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June 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human
Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) on ensuring access to Medicaid services published on May 3, 2023 (CMS 2023a). MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

This proposed rule includes a number of provisions designed to meet the statutory obligations to ensure that Medicaid provides access to services by increasing payment rate transparency, standardizing reporting, and promoting beneficiary engagement. This letter draws on the Commission's work over the years and highlights pertinent recommendations. We also direct the Administrator to our comments on the simultaneously released NPRM related to Medicaid and CHIP managed care access, financing, and quality.

We would like to provide the Commission's overall support for the objectives of the rule. Since its inaugural report, the Commission has recognized the importance of ensuring access to care for Medicaid beneficiaries (MACPAC 2011). More recently, the Commission has focused its attention on opportunities to address limitations of the existing monitoring approach and made a series of recommendations on how to better monitor access in Medicaid, some of which align with the provisions of the proposed rule (MACPAC 2022a, 2017a).

The Commission also notes some general reservations regarding state capacity to implement the proposed changes within the timeframes allotted. Given states' current focus on unwinding activities associated with the end of the public health emergency (PHE), we encourage the Centers for Medicare & Medicaid Services (CMS) to consult with states about a realistic timeline. If states are also required to implement new rules related to access, managed care, and eligibility and enrollment processes, we have concerns that this would hinder states' ability to successfully unwind and may risk inappropriate coverage loss among beneficiaries.

Medicaid and CHIP Payment
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Beneficiary engagement

The Commission supports the principle of including beneficiaries in the design and administration of the Medicaid program, as well as the process for assessing access. Beneficiaries have a great deal to offer in the development of policies and can provide valuable feedback on how well programs are serving them as well as areas for improvement. Beneficiary engagement strategies can help build trust between state Medicaid agencies and the beneficiaries they serve and promote program accountability (MACPAC 2022b).

Beneficiary input on access to care. Although the NPRM does not address it, we reiterate our recommendation that CMS implement a new system to monitor access that specifically incorporates the beneficiary voice and experience. Beneficiary feedback can be particularly useful to understand lived experience, services used, and access barriers. One of the key shortcomings of the existing access monitoring system is that it does not capture all the domains of access, most notably beneficiary experience. For example, many states rely on administrative data to monitor access and utilization of services, but this approach does not capture unmet health needs, barriers to care, beneficiary perceptions of care, or self-reported health status. The Commission noted this gap as a rationale for recommending that CMS field a federal Medicaid beneficiary survey. The proposed managed care rule would require states to conduct an annual enrollee experience survey for beneficiaries enrolled in managed care plans, which would only partially implement MACPAC's recommendation (MACPAC 2022a, CMS 2023b). The Commission is concerned that the lack of information for beneficiaries enrolled in fee for service (FFS), who are among some of the most vulnerable, will limit the ability to compare access across delivery systems and leave a considerable number of individuals enrolled in the program without an opportunity to provide meaningful feedback on their experiences (MACPAC 2017a).

Medicaid Advisory Committees and Beneficiary Advisory Groups. We are generally supportive of promoting beneficiary engagement through Medicaid Advisory Committees (MAC) and exploring opportunities to leverage them to advance health equity. The Commission believes there should be diverse representation of Medicaid beneficiaries participating in policymaking decisions, including beneficiaries of color and individuals with disabilities, who can share their experiences with Medicaid (MACPAC 2022b, 2022c). The proposed rule requires that state Medicaid agencies establish a Beneficiary Advisory Group (BAG). Tailoring engagements to smaller groups with common backgrounds may help participants feel more comfortable sharing their experiences with state Medicaid program and plan officials (MACPAC 2022b).

The Commission supports strategies to increase beneficiary participation (MACPAC 2022c). Beneficiaries may face logistical barriers, such as the inability to take time off work, secure transportation, and procure child care, that limit their participation in advisory councils. The proposed rule will require states to offer in-person and virtual attendance options to increase member participation in MAC and BAG meetings.

Home- and community-based services grievance system

MACPAC appreciates CMS efforts to create consistency in Medicaid home- and community-based services (HCBS) administration between FFS and managed care. Currently, all Medicaid applicants and beneficiaries, including HCBS participants, regardless of delivery system, have the right to a fair hearing before a state Medicaid agency. However, beneficiaries receiving HCBS in FFS do not currently have a mechanism for lodging grievances that do not meet the bar for a fair hearing. The NPRM would require states to make available a process for beneficiaries to submit grievances for Section 1915(c) waiver services delivered via FFS. The grievances may be related to a state or provider's compliance with person-centered planning and service plan requirements as well as HCBS settings requirements, neither of which are subject to a fair hearing requirement.

