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

June 28, 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

RE: CMS–2442–P Medicaid Program; Ensuring Access to Medicaid Services, (Vol. 88, No. 85), May 3, 2023

Dear Administrator Brooks-LaSure:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and 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, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to improve access, quality and health outcomes in Medicaid fee-for-service (FFS) delivery systems and in home and community-based services (HCBS) programs.

The AHA applauds CMS' multi-year commitment to conduct a comprehensive review of access and other care challenges faced by Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and develop policies to address them.[1] In general, the AHA supports the direction of the proposed rule, which would promote greater transparency and accountability in Medicaid FFS programs with a particular focus on mitigating payment related barriers to providers' participation in the program. Below, we provide specific comments on the proposals to increase transparency in provider payment rates, expand stakeholder and beneficiary engagement, and improve access to home and community-based services.

[1] https://www.aha.org/lettercomment/2022-04-15-letter-cms-response-rfi-access-coverage-and-care-medicaid-chip

DOCUMENTATION OF ACCESS TO CARE AND SERVICE PAYMENT RATES

Federal law requires that reimbursement rates for health care providers are sufficient to ensure Medicaid beneficiaries enjoy the same access to health care services as the general population (Medicaid "equal access" standard).[2] CMS plays a crucial role in enforcing this mandate. In the wake of the U.S. Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center, Inc*.,[3] which ended providers' and beneficiaries' right to challenge state Medicaid payment rates in federal court, CMS has become the final arbiter in determining if provider payments are adequate to ensure access under federal statute.[4]

A closer look at just hospital data shows that total Medicaid payment falls far below hospitals' cost of caring for Medicaid patients.[5] According to data from the AHA's annual survey, hospitals received payment of only 88 cents for every dollar they spent caring for Medicaid patients in 2020. This underpayment resulted in a Medicaid shortfall of $24.8 billion in 2020.[6] In addition, analysis by the Medicaid and CHIP Payment and Access Commission (MACPAC) found that FFS rates are often far below Medicare payments for comparable services. For example, MACPAC reported that FFS Medicaid base payment rates were on average 78% of Medicare rates for the 18 Medicare Severity Diagnosis Related Groups studied using 2011 data.[7] And, states continue to look to cutting provider payments to address budget constraints. The Kaiser Commission on Medicaid and the Uninsured in its FY 2023 survey of state Medicaid programs found that 22 states adopted measures to restrict inpatient hospital payments by cutting or freezing payments.[8]

These underpayments put access to care at risk and drive up the cost of care for other patients, such as those covered through employer-sponsored coverage. Medicaid beneficiaries look to hospitals and health systems to address a wide variety of complex health and social needs, but financially distressed hospitals and health systems often are faced with reducing the availability of services, especially higher cost specialty care, which can result in access challenges for Medicaid beneficiaries**.**

CMS' regulatory safeguards are crucial to holding state governments accountable to ensure access for vulnerable populations covered by Medicaid. CMS' proposal would rescind the current regulatory requirements that states develop Access Monitoring

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[2] https://www.aha.org/system/files/content/15/150501-aha-amici-brief.pdf
[3] Armstrong v. Exceptional Child Center, Inc.,135 S. Ct. 1378, - Supreme Court, 2015
[4] Medicaid "Equal Access Standard" Soc. Sec. Act Se. 1902 (a) (30)(A)
[5] Total Medicaid payments include both FFS and managed care payments, Disproportionate Share Hospital (DSH) payments, non-DSH supplemental payments, directed payments and other adjustments, as reported by member hospitals.
[6] AMERICAN HOSPITAL ASSOCIATION (aha.org)
[7] Medicaid Hospital Payment: A Comparison across States and to Medicare: MACPAC
[8] How the Pandemic Continues to Shape Medicaid Priorities - Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023 (kff.org)

Review Plans that analyze the sufficiency of provider rates and access to certain services, and replace them with requirements to:

- Publish current Medicaid FFS payment rates in a standardized format;
- Publish biennial analyses comparing a subset of Medicaid rates against Medicare rates for the same service and disclose rates for certain HCBS services; and
- Submit additional analyses for proposed Medicaid rate reductions that meet a certain threshold.

