July 1, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: CMS-2442-P, Medicaid Program; Ensuring Access to Medicaid Services; Proposed Rule, Federal Register (Vol. 88, No. 85), May 3, 2023

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on access to services for Medicaid beneficiaries, particularly in fee-for-service (FFS) delivery systems.

As noted in the overview of the rule, as of December 2022, the Medicaid program provides essential health care coverage to more than 85 million individuals nationwide, and, in 2021, accounted for 17% of national health expenditures. In California, the staggering size of the Medicaid program (Medi-Cal) makes it a critical component of California's overall health care delivery system. As of November 2022, Medi-Cal covered roughly 15.5 million individuals[1] — nearly 40% of all California residents[2]. This includes over 5.7 million children, nearly 1.5 million individuals over 65, and over 10 million enrollees who are people of color.[3] Furthermore, Medi-Cal funds over half of the births in the state and in 2022-23 is projected to spend nearly $142 billion in total funds across the program[4]. This would make it the largest program in terms of budget in the state and the second-largest programmatic budget in terms of state General Fund dollars behind education California's Medi-Cal program is by far the largest in the country in terms of enrollment[5] and expenditures.[6]

[1] https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-Nov2022.pdf
[2] U.S. Census Bureau QuickFacts: California
[3] Medi-Cal Monthly Enrollment Fast Facts
[4] DHCS FY 2023-24 GB Highlights_1.10.23.pdf (ca.gov)
[5] Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID-19 Pandemic | KFF
[6] Federal and State Share of Medicaid Spending | KFF

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CHA shares CMS' goals of the proposed rule, which would increase overall transparency and accountability, particularly as it relates to provider payments, in an effort to improve access and health equity in the Medicaid program. We appreciate CMS acknowledging the inextricable link between access to care and payment sufficiency. Notably, there are aspects of the proposed rule we generally support but feel could be further strengthened to better achieve CMS' desired outcomes. Furthermore, we have concerns that some provisions, if not considered and implemented in a reasonable fashion, could have the potential to negatively impact access or not allow for a level of transparency and accountability necessary to inform CMS and state administrators. We further detail these concerns and potential challenges and provide comments and suggestions that we believe would improve the regulatory changes proposed under this rule.

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG)

CHA is generally supportive of CMS' intent to modify the stakeholder engagement process to create a more robust and transparent forum through the updated requirements for a MAC and newly proposed requirements to establish a BAG. This would increase the level of engagement and opportunity to provide feedback from individuals being served by the Medicaid program. We also support the expansion of required topics of discussion to include issues beyond "health and medical services," given the increased focus on social determinants of health, quality, health equity, and non-traditional services that can improve overall health and outcomes (such as in lieu of services).

Hospitals and health systems are a critical component in the Medicaid program and serve as the primary access point to vital health services, most notably emergency, acute, tertiary, and quaternary levels of care. They also serve as a critical care coordination entity through their case management and discharge planning roles. For these reasons, they have unique insight into how effective care is being coordinated across the delivery system and what level of access is available to covered outpatient services and supports. Furthermore, hospitals and health systems are often at the forefront in the administration or coordination of programs designed to improve health equity and quality, addressing social determinants of health, and/or referring to non-traditional services. As a result, hospitals' input and insights in the administration of the Medicaid programs in their state are paramount to achieving the goals of increased access to care and improving the quality of services delivered.

Therefore, while we understand CMS' intent to have a diverse group of MAC participants in order to provide feedback and perspectives to the agency, CHA recommends that states be required or at least have the flexibility to establish standing and permanent membership and representation from certain provider types — such as hospitals — on their MACs, which would not be subject to renewal or rotation. To ensure that CMS maintains the proposed goal of transparency into MAC membership, members and organizations chosen or required to have standing membership on the MAC could be clearly articulated and selected as part of a public process and/or publication of bylaws and governance and reporting on the state's website.

Home and Community Based Services

CHA is generally supportive of the newly proposed federal regulations regarding Medicaid Home and Community Based Services (HCBS). We commend CMS for prioritizing consumer protections through the establishment of person-centered service plan requirements, the implementation of a comprehensive grievance system, and the enforcement of investigative requirements for critical incidents. These proposed regulations demonstrate a significant step towards ensuring the well-being and safety of Medicaid beneficiaries receiving HCBS. However, while we do not necessarily have a recommendation, CHA does have some concerns regarding the proposed provisions around HCBS payment adequacy and

whether these proposed requirements could have an unintended consequence, such as a chilling effect on new or expanded participation by HCBS entities due to their inability to meet the wage requirements and therefore resulting in a reduction of access to these HCBS services.