HCBS payment adequacy

As the nation's primary payer for HCBS, Medicaid programs are acutely affected by workforce shortages. A sufficient direct care workforce is necessary to meaningfully serve people in the community, which aligns with beneficiary preferences, as well as statutory and judicial mandates (MACPAC 2023a, 2022d, 2019a). Prior MACPAC work indicates that low wages, when coupled with other factors like limited career advancement opportunities and lack of benefits (e.g., health insurance or retirement accounts), leads to high turnover rates for direct care workers (DCWs). Moreover, these same workers may be able to find higher paying jobs in the private home care sector or in other sectors, such as the fast food or retail industries (MACPAC 2023a, 2022d, Espinoza 2021).

The Commission encourages CMS to work with other federal agencies and stakeholders to consider the implications of defining the direct care workforce, such as for data reporting, payment rates, and training requirements. The current lack of a standard definition has made it difficult to collect data on this workforce. For example, the U.S. Bureau of Labor Statistics collects data on home health and personal care aides, but there is no unique standardized occupational code for direct support professionals (BLS 2020).

Waiting list transparency

MACPAC is generally supportive of increased transparency around waiver waiting list management practices. A 2020 MACPAC analysis of Section 1915(c) waivers and Section 1115 demonstrations documents for all 50 states and the District of Columbia found that 199 out of 254 Section 1915(c) waivers and 11 of 14 Section 1115 demonstrations documented how waiting lists are managed (MACPAC 2020a, 2020b). The proposed rule would require states to provide an annual description of how they maintain their Section 1915(c) waiver waiting list, the number of people on the waiting list, and the average amount of time individuals spend on the waiting list.

Greater transparency around waiting lists may help address issues related to beneficiary confusion and accuracy of waiting list information. We heard in interviews that individuals and families may not understand waiting lists or be unaware of how long they will have to wait to receive services. As with other notices, beneficiaries may find information regarding waiting lists confusing and may need help interpreting and responding (MACPAC 2022e). In addition, waiting lists have varying levels of transparency for beneficiaries and may contain inaccurate or outdated data. A few states that had significantly reduced waiting lists told us they did this by removing duplicate applications, as well as applications for those who had moved out of state, died, or no longer needed services. Some states periodically reassess the needs of individuals on waiting lists, and sometimes find individuals who are eligible for state plan services that would meet their needs in lieu of waiver services (MACPAC 2020b). Transparency of waiting list information, in a consumer-friendly and accessible format, can facilitate program accountability and potentially improve beneficiary understanding of waiting list information (MACPAC 2020b, 2017a).

HCBS quality measures

MACPAC supports efforts to ensure that the HCBS quality measure set is consistent across programs, updated to address possible gaps in measures, and relies on measures that are meaningful to evaluate the delivery of HCBS. The NPRM proposes to require the use of the HCBS quality measure set in 1915(c) waiver programs, which would promote public transparency related to the administration of Medicaid-covered HCBS and would enable comparisons across states on quality performance and the calculation of national performance rates for quality of care. Aligning quality metrics across HCBS programs could allow for more comparative data, as CMS notes.

Prior MACPAC findings point to stakeholder concerns related to the lack of coordination on quality metrics across HCBS programs (MACPAC 2023a). Earlier work on quality measurement for HCBS and behavioral health in Medicaid also points to existing measurements gaps for Section 1915(c) (SHADAC 2016).

The Commission supports efforts to stratify measures by race and ethnicity as a means to identify disparities and adopt policies to promote equity, but also notes that data limitations continue to pose a challenge as some states have high rates of missing data. Although CMS has proposed an imputation method for missing race and ethnicity data, CMS may wish to examine the challenges in collecting these data, including beneficiaries' hesitance to self-report due to concerns about how the information may be used, and inaccurate responses if they do not understand the race and ethnicity questions or do not feel their identities are reflected by the available response options. The Commission made two recommendations to improve the collection of race and ethnicity data in Medicaid applications focused on increasing beneficiaries' understanding and comfort in providing accurate responses (MACPAC 2023b).

Applicability of certain standards in fully fee-for-service states

As noted in our comments on the proposed managed care rule, the Commission generally supports greater alignment between FFS and managed care access monitoring requirements. Specifically, the Commission's June 2022 recommendations called for an access monitoring system that is based on a common set of access measures that are consistent and comparable across states, delivery systems, and populations (MACPAC 2022a).

