Federation of American Hospitals®

Charles N. Kahn III
President and CEO

June 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program; Ensuring Access to Medicaid Services [CMS-2442-P]

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule on the *Medicaid Program; Ensuring Access to Medicaid Services* (Proposed Rule) published in the Federal Register (88 *Fed. Reg.* 27,960) on May 3, 2023.

II.A. Medicaid Advisory Committee and Beneficiary Advisory Group (42 CFR § 431.12)

CMS proposes changes to the regulations requiring each state to establish a Medical Care Advisory Committee (MCAC). The proposed regulation would rename the committee—Medicaid Advisory Committee (MAC)—and expand its scope beyond just medical care to include, for example, policy development and the effective administration of the Medicaid

program. The proposal would also require a separate subgroup called the Beneficiary Advisory Group (BAG). The BAG would have to be comprised of current or former Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries (i.e., their family members and caregivers). The BAG would constitute 25 percent of the MAC membership but would also have its own separate meetings. **The FAH supports these changes, including the increased focus on beneficiary perspectives and feedback, as well as addressing services beyond medical care, such as for social drivers of health (SDOH) and health-related social needs (HRSN).**

CMS proposes that the remaining 75 percent of MAC membership must include representation from each of the following:

- State or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries;
- Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care, including providers or administrators of primary care, specialty care, and long-term care;
- Participating Medicaid managed care plans, or the state health plan association representing such plans, as applicable; and
- Other state agencies that serve Medicaid beneficiaries (e.g., a foster care agency, mental health agency, or health department) as ex-officio members.

Currently, representatives of hospitals, medical centers, and clinics may be included in a MAC, although the regulation does not list them specifically. Thus, while the proposed list of clinical providers and administrators is sensible, it is not clear that a MAC would have to include representation of hospitals, including inpatient rehabilitation, psychiatric, and long-term care hospitals. **The FAH requests that CMS specifically mention hospitals and related providers as part of MAC membership requirements.**

The MAC, in conjunction with the BAG, would address certain issues, including (i) additions and changes to services; (ii) coordination of care; (iii) quality of services; (iv) eligibility, enrollment, and renewal processes; (v) beneficiary and provider communications by the state Medicaid agency and Medicaid managed care plans; and (vi) cultural competency, language access, health equity, and disparities and biases in the Medicaid program. **The FAH supports the ability of the MAC and BAG to raise these broader issues, in order to improve beneficiary outcomes and processes of the state agency and managed care plans[1] to ensure adequate access to care.** This would include, for example, ensuring plans maintain in their provider networks an adequate supply of inpatient and outpatient hospital care, including services in inpatient rehabilitation, psychiatric, and long-term care hospitals. The membership of the MAC and BAG needs to reflect not only the providers but also the consumers of these services.

[1] "Managed care plan" refers to Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs).

II.C. Documentation of Access to Care and Service Payment Rates (42 CFR § 447.203)

Federal Medicaid law—in section 1902(a)(30)(A) of the Social Security Act (hereafter referred to as "1902(a)(30)(A)")—requires state Medicaid plans to:

> *"assure that [Medicaid] payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."*

The FAH believes many state Medicaid programs do not pay hospitals consistent with 1902(a)(30)(A). The FAH disagrees with the 5-4 ruling in the 2015 Supreme Court decision in *Armstrong v. Exceptional Child Center*, 135 S. Ct. 1378 (2015), that left healthcare providers and beneficiaries without a private right of action to bring suit against state Medicaid programs regarding inadequate payment rates under 1902(a)(30)(A). However, given that decision, healthcare providers and beneficiaries are left to seek relief through the CMS rather than through the courts. Thus, CMS is correct to note (88 *Fed. Reg.* 27,997) its unique responsibility to ensure and monitor compliance of states' Medicaid payments with respect to 1902(a)(30)(A).

Current regulations reflect CMS' prior attempt to oversee the adequacy of state Medicaid fee-for-service (FFS) payments and to monitor compliance under 1902(a)(30)(A) by requiring states to submit triennial Access Monitoring Review Plans (AMRPs). The lack of standardized requirements for AMRPs has led to confusion and high burdens on states, with inadequate insights provided to CMS for assessing healthcare access and the adequacy of Medicaid payments. The majority (62 percent) of hospitals receive payments from Medicaid that fail to cover their costs; on average, Medicaid payments cover only 88 percent of hospitals' spending on Medicaid beneficiaries.[2] **The FAH believes many states' Medicaid payments are inadequate, and CMS' oversight and enforcement based on 1902(a)(30)(A) needs to be strengthened to address these shortfalls.**

The proposal would generally replace AMRPs with "a more limited payment rate transparency requirement" (88 *Fed. Reg.* 28,067) on states to publish their FFS rates. States would have a separate requirement to publish every other year a comparison of payment rates between Medicare and Medicaid for certain services—primary care, obstetrical and gynecological (OB/GYN) and outpatient behavioral health services. **The FAH supports the requirement for states to provide periodic comparisons to Medicare regarding these specific services, particularly OB/GYN and outpatient behavioral health services. However, we note that Medicare rates might not always "serve as a reliable benchmark for a level of payment sufficient to enlist providers to furnish the relevant services to a beneficiary" (88 *Fed. Reg.* 28,003) for purposes of assessing the adequacy of Medicaid rates and associated access.** While such published comparisons between Medicaid and Medicare rates will be helpful, CMS acknowledges that comparable rates between Medicare and Medicaid may not generate the same access, due to other issues and program differences not related to payment. However, in those circumstances, it may mean that Medicaid payments above Medicare rates are required to