The inclusion of person-centered service plan requirements, including the requirements to complete a functional reassessment and update of an individual person-centered service plan for 90% of individuals enrolled in an HCBS waiver will hopefully improve the identification of HCBS services that an individual could benefit from, and in a more timely fashion, improve their health and well-being. By emphasizing individual needs, preferences, and goals, this person-centered approach empowers patients and ensures their active participation in decision-making processes related to their care. Therefore, CHA is generally supportive of these newly proposed requirements and allowing for a three-year implementation once the final rule is adopted seems reasonable.

The establishment of a comprehensive grievance and appeals system, as proposed by CMS, is a critical component of ensuring that beneficiaries have access to a fair and timely process for addressing concerns or complaints regardless of delivery system. By creating a transparent and accessible mechanism for beneficiaries to voice their concerns and seek resolution within the FFS delivery system, akin to the similar avenues for redress and due process in managed care, the proposed regulations demonstrate CMS' commitment to promoting accountability and patient-centered care within HCBS offerings regardless of delivery system. Therefore, CHA is generally supportive of these proposed requirements and allowing for a two-year implementation time period once the final rule is adopted seems reasonable.

In requiring states to establish an incident management system and a more robust critical incident investigation process, we are hopeful that oversight of HCBS will be meaningfully improved and patient protections related to instances of abuse and neglect will be strengthened. Having clear, standardized definitions of what constitutes a critical incident, how states collect and report on those incidents, and requiring states to demonstrate how states have responded to those incidents, we are hopeful this will help to improve the quality of HCBS, offer greater protections for a vulnerable population that often are subject to abuse and neglect, and increase overall consumer satisfaction and trust in HCBS providers by creating a system of accountability. Therefore, CHA is generally supportive of these newly proposed requirements and allowing for a three-year implementation time period once the final rule is adopted seems reasonable.

While we support the goal of fair wages for HCBS providers, CHA does have some concerns with the CMS proposal that would require 80% of Medicaid expenditures for homemaker, home health aide, and personal care services to be directly spent on compensation to direct care workers, without additional analysis on the potential consequences and impact this may have on overall access. California hospitals are facing severe challenges as it relates to patient throughput and being able to effectively discharge patients into lower levels of post-acute care. One of the primary drivers for these challenges is the lack of post-acute services and support for these patients. Therefore, we are sensitive to any changes to policy, especially those that may take a limited, one-size fits all approach that may disincentivize or remove the ability of organizations to invest in other program efficiencies that will ultimately negatively impact access to post-acute placement options. At this point, we are not certain of the exact level of current spending on Medicaid HCBS in California that goes toward direct service worker compensation, and believe that more thorough analysis is warranted before codifying what could be an unworkable mandate. Without a further and more comprehensive analysis, tailored to the market and other conditions in each state, CHA is fundamentally concerned with the impact such a wage spending requirement could have on either existing HCBS provider entities by limiting or eliminating services, or

discouraging new HCBS provider entities from entering the market and thus having a negative impact on overall post-acute care access.

While we are optimistic that these proposed changes will improve access, accountability, and the delivery of Medicaid HCBS, we are concerned that without sufficient time and guidance from CMS that these changes could have a negative impact on access to HCBS. Therefore, CHA recommends that CMS take a thoughtful approach that considers differences among states, differences within a state as particularly diverse as California, and allows for sufficient flexibility for states to tailor their implementation in accordance with their own needs and goals. This would include providing specific guidance to states in how to implement these proposals prior to being subject to the requirements, allowing for sufficient time for states to meet the implementation requirements, and ensuring states have access to the information necessary to meet these requirements. Furthermore, CMS should consider possibly starting with implementation on a smaller waiver population to allow for lessons learned that could later be phased in to additional populations and programs over time. We urge CMS to carefully evaluate the impact of these proposed regulations on access to post-acute care placement options. It is imperative that any regulatory changes do not exacerbate the existing challenges faced by hospitals in facilitating efficient patient flow and transitions of care.

