AMERICA'S ESSENTIAL HOSPITALS

August 19, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

As the Centers for Medicare & Medicaid Services (CMS) works to implement new Medicaid supplemental payment reporting requirements in Division CC, Section 202, of the Consolidated Appropriations Act of 2020 (CAA), America's Essential Hospitals asks you to consider the following comments and include our association in future opportunities for stakeholder input. Medicaid supplemental payments are critical to our member hospitals, helping them fulfil their missions and keep their doors open, particularly through the COVID-19 public health emergency.

We recognize the importance of creating a reporting system that can provide timely and useful information to policymakers, as well as the need for additional assurances that Medicaid supplemental payments comply with federal rules. States and providers for decades have worked with CMS to develop a variety of supplemental payments under their state plans that serve valuable policy purposes, including ensuring meaningful access to care for Medicaid beneficiaries. We are hopeful this new reporting system will convey the value of these payments.

Essential Hospitals Serve Vulnerable Patients and Communities

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all. Our more than 300 members form the very fabric of the nation's health care safety net, caring for often marginalized people and anchoring communities across the country. They are sources of specialized, lifesaving care; jobs that create economic mobility; and vital public health functions, including responding to natural disasters and crises, like the COVID-19 pandemic. Our members also lead in training the next generation of health care professionals and in delivering comprehensive, coordinated care in outpatient settings.

Essential hospitals provide a disproportionate share of the nation's uncompensated care and devote significant inpatient and outpatient care to Medicaid or uninsured patients. For our member hospitals, 33 percent of inpatient care and 24 percent of outpatient care is provided to

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Medicaid beneficiaries.[1] Our members provide this care while operating on margins substantially lower than other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.

Essential hospitals play a unique and critical role in the Medicaid delivery system. Given the socioeconomic barriers experienced by our patient populations, essential hospitals are particularly qualified to make a real and lasting impact patients' well-being. 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. Essential hospitals find increasingly innovative and efficient strategies for providing high-quality care to their patients. But the reality is that with their patient mix and margins, our members depend substantially on Medicaid funding to carry out their missions and even to remain viable. In short, our members are at the very heart of the Medicaid delivery system, providing access where none exists, innovating with populations others ignore, and depending on Medicaid support to stay afloat. CMS' goal of providing meaningful access to care for Medicaid patients cannot be achieved without our members.

Our members fill a vital role in their communities, providing specialized inpatient, outpatient, and emergency services, such as trauma, burn, and inpatient psychiatric care their areas would otherwise lack. Across the country, our members operate 34 percent of all level I trauma centers, about 40 percent of all burn-care beds, and three-quarters of our members provide inpatient psychiatric care, compared with about a third of nonmembers that provide such care.[2] Essential hospitals also play a vital role in providing ambulatory care to their communities, with a median of 11 ambulatory care locations per hospital. They also 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. Medicaid supplemental payments often are designed to support these scarce—but vital—services or to target support to hospitals that are the main or only source of these services.

Essential hospitals also broadly address socioeconomic barriers to good health. In the communities served by our members, 370,000 individuals experience homelessness, 9.9 million people have limited access to nutritious food, 22.3 million individuals live below the poverty line, and more than 14.4 million are uninsured. Our members regularly invest in programs to address these barriers.[3] Without supplemental payments, our members would not be able to make investments in this important work.

Our members stand at the intersection of Medicaid's role as both a contributor and potential tool to address structural racism. The history of low Medicaid base rates is part of the fabric of structural racism; according to MACPAC, more than 60 percent of Medicaid beneficiaries identify as Black, Hispanic, Asian American, or another nonwhite race or ethnicity.[4] Chronic underfunding of the Medicaid program compared with Medicare or commercial payers has left hospitals that serve a disproportionate share of Medicaid patients with comparatively fewer

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[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed July 1, 2021.
[2] Ibid.
[3] Ibid.
[4] MACPAC. Fact Sheet, Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography. April 2021. https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf. Accessed August 18, 2021.

resources than their counterparts. Supplemental payments have been a necessary means to mitigate low Medicaid base rates for these providers.

Essential hospitals stand on the front lines of combating structural racism as a public health threat. Through training, innovative programs, and community partnerships, our member hospitals work to remove barriers to equitable health outcomes across all races, ethnicities, and backgrounds. Because essential hospitals have more touch points with Medicaid beneficiaries than the average hospital system, our members also have greater potential to meaningfully address health disparities. Supporting essential hospitals can have an immediate and direct impact on care for people of color by enabling investments that equalize the care systems available to them. Conversely, reducing essential hospital support would likely have an immediate negative impact.

