WISCONSIN HOSPITAL ASSOCIATION

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June 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS 2442-P, Medicaid Programs; Ensuring Access to Medicaid Services

Dear Administrator Brooks-LaSure:

On behalf of our over 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to comment on CMS-2442-P, the Centers for Medicare & Medicaid Services' (CMS) proposed rule for improving access, quality and health outcomes in Medicaid fee-for-service (FFS) and home and community-based services (HCBS) programs.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small critical access hospitals, mid, and large-sized hospitals, and academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers. We also count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

OVERVIEW

Over the past few years, hospitals have faced unprecedented challenges in meeting the care needs of people in their communities fueled in part by a global pandemic and inflationary cost pressures. Chronic Medicaid underpayments put access to care at risk and drive up the cost of care for other patients, such as those covered through employer-sponsored insurance.

Financially distressed hospitals and health systems often are faced with reducing the availability of services which can result in access challenges for Medicaid beneficiaries. While hospitals and health systems in Wisconsin are working diligently to manage their costs, federal and state governments must be responsible for appropriately funding their programs.

WHA in general supports CMS' commitment to conducting a comprehensive review of access in the Medicaid program, as well as the promotion of greater transparency and accountability with a particular focus on mitigating payment related barriers for providers.

PUBLICATION OF PAYMENT RATES

It is widely known that Medicaid payments fall far short of the cost to hospitals of caring for Medicaid patients. According to publicly available data in Wisconsin from the state-mandated hospital fiscal survey, hospitals received only 67 cents for every dollar they spent caring for Medicaid patients in 2021. This underpayment resulted in a Medicaid shortfall of $1.2 billion. Physician payments also are lagging. The national Medicaid-to-Medicare fee index, which measures each state's physician fees relative to Medicare fees in each state, was just .72 in 2019 according to the data published by the Kaiser Family Foundation's State Health Facts.

CMS's regulatory safeguards are crucial to holding state governments accountable to ensure access for vulnerable populations covered by Medicaid. CMS' proposal would rescind the current regulatory requirements that states develop Access Monitoring Review Plans that analyze the sufficiency of provider rates and access to certain services and replace them with requirements to:

- Publish current Medicaid FFS payment rates in a standardized format;
- Publish biennial analyses comparing a subset of Medicaid rates against Medicare rates for the same service and disclose rates for certain HCBS services; and
- Submit additional analyses for proposed Medicaid rate reductions that meet a certain threshold.

WHA supports CMS's proposal to update the agency's regulatory framework to improve transparency for stakeholders, beneficiaries and the public.

FFS PAYMENT RATE TRANSPARENCY

The rule proposes to require states to publish all Medicaid FFS payment rates on a website accessible to the public. FFS payment rates would need to be organized and formatted in a way that the public could determine the amount Medicaid would pay, including for services paid under a bundled methodology. In addition, states must separately identify the Medicaid FFS payment rates if they vary by population (pediatric and adult), provider type or geographical location. States would be required to maintain the website and update the FFS payment rate information within a month of a rate change. CMS proposes an effective date of Jan. 1, 2026 for states' initial publication of the FFS payments rates.

WHA supports CMS' proposal to require states to routinely publish FFS rates in a format accessible to the public and display rates by population, provider type and geography. If enacted, this increased transparency will ensure the federal government and stakeholders have information about provider payments that they can use to help assess the effects of such payments on access. We expect that such transparency will shed light on states' low-base rates in their FFS programs and illuminate states' chronic underfunding of their Medicaid programs. This becomes particularly important as FFS rates often serve as benchmarks for Medicaid managed payments.

PAYMENT RATE ANALYSIS

CMS proposes to require that states publish biennially a comparison of Medicaid FFS base payment rates for a select set of acute, routine, and preventive services to comparable rates under the Medicare fee schedule. The selected services would include those that often serve as the gateway for beneficiaries accessing other medical services, such as evaluation and management services for primary care, OB/GYN care and outpatient behavioral health services. The comparative analysis would also need to examine rates that vary based on geography and site of service.