The AHA supports CMS' proposal to update the agency's regulatory framework to improve transparency for stakeholders, beneficiaries and the public.

FFS Payment Rate Transparency

The rule proposes to require states to publish all Medicaid FFS payment rates on a website accessible to the public. FFS payment rates would need to be organized and formatted in a way that the public could determine the amount Medicaid would pay, including for services paid under a bundled methodology. In addition, states must separately identify the Medicaid FFS payment rates if they vary by population (pediatric and adult), provider type or geographical location. States would be required to maintain the website and update the FFS payment rate information within a month of a rate change. CMS proposes an effective date of Jan. 1, 2026 for states' initial publication of the FFS payments rates. **The AHA supports CMS' proposal to require states to routinely publish FFS rates in a format accessible to the public and display rates by population, provider type and geography.** If enacted, this increased transparency will ensure the federal government and stakeholders have information about provider payments that they can use to help assess the effects of such payments on access.[9] We expect that such transparency will shed light on states' low-base rates in their FFS programs and illuminate states' chronic underfunding of their Medicaid programs. This becomes particularly important as FFS rates often serve as benchmarks for Medicaid managed payments[10]. CMS also notes its intent to align the agency's access to care strategy across the FFS and managed care delivery systems and that provider rate transparency will support that objective.[11]

Payment Rate Analysis

CMS proposes to require that states publish biennially a comparison of Medicaid FFS base payment rates for a select set of acute, routine and preventive services to comparable rates under the Medicare fee schedule. A 2019 study found that Medicaid reimbursement for physicians is significantly lower than Medicare payments for the

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[9] Federal Register :: Medicaid Program; Ensuring Access to Medicaid Services p. 27967
[10] How the Pandemic Continues to Shape Medicaid Priorities - Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023 (kff.org)
[11] Federal Register :: Medicaid Program; Ensuring Access to Medicaid Services p. 27967

same services.[12] The selected services would include those that often serve as the gateway for beneficiaries accessing other medical services, such as evaluation and management services for primary care, OB/GYN care and outpatient behavioral health services.[13] The comparative analysis also would need to examine rates that vary based on geography and site of service. **The AHA agrees that provider rates are a key lever to ensuring access to Medicaid services and that more information is needed regarding the adequacy of provider payment under the program. We support CMS' proposal to require that states evaluate and disclose how rates for certain critical services compare to Medicare FFS rates. However, we urge caution in assuming that Medicare FFS rates are adequate, as Medicare also underpays providers.[14] Indeed, Medicare underpayments to providers in 2020 totaled more than $75 billion.[15] Instead, this analysis should be viewed as one piece of information as policymakers and stakeholders evaluate the impact of provider payment on beneficiary access to care.**

State Analysis for Rate Reduction or Restructuring

CMS proposes a new "threshold access analysis" when states submit a state plan amendment requesting federal approval to reduce or restructure FFS rates. That analysis would include a comparative analysis to Medicare rates, an assessment of the impact on the state's aggregate spending and public comments on the proposed change. CMS requires additional reporting and analyses by the state if the "threshold access analysis" indicates potential access issues. **In general, the AHA supports the approach CMS proposes to require that states conduct a "threshold access analysis," particularly with respect to including concerns raised by stakeholders during a state's public comment process. The AHA, however, raises two points for CMS' consideration regarding the proposed criteria.** If a state is reducing a payment rate, CMS proposes that the comparative threshold should be no less than 80% of the Medicare rates for the same or similar services. **The AHA encourages CMS to establish a threshold above 80% of Medicare rate.** As previously noted, Medicare, like Medicaid, pays providers less than the cost of delivering care. As such, rates at 80% of Medicare could still result in reduced access, especially for certain key services ~~like specialty care and OB/GYN services~~. The AHA also has concerns with the criteria that looks at no more than a 4% reduction in aggregate FFS expenditures and describes such a rate change as nominal. In 2018, CMS proposed a similar approach. We stand by our concerns from that time that such an approach ignores payment variation across states and a 4% reduction could be a significant burden for some Medicaid providers.[16] **The AHA urges CMS to reexamine the appropriateness of a 4% rate reduction as a criterion in the "threshold access analysis" particularly**

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[12] Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019 | Health Affairs; MedPAC March 2023 Report to the Congress: Medicare Payment Policy
[13] Fed. Reg. 88 May 3, 2023, p. 28002
[14] MedPAC March 2023 Report to the Congress: Medicare Payment Policy
[15] AMERICAN HOSPITAL ASSOCIATION (aha.org)
[16] https://www.aha.org/letter/2018-05-23-aha-comments-proposed-rule-medicaid-access-care

when evaluating payment changes for specialty providers and resulting access issues.