[2] American Hospital Association, "Underpayment by Medicare and Medicaid Fact Sheet" (February 2022), available at https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf.

ensure adequate access, given program and beneficiary differences. This is why the statute requires assessing payment adequacy on the basis of the outcome of beneficiaries' access to care. It may also be a reason why, in its proposed rule on access in Medicaid managed care (88 *Fed. Reg.* 28,092), CMS would permit state directed payments to yield payments to providers above Medicare rates, up to the average commercial rate (ACR).

In addition, the proposal would require a more detailed analysis from a state, along with a description of the state's procedures for monitoring continued compliance with section 1902(a)(30)(A), when the state proposes a provider rate reduction that does not satisfy any of the following:

- Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction would be no less than 80 percent of the most recently published Medicare payment rates for each affected benefit category.
- The proposed reduction, including the cumulative effect of all reductions taken throughout the current state fiscal year, would likely result in no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each affected benefit category.
- The current and proposed public processes yielded no significant access concerns from beneficiaries, providers, or other interested parties regarding the affected service(s)—or if such processes did yield concerns, the state can reasonably respond to or mitigate the concerns, as documented in its analysis.

The first two criteria—80 percent of Medicare and the 4 percent reduction limit—are based on Medicaid payment rates for each affected benefit category but "in the aggregate" (88 *Fed. Reg.* 28088). We interpret this to mean that some hospitals, for example, could obtain payments well under 80 percent of Medicare and the state could still obtain streamlined CMS review because the aggregate number could be at least 80 percent due to other hospitals' payments exceeding 80 percent of Medicare. If this interpretation is correct, these aggregate tests could obfuscate substantial variation and disparities in the effects of proposed cuts, which could threaten access and providers' financial viability. **In order for the state to merit streamlined review, the FAH recommends amending these proposed provisions so that no provider's payment would fall below the thresholds.**

The FAH generally supports replacing AMRPs with approaches that are less burdensome to states while also illuminating for CMS those instances where deficiencies in Medicaid payment rates and in beneficiaries' access to care are occurring. In such instances, CMS should take action. **The FAH opposes the proposal to fast-track CMS approval of states' proposals to cut their rates to as low as 80 percent of Medicare.** Such a proposal could lead to a "race to the bottom" by state Medicaid programs, devastate hospital finances, and represent an abrogation of CMS' purported recognition of "the importance of CMS' administrative review of Medicaid payment rates to ensure compliance with section 1902(a)(30)(A) of the Act. CMS' oversight role is particularly important when States propose to reduce provider payment rates …" (88 *Fed. Reg.* 28,025). While Medicaid rates that equal Medicare rates may not necessarily guarantee comparable access due to Medicare's ubiquity and other factors, Medicaid rates so far below Medicare rates are a cause for concern. **We recommend that proposed 42 CFR § 447.203(c)(1)(i) be amended to say "100 percent" rather than "80 percent".**

Another reason for our concern with the 80 percent standard is that CMS based it on information solely about physician payments (88 *Fed. Reg.* 28028). Nevertheless, CMS proposes "that this percentage would hold across benefit categories, because we did not find any indication that a lower threshold would be adequate, or that a higher threshold would be strictly necessary, to support a level of access to covered services for Medicaid beneficiaries at least as great as for the general population in the geographic area" (88 *Fed. Reg.* 28029). First, if the literature did indicate that a particular standard may be appropriate with respect to physician payments (which is debatable), it is unreasonable for CMS to automatically assume that the same standard would be appropriate for other services such as hospital care—particularly when research indicates that Medicare and Medicaid reimburse hospitals less than their costs. Second, the statutory standard for payment adequacy in 1902(a)(30)(A) is about access to care comparable to the general population in that area. However, CMS bases its proposed streamlined review of 80 percent of Medicare relying on different criteria, such as payment rate increases in the quartile where access "improvement was most significant" (88 *Fed. Reg.* 20028). It is unreasonable for CMS to conclude that the effects on access from payment increases for physicians that appear to be "most significant" equates to comparable access for the general population when considering payment decreases. Thus, as previously stated, given the importance of CMS' review of payment decreases and states' compliance with 1902(a)(30)(A), streamlined review of payment decreases should only be permitted as long as payment levels do not fall below 100 percent of Medicare levels.

CMS sought comment on whether states relying fully on FFS payments, rather than managed care, should be required to meet the same time and distance standards and secret shopper survey requirements as proposed in the managed care regulation. **The FAH supports time and distance standards and secret shopper survey requirements as additional tools for assuring beneficiaries' access to care and the adequacy of provider payments in their FFS delivery systems, whether that is fully FFS or partially FFS.** The extent of a state's reliance on FFS rather than managed care should not exempt it from meeting standards that are proposed to apply to managed care plans.

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Thank you for the opportunity to comment on the Proposed Rule. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,