The proposed rule seeks comment on whether any of the additional access standards in the proposed rule on managed care access, financing, and quality should also apply to states with FFS delivery systems. Specifically, the proposed managed care rule includes additional standards for appointment wait times for specified services that are not included in the proposed FFS access rule. CMS also proposes to require secret shopper surveys to validate compliance with the proposed wait time standards. While the Commission has not weighed in on specific timeliness standards or endorsed the use of secret shopper surveys, we support the general principle that requirements for managed care delivery systems similarly apply to FFS delivery systems.

Fee-for-service payment transparency

In general, the Commission supports efforts to promote additional payment transparency and encourages states and CMS to share data in a format that is useful for analysis. The Commission has recommended that CMS collect and report payment information for hospital and nursing facility services at the facility level (MACPAC 2023c, 2016). For nursing facilities in particular, MACPAC's March 2023 report to Congress notes the importance of collecting per diem payment rate information because this information is difficult to calculate using existing payment data in the Transformed Medicaid Statistical Information System (T-MSIS) (MACPAC 2023c).

The proposed access rule would require states to publish FFS rate information for all services on their websites, beginning January 1, 2026. (As noted in our comments on the proposed managed care rule, CMS is not proposing similar payment transparency requirements in managed care.) The intent of this provision is to enable members of the public to determine the amount that Medicaid would pay for a specific service. These payment rate transparency requirements would also be used to support additional reviews of payment rates for specific services required in the proposed rule. MACPAC's prior reviews of state FFS payment methods have identified several technical issues that CMS could consider when implementing this requirement to ensure that payment data are accurate and complete.

First, it is unclear how supplemental payments will be factored into the payment transparency requirements. MACPAC's prior work has illustrated that supplemental payments are a large share of Medicaid spending for many services. For example, in fiscal year 2021, about 22 percent ($51 billion) of FFS payments to hospitals, mental health facilities, nursing facilities, and physicians were supplemental payments (MACPAC 2022f). Since October 1, 2021, states have been required to submit provider-level data on supplemental payments, but CMS has not made these data publicly available, as required (Section 1903(bb) of the Social Security Act). Overall, MACPAC has recommended that CMS collect provider-level data on all payments that providers receive, as well as information on the sources of non-federal share necessary to calculate net Medicaid payments at the provider level (MACPAC 2016, 2023c).

Second, states often vary payment rates by additional factors that are not discussed in the proposed rule. For example, physician payments may vary by the site of care (e.g., office-based vs. hospital-based physicians), nursing facility payments are often adjusted for resident acuity, and for some services, states use value-based payment methods to incentivize quality goals. To facilitate more accurate reporting of payment rates, CMS could provide states with additional guidance about how to account for these factors when reporting payment rates and could also consider providing additional narrative information about state payment methods to help stakeholders interpret the data provided.

Third, the proposal to disaggregate bundled payments into their component services may be operationally difficult to implement for payments to institutional providers, such as hospitals and nursing facilities. For example, many states pay for inpatient hospital services using diagnosis related groups (DRGs) and pay nursing facilities a per diem rate. While it may be feasible to stratify hospital DRGs or nursing facility per diems into categories, such as such as direct care, indirect care, administration, and capital expenses, it would be difficult for states to unbundle these payment rates to identify specific payments for particular procedures covered within a stay. In addition, it may be difficult for states to calculate payment rates for services paid on a cost-based method, such as services financed by certified public expenditures, since it may be difficult to accurately predict facility costs on a prospective basis. As a result, it would be helpful for CMS to further clarify which services should be unbundled and how states should best report payment rates for particular payment methods. Although MACPAC has recommended additional transparency in payments for hospitals and nursing facilities, the Commission's recommendations also underscore the importance of making data available in a format that can enable analyses. For example, data could be reported at the facility-level in a format that can be more easily compared with available information on facility costs or Medicare payment rates (MACPAC 2023c, 2016).

Payment comparison to Medicare

The proposed rule requires states to compare Medicaid payment rates for primary care services, obstetrics and gynecology services, and outpatient behavioral health services to Medicare payment rates. CMS requests comments on the services identified and the proposed methods of comparing payment rates to Medicare.

Services included in additional payment reviews. In general, the Commission supports efforts to analyze payment rates and access for a subset of services that CMS has identified as having key importance, both because they are critical services to those in the program, but also because they serve as entry points to additional care. Our June 2022 recommendations highlighted that an access monitoring system should prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities. The Commission also noted that the measures must be meaningful and reflect the services that are important to those served by the program (MACPAC 2022a).

