



# AMERICA'S ESSENTIAL HOSPITALS

July 3, 2023

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 Ave. SW  
Washington, DC 20201

## **Ref: Medicaid Program; Ensuring Access to Medicaid Services CMS-2442-P**

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the opportunity to comment on the Center for Medicare & Medicaid Services (CMS) proposed rule Ensuring Access to Medicaid Services. We appreciate CMS' clear message that the sufficiency of Medicaid payments is at the core of the statutory obligation to ensure equitable access to care for Medicaid beneficiaries under Section 1902(a)(30)(A) of the Social Security Act. We also support the agency's willingness to learn from and continue to improve its implementation of the statutory requirement, including the gap in effective enforcement to ensure that states address payment deficiencies. However, CMS will not be able to fulfill its unique responsibility of ensuring rates to support equitable access if it continues to omit rate analyses and adequate rate benchmarks for hospital services.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins two-fifths that of other hospitals—3.2 percent on average compared with 7.7 percent for all hospitals nationwide.<sup>1</sup> Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face socioeconomic and sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven and a half million people in communities served by essential hospitals have limited access to healthy food, and nearly 16 million live below the poverty line.<sup>2</sup>

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<sup>1</sup> Clark D, Ramiah K, Taylor J, et al. *Essential Data 2020: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 17, 2023.

<sup>2</sup> Ibid.

Essential hospitals play a unique and vital role in the Medicaid delivery system. 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 on Medicaid funding to carry out their missions and remain viable.

Section 1902(a)(30)(A) of the Social Security Act requires states to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” As noted in the proposed rule preamble, in 2015, the Supreme Court ruled that providers cannot sue to enforce adequate payment rates under this provision.<sup>3</sup> As a result, CMS oversight is the only means 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.

Despite CMS’ efforts to improve current requirements, the agency continues to omit hospital services from the required comparative rate analyses. Rather, it explicitly narrows its focus to professional services delivered primarily by physicians and non-physician practitioners (NPPs) in an office-based setting and excludes facility-based services.

**We urge CMS to take this opportunity to correct the omission of hospital services from its comparative rate analyses in the final rule and ensure equitable access for Medicaid beneficiaries and enable continued progress towards our shared health equity goals.** 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 should include hospital services in the required comparative rate analyses.**

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. Inadequate Medicaid rates harm beneficiaries’ access to care, either by reducing the number or capacity of providers serving Medicaid patients. This is particularly true as compared with the access available to the general population.

Further, Medicaid underpayment continues to challenge the essential hospital workforce. Inadequate rates make it difficult for essential hospitals to recruit and retain providers, ensuring access equal to non-Medicaid patients in their communities. Providers serving Medicaid beneficiaries and the uninsured face high turnover rates and struggle to compete for

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<sup>3</sup> *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378 (2015)

staff with more financially stable systems serving less diverse, less medically complex patients. Today, Black, Latino, and Native Americans are significantly underrepresented in the health care workforce.<sup>4</sup> Challenges finding a health professional similar to a patient's race and ethnicity can negatively impact their experience and outcomes.<sup>5</sup> Low Medicaid rates contribute to the workforce shortage at essential hospitals and negatively affect health equity and outcomes.

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—work they take on despite 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 improving health equity and 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.

America's Essential Hospitals has long argued that Medicaid base rates are not sufficient to enlist enough providers to meet the needs of Medicaid beneficiaries or address their complex needs. Despite efforts to monitor and review payment rates, Medicaid rates remain below costs, Medicare rates, and commercial rates. In fact, industry data shows Medicaid underpaid 62 percent of hospitals in 2020.<sup>6</sup>

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.

**We urge 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.**

- a. CMS should add inpatient and outpatient hospital services to the comparative rate analyses to fulfill its statutory duty to enforce adequate access.**

CMS' current regulations for states to comply with Sec 1902(a)(30)(A) in their fee for service (FFS) programs require access monitoring review plans (AMRPs) for a set of services, including a requirement that states must consider "actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service." But these AMRPs notably omit hospital services (other than behavioral health services that could include inpatient services). States also are required to submit access reviews along with any state plan amendment (SPA) that would cut provider payment rates or impact access by restructuring payments, which could apply to a broader range of services, including

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<sup>4</sup> Salsberg E, Richwine C, Westergaard S, et al. Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce. *JAMA Netw Open*. 2021;4(3):e213789. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777977>. Accessed May 24, 2023.

<sup>5</sup> Takeshita J, Wang S, Loren A. et al. Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings. *JAMA Netw Open*. 2020;3(11):e2024583. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772682>. Accessed May 24, 2023.

