September 13, 2019

Seema Verma
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-P2: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission

Dear Administrator Verma:

Thank you for the opportunity to submit comments on this proposed rule and accompanying Informational Bulletin, “Comprehensive Strategy for Monitoring Access to Care.” In the bulletin, Centers for Medicare & Medicaid Services (CMS) states its “intent is to improve access to care.” America’s Essential Hospitals is encouraged by this intent and shares the same goal. We look forward to opportunities to partner with CMS to see this intent realized. The association also understands CMS desire to eliminate administrative burden associated with current Medicaid access regulatory requirements. However, the association is concerned that rescinding access monitoring review plan (AMRP) requirements in their entirety will lead to inadequate federal oversight of Medicaid payment rates and undermine the statutory assurance that payment rates be sufficient to ensure beneficiary access to needed services.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including vulnerable populations. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—1.6 percent on average compared with 7.8 percent for all hospitals nationwide. Essential hospitals’ commitment to serving all people, regardless of income or insurance status, and complexity of patient mix pose unique challenges.

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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 31 percent of all level I trauma centers, 39 percent of all burn-care beds, and 6,200 psychiatric care beds. Members of America’s Essential Hospitals also play a vital role in providing ambulatory care to their communities—operating a median of nine ambulatory care locations per hospital. Essential hospitals 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.\(^{3}\)

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.

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 adopt a comprehensive and effective strategy to carry out its oversight responsibility to ensure that states adopt payment rates sufficient to provide meaningful beneficiary access to care, especially payment rates for hospital services.**

In previous rulemaking, CMS omitted hospital services from the list of services required for ongoing review through the AMRPs. America’s Essential Hospitals remains concerned by that omission and the impact on beneficiaries’ access to hospital services. Now, CMS proposes to rescind the AMRPs in their entirety. CMS rightly points out that rescission of the AMRP does not remove the underlying responsibility of states to adopt rates that will allow for equal access. Nor does it absolve CMS’ responsibility to enforce that requirement. However, without systematic CMS review to ensure that the rates adopted by states are, indeed, adequate, fiscal pressures on states likely will lead them to give short shrift to this responsibility. CMS must hold states accountable—not just to ensure that access is sufficient, but that rates are adequate to ensure that access is sufficient.

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), in which the court held that providers cannot sue in federal court to enforce adequate payment rates. As a result, CMS oversight is the only means now through which providers and beneficiaries can seek federal redress for inadequate rates. As CMS engages in policymaking of the scope reflected in the proposed rule, it is imperative that the impact on essential hospitals—and more important, on the patients who rely on essential hospitals—be thoughtfully considered.

\(^{3}\) Ibid.
In general, we continue to be frustrated by the lack of a platform for providers to address payment adequacy concerns. While we agree that the AMRPCs were an inadequate means of enforcing states’ statutory obligation to adopt rates that ensure equal access for Medicaid patients, rescinding this process will impose an even greater responsibility on CMS to fulfill its oversight obligations. It is imperative CMS implement a comprehensive process to monitor that payment rates are sufficient and ensure beneficiary access to care.

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 continue to see Medicaid patients often are forced to shift the unreimbursed Medicaid costs onto other payers. While essential hospitals commit to serving Medicaid patients, their ability to meet that commitment becomes severely compromised when reimbursements fall below costs. In short, either by reducing 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 also will 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. This finding is consistent with industry data showing that Medicaid underpaid 62 percent of hospitals in 2017.¹

We cannot emphasize enough the importance of monitoring hospital payment rates and ensuring 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 beneficiaries to leave to a secondary process that depends on multiple actions. For these reasons, America’s Essential Hospitals strongly urges the agency to fulfill its responsibility to guarantee that the Social Security Act’s equal access provision is maintained and to monitor payment rates for hospital services to protect Medicaid beneficiaries’ ability to receive all needed services.

2. CMS is right to convene stakeholders to identify measures, benchmarks, and data that may be used as common access indicators across the Medicaid delivery system, and the agency must ensure it includes the hospital perspective.