In conclusion, CHA fully supports the consumer protections outlined in the proposed federal regulations for Medicaid HCBS. We appreciate CMS' commitment to enhancing the quality and safety of HCBS, and we believe that the measures proposed will significantly benefit Medicaid beneficiaries. We encourage ongoing collaboration between CMS, state agencies, and stakeholders to ensure the successful implementation of these regulations. Furthermore, we emphasize the importance of CMS evaluating the potential impact on access to post-acute services and ensuring that these recommendations will effectively increase access rather than hinder it.

Documentation of Access to Care and Service Payment Rates

CHA strongly believes adequate Medi-Cal reimbursement is critical to supporting access to medically necessary care and is fundamental to fulfilling the commands of the Social Security Act (SSA). Perhaps most foundational, Section 1902(a)(30)(A) of the SSA 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." We support CMS' efforts in this rule to take initial steps that begin to acknowledge the need for robust and ongoing transparency and analysis of Medi-Cal provider payments and recognize the foundational role payment adequacy plays in ensuring the Medi-Cal population has sufficient access to the health care services they need and deserve. We hope this is just the first step in gathering information that would allow for future supporting actions that would address the systemic underfunding of the Medi-Cal program that is limiting, or sometimes preventing, the ability of the State to provide the same level of access to the general public as is required under the SSA. As evidenced by the Kaiser Family Foundation analysis, the average per capita spend on health care in California in 2020 was approximately $10,299[7], while the average per enrollee spend in Medi-Cal was $6,589[8]. Appropriate payment rates support access by increasing provider participation in the Medi-Cal program, supporting the long-term financial stability of essential providers, such as hospitals, and allowing for investments that can improve the quality of care for Medi-Cal members that

[7] https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[8] https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

are often amongst the most vulnerable and disadvantaged populations. Sadly, Medi-Cal rates generally fall far below those of other payers. The Medi-Cal program cannot expect to ensure meaningful and timely access to high-quality services while paying substantially less than other payers, so much so that providers must take a significant financial loss with every Medi-Cal patient they serve.

California's hospitals continue to face unprecedented financial pressure resulting from the COVID-19 pandemic's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[9] (driven by increases in salary costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation. Chronic underfunding by Medi-Cal contributed to the recent closure of one hospital in California (Madera Community Hospital[10,11]), drove another into bankruptcy (Beverly Hospital[12]), and has forced others to eliminate financially unsustainable services to ensure the facilities can remain open. And, unfortunately, more hospital closures are anticipated. Kaufman Hall, a nationally renowned consulting firm, estimates 20% of California's hospitals are currently on the financial brink.

The financial challenges facing hospitals — which were recognized in the Medicare Payment Advisory Commission's (MedPAC) recent hospital payment update recommendations to Congress[13] — threaten access to care for not just Medi-Cal beneficiaries, but all members of the affected community. Following hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that rural hospital closures increase inpatient mortality by 8.7%, with Medicaid patients (including those who are dually eligible) and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively. These are not abstract data points. Sadly, two individuals' deaths have already been attributed[14] to Madera Community Hospital's closing.

For instance, as demonstrated in the most recent federally approved 2022 hospital upper payment limit demonstration, California Medi-Cal FFS payments, which includes base payments and supplementals besides those that are funded through the self-financed hospital fee, are only 70% of the equivalent Medicare rate for those same hospital inpatient services. Furthermore, hospital FFS base level reimbursement rates have not been increased in aggregate for over a decade. This longstanding underpayment trend has been exacerbated by the labor dislocations and supply chain breakdowns directly resulting from the COVID-19 pandemic. These exacerbations are expected to persist, driving further inflation in input costs. Expenses per adjusted discharge have accelerated dramatically, offsetting the limited increases in revenue hospitals have experienced, which has resulted in reduced margins that threaten hospitals' financial viability. California hospital expenses per discharge have increased 25% since 2019 (pre-pandemic) and as stated above, California invested zero dollars in any new Medi-Cal FFS inpatient spending for California hospitals throughout the pandemic.

