Objective 5 Question 3

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?

The Safety-Net Association of Pennsylvania (SNAP) appreciates CMS's efforts to look improve the Medicaid program and appreciates CMS's recognition that comparing Medicaid spending to Medicare spending is sometimes inappropriate because Medicaid encompasses some benefits that Medicare does not. That, CMS acknowledges, sometimes makes for an apples-to-oranges comparison. Any effort to attempt to address health equity through a prism of rates needs to undertake an apples-to-apples comparison in which CMS and stakeholders together explore why and when there are times when a given unit of service for a benefit covered under both programs costs more to provide to a Medicaid patient than to a Medicare patient and that this difference is entirely valid. SNAP believes that Medicare rates themselves are too low a benchmark for assessing the sufficiency of rates for services. These differences drive to the heart of health equity: addressing inequity in part by making Medicaid payments adequate and doing away with the insistence that payments be no higher than Medicare payments.

It is important to begin our comments by focusing on the adequacy of government payments and how that affects access to care and health equity for Medicaid beneficiaries. In most places, Medicaid payments are inadequate: they either do not cover the costs providers incur delivering care to their Medicaid patients or they only barely, or only sometimes, cover those costs. Although only one-quarter of the state's hospitals, Pennsylvania's safety-net hospitals provide 60 percent of the care in the Medicaid program, a program that typically pays them less than the cost of the services they provide. This means that the more Medicaid patients these hospitals serve – and among hospitals, none serve more than safety-net hospitals – the more financially vulnerable they become.

Understanding and addressing this problem begins with recognizing that it frequently costs more to provide a given service to a Medicaid patient than to a Medicare patient, yet for a number of reasons current policy either discourages or prevents payments from reflecting this. At one time, federal law included a clear standard for measuring whether Medicaid payment rates were adequate: they needed to be sufficient to cover the cost of the services for which they ostensibly paid. That requirement, commonly referred to as the Boren amendment, was repealed by Congress in 1997. With this requirement gone, states no longer are required to cover the cost of providing Medicaid services – so many of them – including Pennsylvania - stopped doing so. The current standard of payment adequacy is that they must be sufficient to ensure access to care; this is much more subjective, much harder to measure, and much harder to enforce. It also poses a greater threat to the financial viability of community safety-net hospitals. Unlike the cost-based standard, the current standard merely requires that payments prevent enough providers from closing to ensure that there are still some providers left, at least on paper, to serve the Medicaid population. If health equity is the goal then "on paper" is not good enough.

Ironically, chronic underpayment can end up increasing costs: there is little in this world as expensive as being poor. The lesser standard for defining adequacy of payments consigns many safety hospitals to a condition in which they can never get ahead, can never invest appropriately in capital improvements and contemporary medical technology. Doing these things requires adequate margins, and for so many safety-net hospitals the goal of adequate margins is more a dream than a real possibility and necessitates a constant shuffling of resources and robbing-Peter-to-pay Paul reactions. An example of the consequences

of persistently inadequate payments resulting in persistently inadequate margins would be when a hospital with an HVAC system that has not worked adequately for years has no choice but to make the penny-wise but pound-foolish decision to repeatedly attempt to repair that system because they know they lack the resources to do more. The hospital's leaders know the system needs to be replaced but they opt for repairs because really, from a financial perspective, they have no choice – even though they know that the next round of repairs looms just around the corner.

This predicament has been exacerbated over the years by federally mandated restrictions on payments under both Medicaid fee-for-service and managed care payment systems. Spending caps under fee for service have a detrimental impact on safety-net hospitals in large part because they are tied to Medicare cost reporting principles. In addition, federal restrictions on directed spending under Medicaid managed care have impeded states' abilities to address some of the long-term detrimental effects of those caps. Pennsylvania has no public hospitals, and for safety net hospitals that serve high proportions of Medicaid patients, caps on Medicaid spending are almost indistinguishable from caps on hospital revenues.