In an accompanying informational bulletin, CMS announced its intention to develop a new strategy to measure and monitor beneficiary access to care. The agency intends to work collaboratively with states and other stakeholders through technical expert panels and working groups to develop a streamlined, comprehensive approach that will monitor access across all

Medicaid delivery systems through use of uniform access indicators. America’s Essential Hospitals applauds the agency’s intention to approach measuring Medicaid beneficiary access in this way. The association recognizes that the AMRP process is not an effective one—particularly, with the exclusion of hospital services from the triennial reviews. However, if CMS finalizes its proposed rescission of the AMRP, it is critical the agency work quickly to institute a stakeholder-driven alternative to ensure access to care is not diminished.

a. CMS must include essential hospital representatives on technical expert panels and working groups tasked with developing a comprehensive access monitoring approach.

As CMS works with stakeholders on a strategy to capture whether payment rates are sufficient to ensure Medicaid beneficiary access to care, the agency must include essential hospitals in technical expert panels or working groups tasked with identifying access measures. Hospital services are mandatory benefits under federal Medicaid law because they are crucial to meaningful coverage. 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. Including hospital services in a future access monitoring strategy is key to ensuring Medicaid beneficiaries can obtain these and other critical services and that changes in payment rates do not limit their ability to receive needed care from their preferred providers. As such, CMS must include essential hospital representatives as stakeholders in the agency’s initiative to determine a strategy for a uniform and comprehensive methodology for analyzing Medicaid access.

b. Comprehensive hospital-specific measures must be considered when examining rate sufficiency.

America’s Essential Hospitals understands that identifying what payment level is sufficient to ensure meaningful access to Medicaid-covered services can be a complicated determination. As such, it is important CMS consider hospital-specific measures that truly capture actual access to hospital services.

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. The AMRPs did not include systematic monitoring of access to hospital services, it only required demonstrations when rates were proposed to be cut. However, these nominal reviews were inadequate to monitor payment rates. If hospitals are not adequately funded, they will be faced with difficult decisions, including scaling back services to the community or closing. That will only result in diminishing access to a multitude of services and supports, especially for vulnerable people.

Hospitals are required, by the Emergency Medical Treatment and Active Labor Act, to medically screen every patient who seeks emergency care to stabilize or transfer those with medical emergencies, regardless of their health insurance status. As a result, for hospitals, the measure of access is more nuanced than just whether they accept Medicaid patients. Any consideration of hospital-specific access measures must to go a step further to capture access to long-term and/or expensive non-emergent care. CMS must examine rate sufficiency toward ensuring Medicaid
patients have access to hospital services at least equal to that for other patients in the community. The agency should not base its evaluation solely on whether a hospital merely accepts Medicaid patients through its emergency room doors. While it might be possible to oversee access to, for example, physician services by measuring provider participation, those measures do not apply effectively to hospital services. Most hospitals already participate in their state Medicaid programs, but the extent to which they provide accessible care varies greatly. Unfortunately, some hospitals also affirmatively take discreet or visible actions to limit Medicaid patient access. These nuances make it clear that special measures are needed specific to hospital services.

As CMS convenes stakeholders, the working groups must be tasked with focusing on identification of hospital-specific measures that capture these nuances. They could consider measures that use data to track hospitals that transfer patients after stabilization versus hospitals that keep them (comparing transfer rates for the Medicaid population to other patient populations). Or, measures that capture hospital challenges in discharging patients to post-acute care. Medicaid patients’ access to specific hospital services that are expensive and require long-term patient care, such as oncology, compared with that of the general population also can be considered.

Further, because the statute ties the access requirement to access available to the “general [i.e. non-Medicaid] population” as well as to sufficient payment rates, we recommend that any new oversight mechanisms include an explicit evaluation of payment rates. For example, a rate analysis comparing state Medicaid fee-for-service (FFS) payment rates with Medicare rates, average commercial rates, or Medicaid allowable costs would set an important standard to ensure adequate payments to providers.