MEDICAID ADVISORY COMMITTEE AND BENEFICIARY ADVISORY GROUP

CMS proposes to enhance requirements related to stakeholder and beneficiary engagement to help states improve the administration of their Medicaid programs. The agency intends to establish a bidirectional feedback process between beneficiaries and other stakeholders with the state agencies. CMS proposes to rename the current required advisory committee the "Medicaid Advisory Committee" (MAC) and expand its charge for stakeholder committee members to advise on not only health and medical issues but also on social determinants of health and related social needs. In addition, to ensure the voices of stakeholders such as community-based organizations, CMS proposes to require that states establish a Beneficiary Advisory Group (BAG). The BAG would be comprised of current and former Medicaid beneficiaries, as well as others with direct experience with the program, such as family members. For both the MACs and BAGs, states would be required to establish standardized processes and practices and to post such practices on the state websites to ensure transparency. States would be required to ensure their Medicaid agency staff assist in the advisory member recruitment as well as planning and preparation of MAC and BAG meetings. CMS requires that appointments to the MAC and BAG be made by the Medicaid agency director or higher state authority. In addition, MACs would be required to provide, with assistance from the state, an annual report to the state on activities and recommendations. The annual report must include a separate section for the BAGs with the same information. **The AHA supports CMS' proposals to improve stakeholder and beneficiary engagement through the establishment of the MACs and BAGs.** We encourage CMS to provide states with best practices and technical assistance to ensure optimal engagement from members of these important advisory committees. Such best practices could focus on recruitment strategies of BAG members including providing nominal compensation or engaging employers' support for BAG members' time commitment.

IMPROVING ACCESS TO HOME AND COMMUNITY BASED SERVICES

Through the proposed rule, CMS intends to strengthen safeguards and provide for a more coordinated administration of policies and procedures for individuals receiving Medicaid-covered HCBS. States would be required to:

- Include FFS payment rates for HCBS direct care workers in the public reporting of FFS rates;
- Establish a grievance system for FFS HCBS programs;
- Require that at least 80% of Medicaid payments for personal care, homemaker and home aide services be spent on compensation for the direct care workforce;
- Publish average hourly rates for personal care, home health care and homemaker services;
- Establish an advisory group to advise on direct care worker provider rates; and

- Report publicly on waiting lists for HCBS waiver programs, as well as on a standardized set of quality and compliance measures.

Lastly, if the HBCS proposed requirements are finalized, CMS plans to align the new requirements across the various Medicaid HCBS authorities found in 1915 (c), (i), (j), and (k) as well as 1115 demonstration authority. **In general, the AHA supports CMS' proposal to improve oversight of the HCBS programs and improve safeguards for HCBS beneficiaries and the HCBS workforce.** HCBS programs are a key component of the continuum of care and allow hospitals to transition patients more safely to post-acute services. We are mindful of how additional requirements could burden smaller HCBS organizations. For example, the requirement that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation is likely to help bolster the HCBS workforce through improved wages. However, for some HCBS organizations, especially those that are smaller and/or rural, that requirement may be difficult to initially meet. CMS could consider giving states additional flexibility regarding this compensation requirement if these organizations meet certain criteria supportive of the HCBS workforce.

CONCLUSION

The AHA appreciates this opportunity to share with CMS our views on these very important proposals to improve beneficiary access to needed services. While we are generally supportive of CMS' direction with these proposals, we are mindful that states are under considerable strain right now as they undertake the largest scope of eligibility redeterminations in the program's history. As CMS moves to finalize these policies, we encourage the agency to be mindful of states' capacity and strongly urge against any effective dates that may divert agency staff from the critical mission of eligibility redetermination.

Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, AHA's director for policy, at mcollins@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President