Importance of Medicaid Supplemental Payments

Essential hospitals derive a high proportion of their Medicaid funding from a patchwork of policy-based Medicaid supplemental payments, on which they heavily rely to preserve access for beneficiaries. Low base rates, as described above, are a primary reason for this dependence on supplemental payments. Absent the political will to fund adequate base rates or enforce equal access requirements, supplemental payments became a critical means of enhancing below-cost Medicaid payment levels that are simply unsustainable on their own. Essential hospitals are particularly reliant on supplemental payments because they generally serve greater shares of Medicaid patients, as well as a disproportionate share of other low-income and uninsured patients, and they have a relatively lower share of patients covered by commercial payers.

States use supplemental payments to target funds to essential hospitals and similar providers to fulfill certain policy goals. For example, states target funds to trauma hospitals and air ambulance programs; to fund teaching hospitals and professionals; or to address particular needs of rural hospitals or hospitals providing behavioral health services. Supplemental payments also fund clinics and nursing facilities that play vital roles in the delivery system.

Value of Transparency and Accountability

We support transparency and accountability efforts to preserve the integrity of the Medicaid program and to demonstrate the value of investing in essential hospitals and other providers at the core of the Medicaid delivery system. CMS has done significant work to improve transparency and accountability of supplemental payments. Since 2013, CMS has required states to submit annual demonstrations confirming Medicaid fee-for-service (FFS) provider payments are consistent with regulatory upper payment limits (UPLs).[5] As part of that process, CMS issued reporting templates to help structure and streamline state responses while preserving existing state flexibility under federal rules. Before this accountability initiative, CMS already required states to submit such demonstrations when seeking approval of a state plan amendment (SPA) that would create or amend a supplemental payment. The upper limits on such payments are tied to Medicare or commercial rate thresholds to ensure Medicaid payments are economical and efficient. SPAs increasingly provide more detail about the purpose and methodology of authorized supplemental payments.

Further, the Medicaid Section 1115 waiver approval process involves negotiation of a terms-and-conditions document describing supplemental payment programs in detail, often including

[5] See, e.g., SMD# 13-003, Federal and State Oversight of Medicaid Expenditures (March 18, 2013).

one or more highly detailed attachments outlining methodology and limits. Waiver demonstrations also require evaluations and limits on spending, as federal spending under the waiver cannot be more than what would have been spent without the waiver.

Section 202 of the CAA, which requires the new supplemental payment reporting system, presents an opportunity to bring together these various reporting mechanisms in a user-friendly and transparent way while building on existing efforts to avoid duplication and administrative burden.

Technical Recommendations on Implementing Section 202

We offer the following technical recommendations to inform CMS' work to implement Section 202. As a guiding principle, we urge the agency to adhere to the scope and substance outlined in Section 202. The provision requires CMS to collect and make available information on Medicaid supplemental payments, as well as state assurances of compliance with UPLs under existing rules. Further, as with any transparency and accountability effort, the initiative must consider administrative efficiency, burden on reporting and reviewing entities, and relative usefulness of information obtained.

OPPORTUNITY FOR STAKEHOLDER ENGAGEMENT

CMS's regulatory agenda does not identify intended work on proposed regulations to implement Section 202, so we assume CMS intends to develop the reporting requirements through subregulatory guidance. Given the importance of these payments and the complexity of state Medicaid programs, we urge CMS to provide an opportunity for states, as well as providers who depend on these payments, to provide feedback and share insights.

CLARIFYING THE SCOPE OF REPORTING

Section 202 requires the health and human services secretary to develop a system for states to "submit reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment that would provide for a supplemental payment." The requirements for the report further reference "supplemental payments made under the State plan or a State plan amendment" and the UPLs defined at Section 447.272 of title 42, Code of Federal Regulations (CFR). The state plan defines payments under the FFS Medicaid program, including Medicaid disproportionate share hospital (DSH) payments, although Section 202 explicitly excludes DSH from the definition of supplemental payments.

Based on this statutory language, CMS should clarify in its implementation guidance that the reporting system applies to FFS, non-DSH supplemental payments. New Section 1396b(bb)(2)(A) defines a supplemental payment as "a payment to a provider that is in addition to any base payment made to the provider under the State plan under this title or under demonstration authority." Given that (bb)(1) limits the reporting requirement to payments made under the state plan or an SPA, Congress' intent must have been for "under demonstration authority" to modify the term base payment.