Medicare-Based Cost Standards under Medicaid Fee-For-Service

The statewide upper payment limit and hospital-specific DSH limits both suffer from being defined by Medicare counterparts. Under the statewide upper payment limit, the federal Medicaid program will not match a state's non-disproportionate share hospital (DSH) fee-for-service Medicaid payments that exceed (in the aggregate) the amount that Medicare would have paid for those services. Under the hospital-specific DSH limit, states may not receive federal Medicaid matching funds for DSH payments to hospitals that are in excess of a hospital's allowable costs of providing care to Medicaid-covered and uninsured individuals – and CMS requires states to calculate those costs according to data submitted to Medicare under Medicare's cost reporting principles and additional data subject to those same principles.

In SNAP's view, using Medicare as a maximum threshold for these federal limits is inappropriate because:

- it fails to recognize the additional clinical needs of the Medicaid population,
- it fails to recognize the additional social needs of the Medicaid population, and
- it fails to recognize the additional role hospitals play in financing outpatient care for the Medicaid population.

Most of all, it fails to produce payments that are adequate for the care provided to Medicaid patients and in so doing impedes efforts to pursue health equity.

While not universally true, Medicaid patients often have additional medical conditions – comorbidities – that complicate the delivery of care and necessitate the provision of services that go above and beyond what one might expect for a given medical problem. Take, for example, an ordinarily simple procedure such as an appendectomy. Some Medicaid patients, at the time they are admitted to a hospital, may be found to have comorbidities that were not diagnosed prior to their admission because the patient may not have had access to primary or specialist care or even sought care. Such unrelated diagnoses may require additional testing, treatment, prescriptions, and counseling that is generally not recognized at all under Medicare's inpatient prospective payment system as services associated with performing an appendectomy – and for which that payment system does not pay. In addition, Medicaid patients are more likely to need additional support, such as translation services, post-discharge planning assistance, transportation to follow-up medical appointments, and even help enrolling in Medicaid (if the patient was uninsured upon admission). Medicare's inpatient prospective payment system does not consider any of those costs, nor will it pay for them. While Medicare's DSH adjustment reflects an acknowledgment that low-income patients are costlier to treat than most Medicare patients, it was designed only to estimate the

additional cost of providing care to the low-income portion of the hospital's Medicare patients. In contrast, 100 percent of a hospital's Medicaid patients are low-income individuals. While these costs are likely to be reflected in a hospital's hospital-specific DSH limit, they will not be reflected in a state's statewide upper payment limit.

A patient's comorbidities are often related to social determinants of health: poor living conditions, low income, chronic or episodic unemployment, limited access to health care, limited literacy, mental health or substance use problems, lack of community and family supports, and others. These social determinants both contribute to the development of these medical problems and detract from an individual patient's ability to address them. Payment policies that ignore these challenges puts hospitals in the unenviable position where they may be reimbursed, for example, for amputating the foot of a diabetes patient but not for helping that patient with everything the patient needs to get their blood sugar under control and learn how to manage life with just one foot. Medicare pays for the amputation, and as a result, that is all Medicaid can pay for: another example of payment that is equal but not equitable. Costs associated with addressing these challenges would not be recognized in either a hospital's hospital-specific DSH limit or a statewide upper payment limit.

Medicare cost reporting principles also obscure hospitals' cost of engaging physicians who are willing to care for Medicaid patients. Physicians face many of the same challenges as hospitals when it comes to serving Medicaid patients: in addition to being asked to accept fees far below those paid by commercial insurers and even Medicare, they need to provide significant services for which Medicaid cannot or will not reimburse them. To persuade these physicians to serve such patients – there is a physician shortage in this country today and doctors have many choices about where they will practice medicine and will seldom gravitate on their own to communities where a significant portion of the residents are insured by the lowest health care payer – hospitals may need to help subsidize some physicians' Medicaid losses to ensure those hospitals' ability to serve the many Medicaid patients who reside in their communities. These are legitimate expenditures; unless hospitals spend this money, some of the communities they serve would find themselves without enough doctors to treat their residents, yet the hospital-specific DSH limit and statewide upper payment limit ignore such costs.

State Medicaid programs aim to address social determinants of health (SDOH) and related comorbidities by connecting low-income individuals to services that are available in the community, but these efforts leave safety-net hospitals with costs that cannot be accounted for in either their Medicaid reimbursement or Medicare cost reporting. Pennsylvania, for instance, is developing a screening tool for use in clinical settings like hospital emergency rooms and outpatient clinics to identify patients' needs in nine SDOH domains including: food insecurity, medical access and affordability, housing, transportation, childcare, employment, utilities, clothing, and financial strain. To support patients that have identified needs using the screening tool, the Medicaid program will incentivize managed care organizations to train and provide resources to community-based organizations that can offer non-clinical services, but this program still leaves the hospital with unpaid costs of screening and referring these patients.