As such, we encourage CMS to adopt access measures for hospital-specific services and assess that payment rates for these services are sufficient to protect Medicaid beneficiaries’ access to critical services.

c. Any new process must monitor whether states create flat provider reimbursements by not changing Medicaid payment rates.

In addition to monitoring when state Medicaid payment rates are decreased, just as important is knowing when payment rates remain stagnant from year to year. As CMS and stakeholders think through a strategy to monitor and measure access to services, the impact that flat provider reimbursements have on access must be considered. Data has shown that many states have not increased inpatient hospital provider payment rates in several years. This undoubtedly impacts beneficiary access to services. As noted above, when reimbursements fall below costs, the ability of hospitals to provide critical services is threatened. That directly impacts beneficiaries’ ability to access those services. CMS responsibility to monitor that payment rates ensure access includes situations in which states do not raise their provider payment rates after a certain number of years. CMS must address these instances with the same consideration as when a state proposes to decrease payment rates. A uniform and comprehensive access monitoring strategy must examine changes from year to year to safeguard that states payment rates do not result in

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flat provider reimbursements that could lead to reduced access to Medicaid-covered services.

d. To ensure rate sufficiency, any new monitoring process must incorporate the interaction between FFS and Medicaid managed care rates.

America’s Essential Hospitals urges that the interaction between FFS and Medicaid managed care payment rates is not excluded as the agency and stakeholders deliberate a new strategy to measure access to care within the Medicaid program. 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. Further, 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 FFS. 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 also are likely to be inadequate to support sufficient payments from plans to providers. Therefore, we encourage CMS to ensure that the interaction with managed care and FFS is considered as alternative methods are identified to determine payment rate adequacy and beneficiary access to covered Medicaid services.

3. CMS must identify and address underpayments to hospitals.

CMS must unmask underpayments of hospital services as part of its comprehensive strategy to measure and monitor beneficiary access to care. Many providers contribute to the nonfederal share of Medicaid expenditures through intergovernmental transfers, certified public expenditures, and provider taxes. These financing mechanisms provide critically important flexibility to states in funding their programs. Yet, these often significant provider contributions to the nonfederal share effectively offset the reimbursement they receive for services provided. If CMS is serious about determining whether payment rates are adequate to truly ensure equal access, it must factor in these contributions and look at the actual, net payments providers receive. While we understand that, for other purposes, it might be appropriate for CMS to consider only gross provider payment amounts when monitoring beneficiary access, the access that can be provided is only as great as the actual, net funding providers receive. CMS must safeguard against underpayments of hospital services by factoring in nonfederal share contributions when assessing payment rate sufficiency.

4. CMS must address the disincentives created by its budget neutrality policies for Medicaid demonstrations.

As CMS examines beneficiary access to Medicaid-covered services, the association encourages the agency to consider the related impact its budget neutrality policies for Medicaid demonstrations have on payment rates. Under the budget neutrality policy, the agency will not approve a Medicaid demonstration project that results in costs to the federal government greater than what the costs would be without implementing the project. CMS recently outlined a new approach to budget neutrality that will result in lower budget neutral caps for states with such
demonstrations. In practice, concern about budget neutrality already has led some states to limit provider rate increases that they might otherwise have adopted for fear of exceeding budget neutrality limits. As the new budget neutrality process takes full effect in coming years, we are concerned that such self-imposed limits on provider payments might become more widespread.

CMS has adopted a concept in its budget neutrality policies whereby it will treat as a hypothetical without-waiver expenditure the costs of populations or services the state could otherwise have provided through its state plan or other authorities. Those costs are treated effectively as pass-throughs for purposes of budget neutrality, not requiring the state to realize savings to offset the cost. As part of its comprehensive efforts to ensure payment adequacy under Section 1902(a)(30)(A), CMS may also want to consider treating rate increases that would be available to a state without a waiver as a hypothetical expenditure that similarly would not count toward a budget neutrality cap. We urge CMS to address the impact of budget neutrality policies and remove any disincentives for states to increase payment rates.

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

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

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7 Ibid.