<sup>6</sup> American Hospital Association. Fact Sheet: Underpayment by Medicare and Medicaid. February 2022. <https://www.aha.org/system/files/media/file/2022/02/medicare-medicare-underpayment-fact-sheet-current.pdf>. Accessed May 24, 2023.

hospital services. However, there is no threshold for rate levels that would result in access deficiencies and no mechanism for addressing states that simply fail to increase hospital rates for years.

CMS proposes to eliminate AMRPs and replace them with biennial comparative rate analyses. However, the current proposal continues to omit hospital services in the rate analyses and now also excludes inpatient behavioral health services. While the proposed service categories are critical to Medicaid patient access, CMS' reasoning for selecting these services does not justify excluding hospital services.

*i. Hospital services are equally critical to Medicaid beneficiaries.*

CMS explains the selected services—primary care, OB/GYN, and outpatient behavioral health services—are critical preventive, routine, and acute medical services. But, of course, hospital services also are equally crucial to meaningful coverage and are mandatory benefits under federal Medicaid law and required essential health benefits under alternative Medicaid benefit packages. 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.

CMS further justifies the selection because “they often serve as gateways to access to other needed medical services, including specialist services, laboratory and x-ray services, prescription drugs, and other mandatory and optional Medicaid benefits that States cover.”<sup>7</sup> But CMS efforts to ensure access to gateway health providers (i.e., primary care, OB/GYN, and outpatient behavioral) in no way ensures the availability of the services for which the patients are being referred. For Medicaid patients in many communities, essential hospitals provide these services at their inpatient and outpatient hospital-based facilities.

Only measuring access to physicians is insufficient, as the hospitals upon which physicians rely to perform procedures and subsidize care must be adequately funded. Many essential hospitals subsidize their physicians so that they can afford to serve Medicaid patients, given inadequate rates. If a hospital must close or reduce capacity, then access to a multitude of services and supports goes away. **CMS should add hospital services to the proposed comparative rate analyses to ensure access to care for Medicaid beneficiaries.**

*ii. Administrative burden cannot justify the exclusion of hospital services.*

We understand that by limiting services subject to biennial reviews, CMS attempts to lessen the administrative burden on states. But CMS cannot fulfill its statutory obligation without some meaningful oversight of payments for hospital services. 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.

If the burden to states is too great, **CMS should streamline or reduce other elements of the proposal as necessary to broaden the list of critical services subject to comparative rate analyses by including hospital services.**

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<sup>7</sup> 88 Fed. Reg. at 28002

iii. *Inpatient behavioral health services must be included in comparative payment analyses.*

As explained in the context of proposing to exclude inpatient behavioral health services, CMS attempts to justify exclusion of hospital services from comparative rate analyses because the requirement would be duplicative of existing state submissions documenting compliance with upper payment limits (UPLs) as well as new reporting of supplemental payments to hospitals.<sup>8</sup> But those submissions do not assess the adequacy of hospital services base payments to ensure access for Medicaid patients. CMS does not use this data to track changes in rates over time to determine if states are keeping pace with Medicare increases. Nor does reporting involve certain factors, such as geographic- or population-related payment variations, that CMS has identified as relevant to access considerations. UPL submissions are about limits—demonstrating that total payment rates to groups of hospitals in aggregate do not exceed what Medicare would pay. New supplemental payment reporting, while detailed, is about transparency, not adequacy, and ultimately focused on supplemental payments rather than the base rates appropriately subject to the proposed comparative rate analyses. If anything, the availability of base rate and Medicare comparison data that states already are reporting suggests that some degree of comparative rate analysis should be possible with limited additional burden to the states.

CMS acknowledges the national behavioral health crisis and its disparate toll on Medicaid beneficiaries in the preamble, countering the agency's justification against duplicative reporting. It is critical to build access across the spectrum of care, and there are significant gaps in behavioral health community settings. But hospital services for individuals in crisis are a necessary part of that spectrum, and in the interim, while the community infrastructure is lacking, hospitals are shouldering the burden of increased need for services. Further, essential hospitals are providing outpatient behavioral health services in hospital-based clinics in areas and for populations, such as low-income and Medicaid patients, where other hospitals will not invest. **CMS should address the crisis of inadequate access to mental health services by ensuring hospitals receive adequate payment for behavioral health services so they may continue to fill these gaps and serve patients in crisis.**

**b. CMS should not wait for proposals to reduce hospital rates to review rate sufficiency.**

We recognize hospital payments still would be subject to access review if the state proposes to reduce or otherwise change hospital payments in a way that could diminish access. But we remain concerned this process would not adequately monitor and ensure sufficient hospital payment rates (e.g., a state could simply not increase hospital rates, which would not trigger a review but would represent an effective cut to payments). Further, access to hospital services is too fundamental to the health of Medicaid beneficiaries to leave to a secondary process triggered only under certain circumstances and that depends on multiple actions. **CMS should include a regular review of hospital rates, not just when there is a proposed rate reduction.**

**2. CMS should ensure sufficient payments to professionals practicing in hospital settings.**

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<sup>8</sup> 88 Fed. Reg. at 28006.

