



AMERICA'S ESSENTIAL HOSPITALS

December 21, 2015

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

Ref: CMS-2328-FC: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services

Dear Mr. Slavitt:

America's Essential Hospitals appreciates the opportunity to submit these comments on the above-captioned final rule with comment period. The association supports the Centers for Medicare & Medicaid Services (CMS) work to ensure access to care for Medicaid beneficiaries. We were pleased to see CMS incorporated many of our recommendations into the final rule—especially those requiring states to include a payment analysis in access reviews and the shortened time period for reviews. However, America's Essential Hospitals remains concerned about the impact certain final rule provisions could have on Medicaid beneficiaries' access to hospital services.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our 275 members provide a disproportionate share of the nation's uncompensated care and devote roughly half of their inpatient and outpatient care to Medicaid or uninsured patients—32 percent of inpatient care and 27 percent of outpatient care for Medicaid patients and 15 percent of inpatient care and 24 percent of outpatient care for the uninsured.¹ (This compares with only 23 percent of inpatient care and 21 percent of outpatient care to Medicare beneficiaries, significantly below the industry average.) Our

¹Reid K, Roberson B, Landry C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential Hospitals. March 2015. <http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf>. Accessed July 2, 2015. (hereinafter, "Vital Data 2013")

members provide this care while operating on margins substantially lower than the rest of the hospital industry: an aggregate operating margin of negative 3.2 percent, compared with positive 5.7 percent for all hospitals nationwide.²

In addition, as essential hospitals, our members serve as cornerstones of care in their communities, providing specialized inpatient, outpatient, and emergency services, such as trauma, burn care, and inpatient psychiatric care, which often are unavailable elsewhere in their communities. In the 10 largest U.S. cities, our members operate 34 percent of all level I trauma centers, 69 percent of all burn-care beds, and 33 percent of psychiatric beds.³ Members of America's Essential Hospitals also play a vital role in providing ambulatory care to their communities. The average member operates a network of 20 or more ambulatory care sites. And they deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Essential hospitals play a unique and vital role in the Medicaid delivery system. Given our largely low-income, vulnerable patient populations, we are distinctly positioned to make a real and lasting impact on the lives and well-being of the most disadvantaged among us. We have the expertise, passion, and commitment to apply and adapt proven models of care to the benefit of our patients, and to pioneer new models to meet their specialized needs. Consistently, members of America's Essential Hospitals find increasingly innovative and efficient strategies for providing high-quality, complex care to their patients, all while facing high costs and limited resources. But the reality is that with their patient mix and margins, our members depend utterly on Medicaid funding to carry out their missions and remain viable.

As CMS engages in policymaking of the scope reflected in the final rule, it is imperative that the impact on essential hospitals—and more important, on the patients who rely on essential hospitals—be thoughtfully considered. This policymaking is especially important in light of the U.S. Supreme Court decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378 (2015), where the court held that providers cannot sue in federal court to enforce adequate payment rates. The administrative process outlined in this final rule is now the only means for providers and beneficiaries to seek federal redress for inadequate rates. CMS' goal of providing meaningful access to care for Medicaid patients cannot be achieved without engaging essential hospitals. In that spirit, we urge the agency to consider the following comments.

- 1. CMS *must* ensure hospital services are included in the list of services required for ongoing review.**

²Ibid.

³Ibid.

CMS initially proposed requiring states to perform an access review for all Medicaid covered services every five years. In the final rule, CMS significantly limited the scope of service categories subject to required, ongoing review, but shortened the timeframe to every three years. In the preamble of the rule, CMS notes that services selected are those that are both in high demand and commonly used by Medicaid beneficiaries. Hospital services are notably missing from the subset of services subject to required triennial reviews, as outlined in the final rule. This omission is concerning. The Kaiser Commission white paper, which the agency cites in the rule, makes clear that hospital services are mandatory benefits under federal Medicaid law and part of the essential health benefits required for all alternative benefit packages.⁴ Hospital services are considered mandatory because they are crucial to meaningful coverage. We understand that by omitting hospital services from required triennial access reviews, CMS is trying to lessen the administrative burden on states. But the potential loss of patient access to hospital services that could result from this decision poses a far greater threat than any incremental increase in administrative burden hospital reviews might add.

