



## AMERICA'S ESSENTIAL HOSPITALS

May 22, 2018

Seema Verma, MPH  
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-2406-P: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold**

Dear Ms. Verma:

America's Essential Hospitals appreciates the opportunity to submit comments on the proposed rule on state exemptions to submitting the triannual Medicaid access monitoring review plan. While we recognize the Centers for Medicare & Medicaid Services' (CMS') desire to mitigate regulatory burden on states, the association is concerned about the affect provisions of the proposed rule could have on Medicaid beneficiaries' access to quality care.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Filling a vital role in their communities, our 325 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of member discharges in 2015 were for racial and ethnic minorities—patients who rely on the culturally and linguistically competent care only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than other hospitals—3.2 percent on average compared with 7.4 percent for all hospitals nationwide.<sup>1</sup> Through their integrated health systems, members of America's Essential Hospitals offer a full spectrum of primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health services, substance abuse treatment, and wraparound services vital to disadvantaged patients.

Essential hospitals play a unique and vital role in the Medicaid delivery system.

---

<sup>1</sup> Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2015 Annual Member Characteristics Survey. America's Essential Hospitals. June 2017. [www.essentialdata.info/](http://www.essentialdata.info/). Accessed April 26, 2018.

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. Members of America's Essential Hospitals consistently find 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 on Medicaid funding to carry out their missions and remain viable.

As CMS engages in policymaking related to access monitoring reviews, the association remains concerned that hospital services are missing from the subset of services subject to required triennial reviews. As noted in the Kaiser Commission white paper, which the agency cited in the final rule, hospital services are mandatory benefits under federal Medicaid law and part of the essential health benefits required for all alternative benefit packages.<sup>23</sup> Congress has designated hospital services as mandatory because they are crucial to meaningful coverage. Access to hospital services is too fundamental to the health of Medicaid beneficiaries to leave to a secondary process that depends on multiple actions. America's Essential Hospitals believes that hospital services must be elevated to the automatic process established 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; this is an important step toward fulfilling the Social Security Act's (SSA's) equal access provision.

Requiring states to ensure, through monitoring, that rate reductions do not diminish access to needed services is particularly important now, as access monitoring reviews are the only vehicle left for providers to challenge state payment rate decisions. Because judicial enforcement of payment adequacy has been definitively foreclosed, CMS now has an even greater responsibility to devote more attention to the "quality" and "equal access" prongs of Section (a)(30)(A) of the SSA. CMS must require that payment rates to Medicaid providers meet the statutory standard. Requiring states to review access to all services on an ongoing basis is key to ensuring Medicaid beneficiaries can obtain these services and that changes in payment rates do not limit their ability to receive needed care from their preferred providers.

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

---

<sup>2</sup> 80 Fed. Reg. 67,575 (November 2, 2015).

<sup>3</sup> The Kaiser Commission on Medicaid and the Uninsured. Medicaid Moving Forward. March 2015. <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward>. Accessed April 26, 2018.

It is imperative that CMS thoughtfully consider the effect on essential hospitals—and more important, on the patients who rely on essential hospitals—as the agency continues to engage in policymaking on access reviews. This policymaking is especially important in light of the U.S. Supreme Court ruling in *Armstrong v. Exceptional Child Center Inc.*, in which the court’s decision effectively eliminated the ability of providers and beneficiaries to sue in federal court to enforce adequate payment rates.<sup>4</sup> The administrative process outlined for the access monitoring reviews is now the only means for providers and beneficiaries to seek federal redress for inadequate rates. The reviews, therefore, must be strong and robust. Finally, 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) To ensure access to quality care for Medicaid beneficiaries, CMS must not issue access monitoring review exceptions to states with high managed care penetration.

CMS proposes to offer access monitoring requirement exemptions to states with comprehensive, risk-based Medicaid managed care enrollment rates above 85 percent. In the proposed rule, CMS notes that this exemption is in response to states’ concerns about administrative burden associated with current requirements. We understand the agency’s desire to lessen the administrative burden on states. However, this decision could result in a loss of patient access to needed services, which poses a far greater threat than any incremental increase in administrative burden the reviews might entail—particularly given that CMS now is exclusively responsible for enforcing compliance with the statutory equal access mandate.

While the equal access requirement of Section 1902(a)(30)(A) applies to fee-for-service (FFS) payments but not provider payments under managed care, it still is vital that states with high managed care enrollment comply with the provisions of the triennial reviews. First, even in states with high managed care penetration (above 85 percent), at least some portion of the population and services remain in a FFS structure; that portion often includes some of the most vulnerable Medicaid beneficiaries, such as the elderly and disabled.<sup>5</sup> Moreover, while Medicaid patients’ access to behavioral health and substance abuse services has become crucial amid the nationwide opioid epidemic, many states have carved these services out of their managed care contracts.<sup>6</sup> Therefore, even in states with 85 percent of the population enrolled in managed care, key services might be delivered on a FFS basis. Robust regular reviews are essential to ensuring access to these services.