WHA agrees that provider rates are a key lever to ensuring access to Medicaid services and that more information is needed regarding the adequacy of provider payment under the program. We support CMS' proposal to require that states evaluate and disclose how rates for certain critical services compare to Medicare FFS rates. However, we urge caution in assuming that Medicare FFS rates are adequate, as Medicare also underpays providers. Indeed, according to the American Hospital Association (AHA), Medicare underpayments to providers in 2020 totaled more than $75 billion. Instead, this analysis should be viewed as one piece of information as policymakers and stakeholders evaluate the impact of provider payment on beneficiary access to care.

STATE ANALYSIS FOR RATE REDUCTION OR RESTRUCTURING

CMS proposes a new "threshold access analysis" when states submit a state plan amendment requesting federal approval to reduce or restructure FFS rates. That analysis would include a comparative analysis to Medicare rates, an assessment of the impact on the state's aggregate spending and public comments on the proposed change. CMS requires additional reporting and analyses by the state if the "threshold access analysis" indicates potential access issues.

In general, WHA supports the approach CMS proposes to require that states conduct a "threshold access analysis," particularly with respect to including concerns raised by stakeholders during a state's public comment process. WHA, however, raises two points for CMS' consideration regarding the proposed criteria.

First, if a state is reducing a payment rate, CMS proposes that the comparative threshold should be no less than 80% of the Medicare rates for the same or similar services. **WHA encourages CMS to establish a threshold above 80% of the Medicare rate.** As previously noted, Medicare, like Medicaid, pays providers less than the cost of delivering care. As such, rates at 80% of Medicare could still result in reduced access, especially for certain key services like specialty care and OB/GYN services.

Second, WHA also has concerns with the criteria that looks at no more than a 4% reduction in aggregate FFS expenditures and describes such a rate change as nominal. In 2018, CMS proposed a similar approach. We are concerned that such an approach ignores payment variation across states and a 4% reduction could be a significant burden for some Medicaid providers. **WHA urges CMS to reexamine the appropriateness of a 4% rate reduction as a criterion in the "threshold access analysis"**

IMPROVING ACCESS TO HOME AND COMMUNITY BASED SERVICES

Through the proposed rule, CMS intends to strengthen safeguards and provide for a more coordinated administration of policies and procedures for individuals receiving Medicaid-covered HCBS. States would be required to:

- Include FFS payment rates for HCBS direct care workers in the public reporting of FFS rates;
- Establish a grievance system for FFS HCBS programs;
- Require that at least 80% of Medicaid payments for personal care, homemaker and home aide services be spent on compensation for the direct care workforce;
- Publish average hourly rates for personal care, home health care and homemaker services;
- Establish an advisory group to advise on direct care worker provider rates; and
- Report publicly on waiting lists for HCBS waiver programs, as well as on a standardized set of quality and compliance measures.

Lastly, if the HBCS proposed requirements are finalized, CMS plans to align the new requirements across the various Medicaid HCBS authorities found in 1915 (c), (i), (j), and (k) as well as 1115 demonstration authority.

In general, WHA supports CMS' proposal to improve oversight of the HCBS programs and improve safeguards for HCBS beneficiaries and the HCBS workforce. HCBS programs are a key component of the continuum of care and allow hospitals to transition patients more safely to post-acute services. However, we are mindful of how additional requirements could burden smaller HCBS organizations. For example, the requirement that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation is likely to help bolster the HCBS workforce through improved wages. However, for some HCBS organizations, especially those that are smaller and/or rural, that requirement may be difficult to initially meet. CMS could consider giving states additional flexibility regarding this compensation requirement if these organizations meet certain criteria supportive of the HCBS workforce.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS's proposals to alleviate provider burden and improve patient care. If you have any questions, please feel free to contact Joanne Alig, WHA's Senior Vice President for Public Policy, at jalig@wha.org.

Sincerely,

Eric Borgerding
President & CEO