Requiring states to ensure, through monitoring, that payment rate reductions do not diminish access to hospital services is particularly important now that the access monitoring reviews outlined in the final rule are the only vehicle providers have to address state payment rate decisions, as noted earlier. Now that judicial enforcement of payment adequacy has been definitively foreclosed, CMS has an even greater responsibility to devote significantly more attention than it has in the past to the “quality” and “equal access” prongs of Section (a)(30)(A). CMS must require that payment rates to hospitals meet the statutory standard.

Essential hospitals offer a variety of inpatient and outpatient services on which Medicaid patients depend, including highly specialized surgeries and procedures, burn care, trauma care, psychiatric care, and substance abuse treatment. Requiring states to review access on an ongoing basis is key to ensuring Medicaid beneficiaries can obtain these and other services and that changes in payment rates do not limit their ability to receive needed care from their preferred providers. CMS included access to physician specialist services among the services it identified for ongoing review, but that will not capture the specialists whose services are billed as part of a hospital service. Further, only measuring access to physicians is insufficient if we do not adequately fund the hospitals upon which they rely to perform procedures and subsidize care to low-income patients. If a hospital has to shut its doors or scale back support for vulnerable populations, then access to a multitude of services and supports goes away.

The vital link between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries cannot be overstated. When Medicaid rates fall, many providers either cannot afford or choose not to treat Medicaid patients. Those that do

⁴ The Kaiser Commission on Medicaid and the Uninsured. Medicaid Moving Forward. March 2015. <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward>. Accessed November 2015.

are often forced to shift the unreimbursed Medicaid costs onto other payers. While we can still rely on the commitment of essential hospitals to serve Medicaid patients, their ability to meet that commitment becomes severely compromised when reimbursements fall so far below costs. In short, by reducing either the number or capacity of providers serving Medicaid patients, inadequate Medicaid rates harm beneficiaries' access to care, particularly as compared with the access available to the general population.

Reductions in Medicaid funding will also undermine the work of essential hospitals to lead development of accountable care organizations, patient-centered medical homes, and other delivery system reforms to provide high-quality, cost-effective care to low-income patients—even at Medicaid's current low rates. Members of America's Essential Hospitals have worked with states on Medicaid waivers and other initiatives that have proved to be effective models for providing cost-effective care to a population of low-income, uninsured patients. Hospitals are unable to assume the risk associated with these innovative models and reforms if the stability of Medicaid payments is threatened.

Medicaid pays providers substantially less than Medicare, commercial insurers, and other payers for similar services. In fact, Medicaid payment rates often are insufficient to cover provider costs. For example, in analyzing the adequacy of Medicaid payments to hospitals in four states, the Medicaid and CHIP Payment and Access Commission found that in three of the states, Medicaid payments to hospitals failed to cover their costs of care to Medicaid patients.⁵ This finding is consistent with industry data showing that Medicaid underpaid 62 percent of hospitals in 2013.⁶ Additionally, a recent study shows that although states are generally raising payment rates to providers in fiscal year 2016, they are still decreasing hospital inpatient rates.⁷

The association recognizes that hospital payments would still be subject to access review if the state proposes to cut hospitals or otherwise change hospital payments in a way that could diminish access; or if hospitals or other stakeholders submit a higher-than-usual volume of payment rate complaints to the state or CMS. However, we remain concerned this process would not adequately monitor hospital payment rates and ensure those rates are sufficient and do not reduce beneficiaries' access to needed services. Access to hospital services is too fundamental to the health of Medicaid

⁵ Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. March 2014; at 192.

<https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NDJlZjgxMGVjMDQyYmI2Zg>. Accessed November 2015.