DEFINITIONS OF BASE PAYMENT AND SUPPLEMENTAL PAYMENT

The statute does not define "base payment" or "supplemental payment" other than to state a supplemental payment is "in addition to any base payment." We urge CMS to interpret "base payment" to include payment adjustments and add-ons to claims, such as those made to account for a higher level of care or complexity or intensity of services, as well as payment methodologies that involve an interim payment followed by a final settlement. Methodologies involving interim and final payments are intended to provide a per-claim amount equal to a

defined threshold (for example, cost or Medicare rate). The settlement payment is necessary only because the exact amount that should be paid per claim cannot be known until later. States using these methodologies typically pay a more conservative interim rate and then make a settlement payment in a lump sum for the applicable claims. For example, with cost-based payments, actual costs must be calculated and then settled to the interim payments. Similarly, a state might make payments under an interim fee schedule that later gets settled to a calculated average commercial rate for the services provided.

FREQUENCY AND TIMING OF REPORT SUBMISSION

Section 202 does not specify the frequency or timing for submission of the FFS supplemental payment report by states; the provision only states it is "a requirement for a State plan or State plan amendment that would provide for a supplemental payment." Because Section 202 requires reports only when a state plan or SPA "*would*" provide for a supplemental payment, we believe Congress intended prospective reporting. Consistent with the statute and with the goal of reducing the burden on states, we suggest CMS require these reports as part of the process of submitting an SPA to propose a new supplemental payment or amend an existing supplemental payment. CMS will still have information about compliance of all existing supplemental payments with UPLs, either from the UPL calculations submitted as part of this new reporting or the annual submissions under the current accountability initiative. We believe this approach would strike an appropriate balance between providing comprehensive information about supplemental payments and minimizing reporting burden on states.

USE OF STATE DATA, NOT PROVIDER DATA

Section 202 directs CMS to create a new system for reporting by states. Based on the requirements outlined in statute, states should be able to provide the necessary information from their own data and state plan materials. We ask CMS to clarify there is no need for providers to supply related data.

PRESERVING STATE FLEXIBILITY AND AVOIDING DUPLICATION OF EFFORT

The requirements for the substance of the report involve several descriptions and explanations. We urge CMS to give states flexibility in providing these answers, consistent with the state's flexibility in designing the programs. For example, CMS might provide a template that includes text boxes for open-ended descriptions. In addition, to the extent that certain information is available in easily-referenced, public materials, we urge the agency to allow reference to those sources to avoid duplication of effort. This is particularly true for the one-time report on existing supplemental payment programs.

We provide more specific comments on each section of the requirements section (42 USC §1396b(bb)(1)(B)) below:

- (B)(v) UPL Demonstrations: Section (B)(v) requires "[i]f not already submitted, an [UPL] demonstration under section 447.272 of title 42, [CFR]." Importantly, Congress has acknowledged CMS currently requires submissions of UPL demonstrations under its accountability initiative, either with new SPAs or on an annual basis. We urge CMS to avoid requesting multiple submissions from states. In addition, we note that 42 CFR 447.272, referenced in this statutory provision, applies only to limits on payments for inpatient services furnished by hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disability. While CMS' existing initiatives include a broader set of UPLs, the scope of UPLs Congress requires as part of this reporting initiative is more limited;

- (B)(i) Consistency with Section 1902(a)(30)(A): CMS should permit states to provide open-ended descriptions of the purpose and intended effects of the payments;
- (B)(ii) Eligibility Criteria: State plan provisions authorizing supplemental payments should include criteria for determining eligible providers. Where such criteria are clearly outlined in the state plan, CMS should permit states to reference the specific state plan provision and page(s) (if publicly available) or attach the relevant pages;
- (B)(iii) Payment Methodology: Similarly, federal regulations already require state plans to include information on payment methodologies. Specifically, Title 42, Section 447.201 of the CFR notes the state plan "must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program." Additionally, Section 447.252 notes the state plan "must specify comprehensively the methods and standards used by the agency to set payment rates." Such state plan provisions often specify the timing of payments. CMS should allow states to reference what is publicly available or attach the provision to the extent such information is available and provide supplemental information when necessary. With regard to specifying sources of data on Medicaid service, utilization, or cost as the basis for the payments, states typically rely on a wide variety of data sources. We urge CMS to retain this flexibility. For example, CMS might list typical data sources but allow states to select an "other" source and provide a text box for description; and
- (B)(iv) Assurances of Compliance with UPL: Section 202 requires the state to provide assurances that "the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed [UPLs]." We note that states already must provide such an assurance to receive approval of a change to a payment under the state plan, at least with respect to inpatient services, per Section 447.253 of the CFR (specifically subparagraph (b)(2), which specifies the proposed payment rate will not exceed the inpatient UPL at Section 447.272). We encourage CMS to coordinate these requirements to avoid duplication of effort. Based on our experience, we believe states are very mindful of upper limits and we support continued accountability so providers can depend on the payments they receive and policymakers can be confident in program integrity.

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Thank you again for your thoughtful consideration of our comments. We look forward to working with you on this and other Medicaid issues of importance to CMS and our members.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

CC:
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