Medicaid should be able to reimburse hospitals for these additional services – additional services, to be sure, but essential services, just as sure. Current federal policy that links Medicare and Medicaid payments, however, hamstrings that pursuit. Hospitals' ability to address inequities is stymied by current Medicaid reimbursement policy that links Medicaid payments to Medicare cost principles.

Federal policy can address these problems in several ways.

First, CMS can adopt a policy that Medicaid payment rates will not be considered sufficient to ensure access if they are lower than the reasonable cost of the services for which they are supposed to pay.

Second, it can define "reasonable costs" in a manner that recognizes the additional costs hospitals incur addressing the Medicaid population's additional clinical needs and responding to social determinants of health. These costs are necessary to provide adequate care and services to the Medicaid population and seriously affect the well-being of Medicaid enrollees and the communities in which they reside. This definition of reasonable costs should reflect all Medicare allowable costs as well as the cost of non-hospital (according to Medicare) services, including addressing social needs and underwriting access to outpatient professional services. Such a standard should be applied to the new cost-based access standard we proposed previously as well as to the calculation of the statewide upper payment limits and hospital-specific DSH upper payment limits. This would be a major step toward health equity because it would not penalize either entire states or individual hospitals for spending on additional services for Medicaid patients whose needs go beyond the services for which Medicare ordinarily pays.

Current Limitations on Pass-Through Payments and Directed Payments under Medicaid Managed Care

While the changes described above address Medicaid services delivered through fee-for-service programs they do not tackle the challenges posed by Medicaid services delivered through managed care. In theory, Medicaid managed care plans, which currently serve nearly 70 percent of Medicaid beneficiaries in the U.S. and nearly all of Pennsylvania's Medicaid population including physical health, behavioral health, and long-term services managed care programs, could pay providers more appropriately since their rates are capped by a broader standard of being "actuarially sound" instead of based on what Medicare would pay. Unfortunately, as recent experience with Hahnemann University Hospital has shown, this is not always sufficient to ensure the viability of long-standing Medicaid-reliant community anchor institutions.

The new Medicaid rules that prohibit pass-through payments through Medicaid managed care plans and limit the types of directed payments states may make hinder states' ability to fulfill their historic role in maintaining continued access to care provided by community safety-net hospitals. Managed care plans are private entities whose actions are driven by their contracts with the state. By forbidding states from building protections for essential community providers into these contracts, CMS is tying the hands of state policy-makers from protecting these vital institutions.

With this in mind, SNAP urges CMS to create an exception to its policy of prohibiting states from directing payments under Medicaid managed care programs to enable states to encourage and enact cross-plan policies to address health equity and social determinants of health. In addition, CMS should create an exception to the prohibition against pass-through payments to enable states to preserve access to care by financially stabilizing vulnerable providers.

Eliminate Medicare Payments as a Standard of Appropriateness of Payments

Beyond Medicare's inability to recognize the costs of the Medicaid population's additional clinical and social needs, Medicare itself is no longer a reasonable yardstick for what constitutes fair, reasonable reimbursement. While it could be debated whether a Medicare-based threshold was ever reasonable for identifying the adequacy of hospital payments for serving the Medicaid population, it is clear that it does not provide a reasonable threshold today. That threshold has been rendered meaningless by a litany of congressionally mandated reductions of Medicare hospital payments: reductions in annual payment system update factors, reduced reimbursement for Medicare bad debt, the two percent Medicare sequestration that will extend into 2030s, and more. Medicare payments have become so poor that MedPAC, which recently embarked on a new project to define "safety-net hospital," declared that

Medicare is no longer "materially profitable" even for the Medicare population[1] and concluded that even "efficient" hospitals experience negative Medicare margins[2].

