



A Passionate Voice for Compassionate Care

July 3, 2023

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

Re: CMS-2442-P - Medicaid Program; Ensuring Access to Medicaid Services (88 Fed. Reg. 27960, May 3, 2023)

Dear Administrator Brooks-LaSure,

The Catholic Health Association of the United States, the national leadership organization of the Catholic health ministry, representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organization across the continuum of care appreciates the opportunity to comment on the Center for Medicare & Medicaid Services' (CMS's) proposed rule, "Ensuring Access to Medicaid Services."

Medicaid is a crucial element of our nation's safety net and provides essential health care services to working families, children, the elderly and the disabled, many of whom would be uninsured and without access to health care in the absence of a strong and vital Medicaid program. It is imperative that people who rely on Medicaid have timely access to the care they need, which is why it is so important that state and federal financing for Medicaid is sufficient to provide adequate payment to Medicaid providers. CHA welcomes and supports CMS' efforts to increase transparency and accountability in Medicaid fee-for-service programs and offers comments in the following areas.

- **Medicaid Advisory Committee and Beneficiary Advisory Group**

CHA supports CMS' proposals to replace the current Medical Care Advisory Committee and replace it with a Medicaid Advisory Committee (MAC) and a dedicated Beneficiary Advisory Group (BAG). CHA supports the broadened scope of topics on which these groups would advise the state Medicaid agency, particularly with respect to beneficiary and provider communications, cultural competency, language access, health equity and other issues that impact the provision or outcomes of health and medical services.

The proposed MAC membership requirements would include "clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and

with the resources available and required for their care,” including “providers or administrators of primary care, specialty care, and long-term care.” CHA urges CMS to specify that at least one MAC member should represent the perspective of hospitals serving a significant volume of Medicaid patients. Such hospitals, including many of our members, anchor their communities in terms of clinical care, connection to social services, and employment. Moreover, they often grapple with thin or negative margins due in part to Medicaid rates that are insufficient to cover the cost of care. Their voice is essential in the MAC.

The BAG membership would be current or former Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries (i.e., their family members and caregivers), and BAG members would comprise at least 25 percent of the MAC. **CHA strongly supports giving those with direct experience with Medicaid services a voice in how the program is structured and administered.** We urge CMS to develop best practices and provide states with resources to ensure the BAGs include representatives from diverse cultural and regional backgrounds. CMS should also encourage and assist states to provide BAG members with transportation, financial and other assistance as needed to ensure their participation.

- **Home and Community-Based Services (HCBS)**

CMS makes several proposals to strengthen and coordinate home and community-based services (HCBS), many related to the payment of HCBS direct care workers. To help address direct care workforce shortages, CMS proposes to require that at least 80% of all state Medicaid MCO and FFS payments for homemaker services, home health aide services, and personal care services be spent on compensation to direct care workers. CMS also proposes to require states to annually report on the percentage of payments for homemaker, home health aide and personal care services that is spent on compensation for direct care workers. To support stakeholders’ awareness of how Medicaid payment rates for these services are established, CMS proposes to require states to publish every two years the average hourly rate paid to direct care workers delivering personal care, home health aide, and homemaker services.

CHA appreciates the focus on HCBS caregiver wages, necessary to ensure both workforce adequacy and just payment of these increasingly crucial workers. CMS has invited comment on whether 80 percent is the appropriate figure for the proposed minimum payment. As CMS moves toward finalizing the policy, **CHA urges the agency to factor in considerations such as the administrative burden of implementation and the varying capacities of HCBS organizations, especially smaller ones and those in rural areas.** We agree with the proposed four-year implementation timeline and suggest CMS consider a phased-in approach to the minimum payment policy as well.

- **Documentation of Access to Care and Service Payment Rates**

The Social Security Act (the Act) requires that states pay Medicaid providers an amount “sufficient to enlist enough providers so that care and services are available...at least to the

extent that such care and services are available to the general population in the geographic area.” (Section 1902(a)(30)(A)). States and CMS have a shared responsibility under the law for ensuring compliance. In 2015, the U.S. Supreme Court in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378, held that Medicaid providers and beneficiaries do not have a private right of action to challenge states’ Medicaid payment rates in federal courts under the federal access standard. That decision left CMS as the sole source of oversight of the adequacy of state Medicaid rates, a crucial responsibility because failure to reimburse providers enough to cover the cost of care puts access to health care at risk for Medicaid beneficiaries,

CMS currently requires states to develop access monitoring review plans (AMRPs) that analyze the sufficiency of provider rates and access to certain services. In the current proposal, CMS would rescind the AMRPs and replace them with a requirement that states:

- Publish their current Medicaid FFS payment rates in a standardized format;
- Publish biennial analyses that compare a key subset of Medicaid rates against Medicare rates for the same services, in addition to rate disclosures for certain HCBS; and
- Submit additional analyses in connection with proposed Medicaid rate reductions.

CMS notes that it believes that the newly proposed processes would more appropriately balance state administrative burden while also providing more robust and meaningful oversight of beneficiary access to care. **CHA supports these steps to improve payment transparency, which will benefit patients, providers and the public.**

Payment Rate Transparency – Publication of Rates

CMS proposes to require states to publish all their Medicaid FFS payment rates in a clearly accessible, public location on the state’s website accessible to the general public, easily accessed from a hyperlink on the state Medicaid agency’s website and organized so that a member of the public can readily determine the amount that Medicaid would pay. In the case of a bundled methodology, each service included in the rate must be identified. Payment rates that vary by population (pediatric and adult), provider type and geographical location must also be identified. **CHA supports the proposal for publication of state Medicaid FFS rates.** The publication of this information will contribute to the assessment of whether payment rates to providers are adequate to ensure patient access. The increased transparency will benefit policy makers, government entities and beneficiaries.

Payment Rate Transparency – Comparative Rate Analysis

In addition to the annual publication of all payment rates, CMS proposes that every other year states publish an analysis comparing Medicaid FFS and Medicare payment rates for the following critical services: evaluation and management services for primary care, obstetrical and gynecological services, and outpatient behavioral health. CMS notes these services were selected because they are critical preventive, routine, and acute medical services that often serve as first

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steps to accessing other needed medical services. The states would have to stratify payment rates by population (pediatric and adult), provider type, and geographic location, as applicable. **CHA supports comparing Medicaid FFS rates to Medicare rates as one means of analyzing Medicaid payment sufficiency.** We note that Medicare also under-reimburses providers for the cost of care and therefore should not be the only standard for Medicaid payment adequacy.

State Analysis Procedures for Rate Reduction or Restructuring

CMS proposes changes to its system for assessing if state plan amendments designed to reduce or restructure provider payment would also reduce access to services. Specifically, CMS proposes that states would be required to demonstrate that any SPA seeking to reduce provider payment rates or to restructure provider payments will not put access to care at risk. The required analysis would include a comparison 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. **CHA supports these proposals but reiterates concerns expressed above about using Medicare alone as the yardstick for Medicaid payment adequacy.**

In closing, thank you for the opportunity to share these comments regarding the proposed Medicaid access rule. We appreciate and share CMS' commitment to ensuring providers are reimbursed at a level that will ensure access to beneficiaries in need of health care. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



Lisa A. Smith
Vice President
Advocacy and Public Policy