CMS requests comments on its decision to exclude inpatient behavioral health services from the payment comparison analysis. These services are required to be included in the current access monitoring review plan

requirements that CMS is proposing to replace. CMS states that information on inpatient behavioral health service payment rates is not needed because FFS hospital payments are reported on annual upper payment limit (UPL) demonstrations. However, these data are not currently publicly available. In March 2019, MACPAC recommended that CMS make UPL demonstration data and methods publicly available in a standard format that enables analysis (MACPAC 2019b). In addition, even if UPL demonstration data are made available, these data have limited usefulness for analyses of inpatient behavioral health services because they do not distinguish inpatient behavioral health services from other types of inpatient hospital payments.

CMS is also proposing to exclude primary care provided in federally qualified health centers (FQHCs) from the proposed payment analysis, even though these services are also part of the current access monitoring review plan requirements. CMS notes that it excludes FQHCs from this analysis because of concerns that FQHC encounter rates are not comparable to non-facility Medicare payment rates. Although the Commission acknowledges the need to use appropriate benchmarks, we also note that FQHCs are an important source of primary care for many Medicaid beneficiaries (MACPAC 2017b). To provide context for the share of primary care visits that are excluded from the proposed payment comparison analysis, it could be helpful for states to report the number of primary care claims provided in FQHC and non-FQHC settings as well as other contextual information, such as the number of patients served in each setting and total spending. CMS notes in the preamble to the proposed rule that it is considering requiring additional reporting about claims volume for specific services and reporting claim volume by setting would be consistent with this approach.

The rule does not propose assessments of nursing facility payment rates, but the Commission recently highlighted the need for more state and federal oversight of nursing facility rate setting policies. Current federal regulations require states to assure that FFS nursing facility rates are reasonable and adequate to meet the costs of efficiently and economically operated providers, however, CMS has not enforced this requirement since the Boren amendment was repealed in 1996 (42 CFR 447.253). Because Medicare is not an appropriate benchmark for assessing Medicaid nursing facility rates, different standards are needed than those proposed for primary care, obstetrics and gynecology, and outpatient behavioral health. Instead, MACPAC recommends that CMS require states to conduct regular analyses of Medicaid nursing facility payment rates relative to the cost of care of Medicaid-covered nursing facility residents and also consider how payments relate to quality outcomes and health disparities (MACPAC 2023c).

Payment rate benchmarks. The Commission supports assessments of payment rates that rely on data and benchmarks that are feasible to collect and meaningful. Although the Commission has not explicitly endorsed the use of Medicare payment rates as an appropriate benchmark, MACPAC's earlier work reviewing state access monitoring review plans found that a majority of states made comparisons to Medicare payment rates, while a smaller number looked at the rates paid by Medicaid in other, typically neighboring, states. Few states had available private payer data, although those with access to exchange plan data or all-payer claims databases included such comparisons or benchmarks to compare access. The Commission also noted that, although Medicare rates may be available for comparison, Medicare services may not be comparable to all services provided in Medicaid because of differences in the populations covered. For example, Medicare providers may not conduct certain pediatric screenings or serve similar populations of obstetric patients (MACPAC 2017a).

The preamble to the proposed rule notes that supplemental payments should be excluded from the proposed payment comparison to Medicare rates for primary care, obstetrics and gynecology, and outpatient behavioral health. However, as noted above, supplemental payments can have a substantial effect on payment rates for these services. The Commission continues to urge CMS to make provider-level data on supplemental payments publicly available as well as data on the sources of non-federal share necessary to calculate total net payments to providers.

Assessment of payment changes on access

Under the proposed rule, states must provide additional analysis of the effects of payment reductions or restructuring for any service in a manner that could significantly diminish access. Among other things, the additional analysis includes a comparison of relevant Medicaid and Medicare payment rates. However, CMS may need to provide additional guidance about how to conduct this comparison. MACPAC's prior work comparing Medicaid hospital payments to Medicare highlights many technical challenges involved in accurately comparing these rates (MACPAC 2017c).

As noted above, the Commission is also concerned about using Medicare payment rates as a benchmark for Medicaid services that are not comparable to Medicare. For example, the Commission recently articulated a series of principles for assessing Medicaid nursing facility payment policy and concluded that Medicare is not an appropriate benchmark for Medicaid nursing facility residents because of differences in the acuity of short- and long-stay nursing facility residents and the different services covered by the Medicaid and Medicare nursing facility benefit.

Thank you for the opportunity to comment on this proposed rule. The Commission appreciates CMS efforts to fulfill its statutory obligation of ensuring access for beneficiaries by collecting consistent and comparable data across states, while also balancing state administrative capacity constraints. If there is any further information MACPAC can provide you to aid in your consideration of our comments, please let us know.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Cathy McMorris Rodgers, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone, Jr., Ranking Member, House Energy and Commerce Committee

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