update to the Medicaid and Children's Health Insurance Program. We commend CMS for its dedication to advancing access, finance, and quality in the managed care program. However, as we have expressed, we are concerned about policies that undermine access to financial resources, which are crucial for ensuring high-quality health care. There is a persistent shortfall in Medicaid payments to providers, posing a threat to patient access and provider sustainability. We urge CMS to take further measures to rectify this disparity and ensure fair compensation. Additionally, we support the strengthening of network requirements to improve beneficiary access to health care services and recommend revisiting reporting requirements to streamline administrative tasks. Finally, we emphasize the importance of the medical loss ratio (MLR) standard in proper allocation of premium funds and urge CMS to standardize MLRs across managed care plans to prevent undue profit generation. By addressing these issues, we can enhance access, fairness, and quality of care for Medicaid beneficiaries.

Thank you for your consideration of our comments and others submitted from the hospital community about these proposed changes.

Sincerely,

Bo Ryall
President and CEO
Arkansas Hospital Association

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