By excluding hospital services, CMS' comparative analysis review will not capture professionals whose services are billed as part of a hospital service. Even a subset of OB/GYN services CMS identified as critical to the payment analyses will not be included in the analysis when provided on an inpatient basis and paid as part of the hospital service. Including hospital payment rates in the access analysis would help ensure access to identified priority professional services.

The preamble also says CMS is proposing to limit the services to those delivered primarily by physicians and NPPs in an office-based setting and excludes facility-based services. To limit burden on states, CMS identified the services to be reviewed so that the same evaluation and management (E/M) current procedural terminology (CPT)/healthcare common procedure coding system (HCPCS) code level methodology for comparing Medicaid rates to Medicare rates could be used for all categories of services. Specifically, CMS is proposing that Medicaid rates be compared with Medicare non-facility fee schedule rates for the same set of E/M CPT/HCPCS codes, with certain alternative comparisons available when analogous services do not exist in Medicare.

CMS cannot ensure access to professional services if it does not include a review of payment for professional services provided in hospital-based outpatient departments (HOPDs). Professional services are a significant portion of visits at essential hospitals; essential hospitals average 375,000 outpatient visits per hospital a year, compared with 17,000 inpatient discharges.<sup>9</sup> Medicare pays for the professional component of payment for services in HOPDs through fee schedule rates, so CMS could direct states to break out the analysis by site of service and use the corresponding Medicare fee schedule rates for comparison.

Finally, CMS has chosen to identify primary care, OB/GYN, and outpatient behavioral health specialists as the only specialties necessitating access review. While these specialties are critical, access challenges facing Medicaid beneficiaries are not limited to these services. Physician services are mandatory services under federal Medicaid law, and CMS could propose to include all specialties in the reviews. In the alternative, CMS must at least provide a mechanism to add services when there is a real concern about access deficiencies. CMS proposes to eliminate the requirement to add additional services to the regular reviews when "the state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area." CMS should include this or some similar requirement in the final rule.

**We urge CMS to include services provided by physicians and NPPs in hospital settings in payment analyses to ensure sufficient rates.**

### **3. CMS should provide a benchmark to ensure sufficient Medicaid rates.**

We agree with CMS' determination that the comparative rate analyses should focus on Medicaid base rates. Supplemental payments are unevenly available and are subject to ever-changing federal and state rules and limits and, sometimes, significant cuts, such as the disproportionate share hospital payment program.

CMS proposes states perform the required analyses and show Medicaid base rates as a percentage of Medicare rates. Beyond that, CMS does not provide any benchmark for rate levels

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<sup>9</sup> Clark D, Ramiah K, Taylor J, et al. *Essential Data 2020: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed June 7, 2023

that raise access concerns. In the preamble, CMS discusses that the analyses should enable it and states to track trends in payment rates over time to identify potential deficiencies. But despite the laudable proposal to change the reviews to make comparative payment analyses the central focus, the requirements do not guarantee sufficient rates. Even in the proposal to add explicit compliance requirements and enforcement mechanisms through deferral of federal matching funds, the enforcement relates to timely and full completion of analyses and disclosure requirements. If Medicaid base rates are less than Medicare rates, which are less than commercial rates, Medicaid payments are inequitable. Given the relation of rates to access, the resulting availability of access to providers would be inequitable.

- i. An additional review process is needed if Medicaid base rates follow below a set threshold.*

**CMS should incorporate thresholds at or above which base rates would be considered sufficient. Payment rates below the threshold would require additional review** and, in such cases, CMS should have the authority to identify potential access deficiencies and require a state remedy. Even if CMS is unwilling to specify a percentage of Medicare that warrants additional scrutiny and justification, the agency should, at the very least, incorporate authority like that in proposed Section 447.203(c). Under that authority, CMS would use a two-tiered analysis to identify potential access deficiencies, require additional justification, and require a remedy for demonstrated deficiencies when a state submits a SPA to reduce provider payment rates.

- ii. Medicaid base rates should be compared with commercial rates.*

**We further urge CMS to incorporate comparisons with commercial data, at least where available.** States access commercial data for professional services UPL demonstrations under FFS Medicaid and increasingly access hospital commercial data for purposes of Medicaid managed care directed payments. We acknowledge accessing commercial data could prove challenging for some states and that this data might not include all providers for a service or enable the granularity of analysis proposed. That said, if rates must be adequate to give Medicaid beneficiaries the same access as other individuals in their communities, comparative analyses should include rates paid by other representative payers in the area, including commercial rates, which have been shown to be higher than Medicare.