---

<sup>4</sup> *Armstrong v. Exceptional Child Center Inc.* 135 S.Ct. 1378 (2015).

[https://www.supremecourt.gov/opinions/14pdf/14-15\\_d10e.pdf](https://www.supremecourt.gov/opinions/14pdf/14-15_d10e.pdf). Accessed April 26, 2018.

<sup>5</sup> Kaiser Family Foundation. Medicaid Managed Care Penetration Rates by Eligibility Group. July 1, 2017. <https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Population%22,%22sort%22:%22desc%22%7D>. Accessed April 26, 2018.

<sup>6</sup> Brooks T, Wagnerman K, Artiga S, Cornachione E. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey. March 21, 2018.

<https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/>. Accessed April 26, 2018.

Further, state plan FFS rates are relevant in determining whether capitation payments to managed care entities are actuarially sound. Insufficient rates in the FFS system—even if a low percentage of Medicaid provider payments are made under that system—will lead to equally insufficient capitation payments to plans. Without adequate resources, the plans are forced to pay inadequate rates, which providers with large Medicaid patient populations are forced to accept. Ensuring access in the FFS system, therefore, will have a positive spillover effect on access under managed care. **To ensure access for all Medicaid beneficiaries, CMS must not exempt states with high managed care enrollment from triennial access reviews.**

- 2) CMS should fully assess the monitoring reviews before granting any states an exemption from the requirements.

CMS finalized the access monitoring review requirements in November 2015—a little more than two years ago. This is not enough time to determine the effectiveness of these reviews and to test alternative methods to improve them if needed. States have submitted to the agency review plans in accordance to the guidelines set in the finalized rule. **CMS should fully assess the submitted reviews, determine the effectiveness of the monitoring review process, evaluate how to strengthen the reviews, and fully understand the connection between FFS rate monitoring and managed care access before scaling back the requirements.**

- 3) CMS must fulfill its role as sole arbiter of adequate Medicaid provider payment rates.

CMS proposes to provide an exemption for states that submit state plan amendments to reduce rates or restructure payments where the overall reduction is 4 percent or less in one year or 6 percent over two consecutive years. The agency notes that the proposed thresholds represent nominal changes to Medicaid payment rates. CMS also proposes to allow states to provide the agency an assurance that current access is sufficient when the rates are reduced or restructured, rather than an analysis anticipating the effects of the change that currently is required. We are concerned with the thresholds proposed by the agency. When rates already are low—below cost, below market, below Medicare—even small reductions have an effect, on both providers’ willingness to treat and ability to provide high-quality care to Medicaid beneficiaries. *No cut to Medicaid rates should be deemed minor and insignificant.* Allowing exemptions based on the proposed payment rate changes could mask underpayments of services and potentially make it more challenging for providers to understand the effect of a state’s proposals—which, in turn, could negatively affect beneficiary access to vital services.

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, a Medicaid and CHIP Payment and Access Commission analysis found that in three of four states examined, Medicaid payments to hospitals failed to cover the costs of care to beneficiaries.<sup>7</sup> This finding is consistent

---

<sup>7</sup> Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. March 2014. <https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWwYWN8Z3g6NDJlZjgxMGVjMDQyYmI2Zg>. Accessed April 26, 2018.

with industry data showing that Medicaid underpaid 66 percent of hospitals in 2016.<sup>8</sup> CMS must ensure that payment rates are sufficient and do not reduce beneficiaries' access to needed services. Access to needed services is too important to leave to a state's assurance. For these reasons, **we strongly urge the agency not to provide an exemption from access monitoring review requirements to states requesting to reduce or restructure payment rates within the proposed thresholds.**

- 4) CMS must require states to provide more than an assurance of payment adequacy to the agency when proposing to change payment rates.

The association recognizes that CMS is considering allowing states to submit an assurance of current payment adequacy when proposing to change payment rates, rather than the required analysis of the effect of the reduced rate. CMS asserts that states have had difficulty anticipating the effect of changes on access to care, and that their projections have not proved to be accurate. Yet, eliminating the requirement altogether because it is difficult to fulfill would put beneficiaries needlessly at risk and allow states to cut rates with no consideration of the impact on access.

Instead, states and CMS should learn from their experience in projecting access changes caused by rate reductions to inform future rate setting. Projections of adequate access that turn out to be inaccurate should lead states to reexamine their assumptions and methodologies, and help them to adopt more sophisticated analyses the next time they consider a rate cut. Understanding the connection between assumed impact on access and the actual impact is a crucial step in ensuring payment adequacy. CMS should not jettison the requirement simply because it is hard to do. Instead, the agency should provide technical assistance to states on how to capture the effect of rate changes on access. **As such, CMS should not allow states to only provide an assurance of payment adequacy to the agency when proposing changes in payment rates.**

\*\*\*\*\*

America's Essential Hospitals appreciates the departments' consideration of these comments and welcomes the opportunity to work with you on this vital issue. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH  
President and CEO

---

<sup>8</sup> American Hospital Association. Fact Sheet: Underpayment by Medicare and Medicaid. December 2017. <https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf>. Accessed April 26, 2018.