Conclusion

The current low standard for judging the adequacy of Medicaid payments, combined with spending caps that are tied to the Medicare payment system and restrictions on state assistance to critical providers of Medicaid services under managed care, are making it harder than ever for hospitals that serve especially large numbers of financially and medically vulnerable patients who face significant obstacles to gaining the care they need – obstacles in the form of social determinants of health – to care effectively for their patients. Health equity is something they can talk about, it is something to which they can aspire, and it is something they can pursue every single day, but ultimately, it is a goal that is going to continue eluding their grasp under current conditions.

Objective 4 Question 1

1. What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

Medicaid patients need – they deserve – a choice of providers. Often they have a choice on paper but not in practice. Medicaid managed care plans, for example, often have provider manuals that are out of date. This might be understandable if they were printed two or three times a year and mailed to their members but it is unacceptable when those manuals are posted on the plans' web sites and can easily be updated daily. Often, Medicaid managed care plans list providers that are not accepting new Medicaid patients – or list providers to which they, as a matter of policy, never direct their members. In addition, there are times when a Medicaid patient needs a specialist – say, an orthopedist – and is told "You must go to Dr. X" and be given no choice in the matter. Finally, there are times when a patient newly enrolled in a Medicaid managed care plan does not respond to that plan's request to choose a primary care provider and that plan must make that choice for its new member. Too often when this is the situation the physician to which the new member is assigned is not even a primary care provider – for example, when a plan assigns a Medicaid-covered newborn to the obstetrician who delivered the child.

Medicaid managed care plans should be required to have up-to-date directories of providers who are currently accepting Medicaid patients; to exclude from those directories providers who are not accepting such patients; to assign such practitioners on a fair basis when new members fail to choose a primary care practitioner; to assign primary care practitioners, not specialists, to new members who fail to choose a primary care practitioner when asked to do so; and to ensure that all beneficiaries enrolled in such plans have a true choice, not a paper choice, of practitioners to meet their needs through clear provider network

[1] https://www.medpac.gov/wp-content/uploads/2021/10/Safety-net-MedPAC-March-2022.pdf
[2] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf

adequacy standards. Finally, to back up these requirements and give them meaning, the federal government can hold Medicaid managed care plans accountable for meeting these requirements in tangible ways and with real consequences for failing to do so.

Objective 2 Question 1

1. How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

Another obstacle to health equity is the practice in many states of requiring Medicaid eligibility redetermination every six months. SNAP believes that once an individual qualifies for Medicaid they should – whether they are an adult or a child – remain on Medicaid (or CHIP) for up to one year before eligibility redetermination is required. This will lead to better care and better outcomes because there will be less churn, people will move less frequently from plan to plan and provider to provider, and recipients will benefit from better continuity of care by having a meaningful opportunity to develop relationships with their providers. Such a practice, we are confident, would lead to better outcomes for patients and possibly, over time, reduced Medicaid costs because the health status of some Medicaid beneficiaries would stabilize because of more accessible, more consistent care. Reducing the frequency of eligibility redeterminations would also reduce administrative burden on the Medicaid program.

What Other Comments Do You Have

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the low-income and medically vulnerable residents of the commonwealth. These hospitals are on the front lines in working with their communities to pursue solutions to health equity challenges across the commonwealth, address the social determinants of health, and enhance access to care for all.

Because of their mission-driven performance, these hospitals start out at a disadvantage. Community safety-net hospitals often have lower operating margins and smaller endowments. Even so, they routinely offer services they know will lose money because they know their communities need those services and have few other places to get them.

Despite these many challenges, safety-net hospitals are constantly testing new ways of doing more to serve their communities. In their continued pursuit of health equity they want to do more because there is more that needs to be done. They know their mission: to serve their patients, serve their communities, and ensure equitable access to quality care.

SNAP appreciates CMS's decision to reach out to stakeholders for their perspectives on how to improve access to coverage and care in the Medicaid and CHIP programs. Access and coverage are among the

keys to health equity and they are goals to which SNAP and its members, 37 Pennsylvania community safety-net hospitals that provide a significant proportion of care to the state's one million uninsured residents and its 3.2 million Medical Assistance recipients, aspire and work toward every day because health equity is at the heart of our mission. We hope you find our views worthwhile and welcome an opportunity to work with you and other stakeholders to improve access to Medicaid and CHIP coverage and care – as we have attempted to convey in our responses, we believe coverage without access to actual care is of limited value – and make strides toward the health equity that we all seek.