- iii. Comparative payment analyses must note when Medicaid rates have not been updated.*

The comparative payment analysis also should specify if rates were unchanged since the prior review and the last time there were meaningful updates. Some states might choose not to update rates for years. The failure to do so effectively cuts rates to providers and could have significant access implications yet would not be captured in the review of proposed rate reductions. **CMS should signify when rates have remained unchanged in comparative payment analyses.**

#### **4. CMS should strengthen its criteria and state remedies for rate reductions that present a low risk of access issues.**

Closer scrutiny of proposals to reduce provider rates is critical. CMS proposes to replace current requirements for SPAs proposing to reduce rates with a two-tier analysis system that imposes a

more extensive access analysis when states cannot meet certain conditions demonstrating less risk to access. CMS also requires additional transparency and enforcement actions for failure to perform required analyses or address identified access deficiencies. We support efforts like the proposed two-tiered process to focus state and federal resources on review of proposals most likely to impact access. We urge CMS to consider the following in finalizing its proposal.

CMS proposes that one of the criteria a state must meet to avoid second-tier review is to demonstrate that payments for the affected service, including both base and supplemental payments, will equal at least 80 percent of Medicare rates. This benchmark is based on a literature review demonstrating that increasing rates to the third quartile of Medicaid to Medicare fee ratios among pediatricians had the greatest impact on increased acceptance of Medicaid beneficiaries, and that the third quartile of states in terms of Medicaid to Medicare fee ratios had ratios of about 80 percent.<sup>10</sup> While we appreciate CMS' efforts to identify published benchmarks, those studies look at payment levels that result in increases in access for Medicaid patients but not payment levels necessary for equitable access. Those same studies still indicate that access at Medicare rates is lower than access at commercial rates, and it follows that access would be lower for Medicaid payments, at 80 percent of Medicare rates. The cumulative impact of that payment gap is significant for essential hospitals and their professionals, who serve an outsized share of Medicaid beneficiaries. Access gaps would be more severe without hospitals subsidizing professional services and stitching together a patchwork of other support.

In our response to CMS' prior request for information on equal access, we proposed that a state could demonstrate sufficient rates by documenting that Medicaid rates either (1) cover the average costs incurred by providers (looking at costs by certain provider characteristics to account for providers of high-cost services, of particular subspecialties, etc.); (2) are equivalent to what Medicare would have paid; or (3) equal the prevailing commercial rates in the geographic region. If Medicaid payments met one of these three benchmarks, rates might be high enough to increase the number of providers willing to see Medicaid beneficiaries. If states propose reductions when rates already do not meet such thresholds, access issues could exist, and CMS should at least require second-tier scrutiny.

If CMS does not alter the proposed payment threshold of 80 percent of Medicare rates, given the potential of access deficiencies at the proposed threshold, CMS should at least retain the requirement that second-tier scrutiny be required when public comments identify significant access concerns and not permit states to implement remedies other than rate increases without rigorous review.

Further, only evaluating total (base and supplemental) payments does not ensure adequate state investment in base payment rates, which CMS determined to be the appropriate basis for comparative rate analyses. **CMS should review base rate levels as well and consider whether base payments as a share of total payments suggest potential access deficiencies.**

We also support CMS' proposed review of cumulative reductions in rates. **We would further urge CMS to consider the context of reductions in rates that have not been updated for several years.** The cumulative impact of reductions in already inadequate rates could have equally damaging impacts on access.

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<sup>10</sup> 88 Fed. Reg. at 28028.



We appreciate CMS' efforts to add enforcement provisions related to access deficiencies, including disapproval of an SPA and withholding of federal matching funds when deficiencies identified as part of the review are not sufficiently remedied. If states undertake remedies other than rate increases, **we urge CMS to rigorously review the required demonstration of improved access and reserve the ability to require rate increases if access is negatively impacted.**

**5. CMS should include states with high Medicaid managed care enrollment in FFS rate reviews.**

CMS issued a separate proposed rule addressing access in Medicaid managed care and aims to coordinate improvements in access across FFS and managed care delivery systems. We applaud this effort. While it might 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 states with high managed care enrollment comply with the provisions of the biennial rate analyses and rate reduction proposal 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 FFS. 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.

CMS asks for feedback on a prior proposal, never finalized, to exclude states with high managed care enrollment from access reviews. For the reasons above, **we urge CMS to include states with high managed care enrollment in FFS access reviews.**

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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 202-585-0127 or [eomalley@essentialhospitals.org](mailto:eomalley@essentialhospitals.org).

Sincerely,

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President and CEO