American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

**Statement**

**of the**

**American Hospital Association**

**for the**

**Committee on Energy and Commerce**

**Subcommittee on Health**

**of the**

**U.S. House of Representatives**

**"Legislative Proposals To Increase Medicaid Access And Improve Program Integrity"**

**April 30, 2024**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on legislation before the subcommittee related to Medicaid access and program integrity.

The Medicaid program serves the nation's most vulnerable patients and has grown to be an essential part of the health care delivery system, providing care for approximately 85 million individuals. However, enrollment in Medicaid is not enough to ensure access to quality care. We appreciate that Congress is examining a range of legislative proposals to ensure the Medicaid program can continue to best serve its beneficiaries. The AHA's review of selected bills follows.

**H.R. 468: Building America's Health Care Workforce Act.** The COVID-19 public health emergency offered skilled-nursing facilities (SNFs) key flexibilities, particularly regarding workforce, to ensure they could continue providing high quality care to patients. One of the waivers allows nurse aides in these facilities to stay in their roles beyond the required four months and for those additional hours to count toward 75-hour state-approved training-and-competency evaluation programs. At a time when health care providers continue to face workforce shortages, this would provide stability by allowing SNFs to retain their workforce, while also providing nurse aides with the job experience needed to become certified nursing assistants. **The AHA supports H.R 468.**

**H.R. 7513: Protecting America's Seniors Access to Care Act.** The AHA and its members are committed to safe staffing to ensure high-quality, equitable and patient-centered care in all health care settings, including long-term care (LTC) facilities. Yet, the process of safely staffing any health care facility is about much more than achieving an arbitrary number set by regulation. It requires clinical judgment and flexibility to account for patient needs, facility characteristics and the expertise and experience of the care team. The Centers for Medicare & Medicaid Service's (CMS) one-size-fits-all minimum staffing rule for LTC facilities creates more problems than it solves and could jeopardize access to all types of care across the continuum, especially in rural and underserved communities that may not have the workforce levels to support these requirements.

Safe staffing is complex and dynamic. It must account for the acuity of the patients' needs, the experience and clinical expertise of the nurses and health care professionals on the care team and the technical capabilities of the facility. Mandated nurse staffing standards remove from the practice of nursing real-time clinical judgment and flexibility. Numerical staffing thresholds do not consider advanced capabilities in technology or the interprofessional team care model that supports data-driven decision-making and collaborative practice. Emerging care models incorporate nurses at various levels of licensure, respiratory therapists, occupational therapists, speech-language pathologists, physical therapists and case managers. A simple mandate of a base number of registered nurse (RN) and nurse aide hours per resident day emphasizes staff roles of yesterday, rather than what current and emerging practices may show is most effective and safe for the patient, and best aligned with the capabilities of the care team. AHA is concerned that these rigid standards will stymie innovation in care delivery.

The AHA is also concerned that this final rule could lead nursing homes to reduce capacity or close outright, including those that are otherwise performing well on quality and safety metrics. The loss of these nursing home beds could adversely impact patients who have completed their hospital treatment and need continuing care in nursing facilities. The AHA has already documented rising lengths of stay for hospital patients in need of skilled post-acute care, with patients waiting days, weeks or even months for post-acute care placements. As those patients continue to occupy hospital beds, other patients awaiting elective surgeries or other scheduled procedures may find their care disrupted because there is no bed for them in the hospital. Even more

troubling, this final rule could lead to delays in urgent medical care as patients coming into hospital emergency departments (EDs) may experience longer waits as EDs and inpatient beds are occupied by patients awaiting nursing home placements. The AHA urged CMS not to finalize the rule and to instead focus on developing more patient and workforce-centered approaches to safely staff nursing facilities.

Lastly, we believe this final rule could exacerbate the already serious shortages of nurses and skilled health care workers across the care continuum. The agency estimates that 79% of LTC facilities would have to increase staffing to meet the proposed standards, including the new standard requiring 24/7 RN staffing. Considering the massive structural shortages described by recent studies, it is unclear from where this supply of nurses will come, and it is inconceivable that LTC facilities will be able to meet these standards without detrimental effects to workforce availability throughout the care continuum. Strengthening the health care workforce requires investment and innovation, not inflexible mandates. **Therefore AHA supports H.R. 7513 to prohibit the Secretary of Health and Human Services (HHS) from implementing or enforcing this rule.**

**H.R. 8113: To amend title XIX of the Social Security Act to require reporting on certain directed payments under the Medicaid program.** CMS published regulations governing State Directed Payments (SDPs) on April 22, 2024. These rules bring new guardrails and structure to SDP programs. CMS, states and providers will need time to transition SDPs as the requirements take effect. The regulation also requires that states report provider-level directed payments in T-MSIS.

H.R. 8113 could create confusion rather than clarity. Given data lags, the proposed legislation would result in states reporting information about SDPs created before the new requirements. This could give an outdated sense of what payments are for, which providers receive payments and the structure of those payments. Considering the recent rule, we urge Congress to allow these regulations to take effect before placing additional reporting and transparency requirements on states. This would allow stakeholders to better understand what provisions of the regulations are working well and identify gaps that may emerge under the new regulatory environment. **While the AHA supports the goal of improving the transparency of SDP programs, we have concerns about the timing of the proposed legislation given the recent release of new regulations.**

**H.R. 8115: To amend title XIX of the Social Security Act to allow for the deferral or disallowance of portions of payments for certain managed care violations under Medicaid.** The bill would provide CMS with the flexibility to disallow or defer partial federal matching payments associated with contracts with Medicaid managed care organizations. Under current law, CMS and states' authority to disallow payments is limited to an "all or nothing" arrangement; that is, they can disallow or allow all payments, but do not have authority to limit to a portion based on certain services, or other categories. H.R. 8115 remedies this situation.

Some Medicaid managed care organizations' policies and practices can compromise patient safety and increase costs. Corporate plans' excessive use of prior authorization denials results in delays for patients, patients not receiving the care they need or getting care in the wrong setting. A report by HHS found that prior authorization denials happen more than twice as often in Medicaid managed care plans compared to Medicare Advantage plans. New rules and regulations intended to curb these practices will come into effect over the next several years. H.R. 8115 will give CMS additional tools that can help enforce compliance with these rules for Medicaid managed care plans. **The AHA supports H.R. 8115.**

**CONCLUSION**

Thank you for your consideration of the AHA's comments on these Medicaid access and program integrity legislative proposals. We look forward to continuing to work with you to strengthen this critical health care program.