For these reasons, we support CMS' efforts to begin to get a better handle on payment rates provided by Medicaid programs across the country. We strongly support the requirement for states to publicly report all FFS rates for Medicaid services. Transparency is a good first step to identifying further steps that need to be taken to better support providers and better allocate finite resources to areas of greatest

[9] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update
[10] https://calmatters.org/health/2023/01/hospital-closure/
[11] https://abc30.com/madera-commuity-hospital-remains-closed-emergency-services-residents/12922392/#:~:text=Ashraf.-,Madera%20Community%20Hospital%20closed%20its%20doors%20in%20December%20of%20last,Madera%20for%20over%20forty%20years.
[12] https://www.latimes.com/california/story/2023-04-20/beverly-hospital-in-montebello-files-for-bankruptcy-in-effort-to-avoid-closure
[13] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[14] https://www.fresnobee.com/news/local/article272712840.html

need. However, we believe it is important that when those rates and comparisons to Medicare are published, they separately include the base payment absent supplemental payments compared to Medicare and the aggregate net payment compared to Medicare, after taking into account any self-financing through hospital fees, intergovernmental transfers, or certified public expenditures. While this may be complicated, CHA believes this is necessary in order to provide a clear and accurate picture as to what hospitals actually receive on a net basis in FFS Medi-Cal payments.

Similarly, while we support the comparative rate analysis requirements in the proposed rule as a first step in reviewing Medicaid rates for primary care, obstetrical, gynecological, and outpatient mental health services versus what is provided under Medicare, we feel this analysis should be further expanded to hospital and emergency department services, including hospital inpatient psychiatric services. As stated above, hospital FFS inpatient Medi-Cal rates have not seen a base rate increase in over a decade and hospital emergency department base rates have similarly not been adjusted in years and are inadequate. Conducting this analysis will provide systematic information on Medi-Cal payment rates for these services and how they compare to Medicare levels. We would also note that, while Medicare is a justifiable benchmark to be used for standardizing comparisons, we would argue Medicare should not be seen as adequate as it still does not cover the totality of costs of providing care to the Medi-Cal or Medicare population. Based on CHA analysis of HCAI data, hospitals in California lose $.25 per dollar of cost providing care to Medicare beneficiaries. CHA believes it is critical that hospital inpatient and emergency services be subject to this required and periodic analysis, and should not be only analyzed when a state proposes to reduce or restructure rates, which fails to acknowledge those payment rates that have historically been underfunded.

Process and Cost Concerns

The volume and scope of changes being proposed under this rule (particularly in conjunction with the Managed Care, Access, Finance, and Quality rule) if adopted would result in significant changes to the Medicaid program and would require adequate time and resources to implement. Furthermore, CMS has requested feedback on issues or policy options in the preamble, but did not make any proposed changes to the regulations themselves nor conduct the necessary level of impact and fiscal analyses. CHA is concerned that these policies alluded to in the preamble would be finalized within new regulatory language that was not subject to traditional notice-and-comment, and thus not vetted in accordance with what the federal Administrative Procedure Act requires. Therefore, CHA strongly suggests that any new regulatory text changes not noticed in the immediate rule are subject to subsequent rulemaking, where the public may respond to full fiscal and impact analyses and afford a meaningful opportunity for public comment as to the actual regulatory language prior to finalizing.

Also, the volume and scope of these changes, across both this rule and the companion Managed Care rulemaking, if finalized, will create a significant level of administrative workload and cost on states to implement. Therefore, we are concerned about some of the proposed timelines for implementation, but we also are concerned on the administrative cost these new requirements will have on states. As mentioned above regarding FFS rate transparency, CHA has strong concerns about the level of hospital base reimbursement and the lack of any meaningful increase to these rates in over a decade. One of the reasons for this lack of investment is due to limited state budget resources. If finalized, these rules would result in considerable additional administrative costs on the state in order to implement them, which further reduces budget resources that we believe would be better invested into providing actual care to Medi-Cal members. If providers are not reasonably compensated for the services they provide to Medicaid enrollees, it only would serve to undermine the very goal of improving access to high quality health care services. Therefore, while CHA supports these overall goals and many of the proposed

changes, we would request that CMS consider enhanced federal matching funds to states in order to design, develop, and implement the finalized rules. This would be similar to enhanced federal matching funds that are already made available to states for certain investments such as their information technology systems.

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact me at rducay@calhospital.org or (916) 552-7643, or Chad Mulvany, vice president of federal policy, at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Robert Ducay
Vice President, Policy