⁶ American Hospital Association. Fact Sheet: Underpayment by Medicare and Medicaid. 2015. <http://www.aha.org/content/15/medicaremedicaidunderpmt.pdf>. Accessed November 2015.

⁷ The Henry J. Kaiser Family Foundation and National Association of Medicaid Directors. Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016. October 2015; at 54. <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>. Accessed November 2015.

beneficiaries to leave to a secondary process that depends on multiple actions. **For these reasons, America's Essential Hospitals strongly urges the agency to elevate hospital services to the automatic process proposed for other services subject to the triennial access reviews. Inclusion of hospital services in the access reviews will protect Medicaid beneficiaries' ability to receive all needed services and takes an important step toward fulfilling the Social Security Act's equal access provision.**

- 2. CMS should modify the requirements for the payment comparison analysis to include comparisons to Medicare rates, average commercial rates, and costs, and require states to provide estimates of payment decreases resulting from any rate changes.**

America's Essential Hospitals is pleased CMS recognized the importance of including analysis of Medicaid payment rates as part of the access monitoring review plan. The association believes that an analysis of Medicaid payment rates compared with other payers must be an explicit consideration equal in importance to the other access-related factors included in the reviews. We are pleased the final rule elevates the payment comparison analysis as part of the ongoing reviews, as well as upon submission of a state plan amendment that would reduce payment rates.

However, CMS has revised the required payment comparisons in a way that detracts from their usefulness. The final rule requires states, as part of the triennial monitoring analysis, to perform a rate analysis comparing state Medicaid fee-for-service (FFS) payment rates as a percentage of other public and private payment rates in the same geographic area, by provider types and sites of service. This is a change from the proposed rule, which explicitly required a comparison with Medicare rates, average commercial rates, or Medicaid allowable costs. CMS was right to include comparisons with these specific rates and costs, as it represents an important standard to ensure adequate payments to providers. In addition, the proposed rule would have required the state to estimate the decrease in payments resulting from requested rate changes, which would help providers and other stakeholders better understand the magnitude and, thus, implications of a rate change; the final rule omitted this requirement.

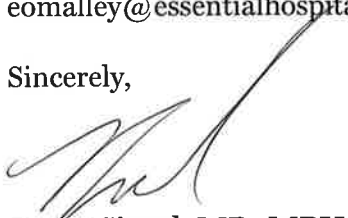
The association is concerned that these changes could mask underpayments of services and potentially make it more challenging for providers to understand the impact of a state's proposals—which, in turn, could negatively affect beneficiary access to vital services. **As such, we urge CMS to include comparisons with Medicare rates, average commercial rates, and costs in the payment comparison analysis and require states to provide estimates of payment decreases resulting from proposed rate changes.**

- 3. CMS should not grant exceptions from the triennial reviews to states with high managed care enrollment.**

America's Essential Hospitals urges CMS not to exclude states from the triennial access reviews based on state program characteristics. In the final rule with comment period, CMS seeks feedback on whether states should be granted exemptions from the provisions of the rule based on state program characteristics, such as high managed care enrollment. While it may be true that the equal access requirement of Section 1902(a)(30)(A) applies to payments to providers and not to capitated payments to managed care entities, it is still vital that states with high managed care enrollment comply with the provisions of the triennial reviews. First, even in a state where most of the population is in managed care, at least some portion of the population and services remain in FFS. Furthermore, state plan FFS rates are relevant in determining whether state payments to managed care entities are actuarially sound. Capitation payments are payments made for care and services under the state plan, even though they are risk-based rather than fee-for-service. Too often, current Medicaid managed care rates result in less access to services for beneficiaries. If FFS rates are inadequate, then managed care capitated payments based on these rates are also likely to be inadequate to support sufficient payments from plans to providers. **Therefore, CMS should not exclude states with high managed care enrollment from triennial access reviews.**

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at eomalley@essentialhospitals.org or 202-585-0127.

Sincerely,



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President and CEO