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NATIONAL RURAL HEALTH ASSOCIATION

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January 29, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: CMS–2393–P, Medicaid Program: Medicaid Fiscal Accountability Regulation (Vol. 84, No. 222), November 18, 2019 and CMS-2393-N (Vol. 84, No. 249) December 30, 2019

Dear Administrator Verma:

The National Rural Health Association (NRHA) appreciates the opportunity to offer our comments and concerns regarding access to quality healthcare in rural communities. NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. NRHA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation related to Medicaid program financing and supplemental payments.

Compliance

If finalized, the rule would significantly change hospital supplemental payments and could severely harm state Medicaid program financing. The rule includes definitional changes to supplemental hospital categories and public funds. The agency also proposes to change the review process for supplemental payment programs and provider tax waivers. In addition, the agency would grant itself unfettered discretion in evaluating permitted state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden." These vague standards for determining compliance are contrary to the legal requirements of administrative law because they will make it impossible for a state to know whether its program complies with the Medicaid statute.

State Access and Payment Considerations

The proposed regulations would restrict state access to important funding streams, limit the use of supplemental payments which are vital in rural areas, and introduce significant uncertainty with respect to how the agency would evaluate state approaches. The proposed changes are numerous and varied, and the agency would give states virtually no time to make policy and budgetary adjustments to offset the loss of federal funds, assuming they could mitigate them at all. NRHA supports efforts to increase transparency but feels the proposed rule does not meet this goal.

There are 75 million individuals who rely on the Medicaid program as their primary source of health coverage. Medicaid pays for approximately half of the births in the country, as well as care for almost half of all children and adults with special health care needs, such as physical and developmental disabilities, dementia and serious mental illness. Medicaid also is the primary source of coverage for individuals living in nursing homes and individuals with other long-term care needs, many who reside in rural areas. In most instances, there is no other form of health coverage available to these individuals – either because they are too young, too old or too disabled to work – or because they work in part-time or low-wage jobs that do not offer health care coverage. Overall, the most vulnerable of our society rely on the Medicaid program.

Cuts to eligibility would remove a key lever that states have to implement population health efforts, including public health interventions, and would result in widespread and compounding economic losses that would be felt well beyond the health care sector. Benefit cuts, such as to optional services like substance use disorder treatment, opioid treatment and prescription drug coverage, would reduce states' abilities to provide high quality care, which in turn would likely increase spending on other services to treat unmanaged conditions. Provider payment cuts would exacerbate access challenges, especially for rural areas, when providers can no longer sustain the losses and decline to participate in the program or are forced to close their doors.

Reductions in Medicaid enrollment or provider payments would put access to care at risk for both Medicaid beneficiaries and entire communities. Medicaid payments, including disproportionate share hospital (DSH) and non-DSH supplemental payments, historically have been lower than the cost of providing care to Medicaid patients,[1] and many providers would be unable to sustain further payment cuts. A number of studies have shown that lower Medicaid reimbursement rates reduce Medicaid beneficiaries' access to care.

Entire communities also could lose access to care if such payment or enrollment reductions were realized. This is especially true in our rural communities with hospitals and health systems already teetering on the financial brink. Since 2010, 121 rural hospital have closed[2], with 19 of those in 2019 alone – the largest number of closures in a single year since at least 2005. The relationship between rural hospital sustainability and Medicaid is unequivocal. Roughly, 15% of rural hospital revenue is based on Medicaid, making it a key factor in supporting health care access in rural communities[3]. In addition, at least 80% of rural hospitals that have closed since 2014 occurred in non- expansion states, a finding that was echoed in a recent Government Accountability Office (GAO) report showing that states that expanded their Medicaid program saw fewer rural hospital closures[4]. **Decreasing Medicaid enrollment or further payment reductions would further strain such vulnerable hospitals and could ultimately result in more hospital closures – a devastating consequence for the entire community.**

Medicaid Supplemental Payments

Limitations on Practitioner Supplemental Payments to a Percentage of Base Payments (Sec. 447.406)

[1] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medic

[2] University of North Carolina Sheps Center (January 2020)

[3] 2018 American Hospital Association Annual Survey

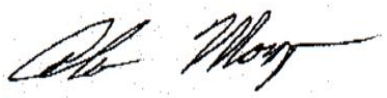
[4] https://www.gao.gov/products/GAO-18-634#summary

The proposed rule would set new limits on Medicaid supplemental payments to physicians and other practitioners at 50% of Medicaid base payments or 75% for practitioners in underserved areas designated as health professional shortage areas. Medicaid physician payment rates have historically been lower than Medicare payment rates. Many predominately rural states have used these supplemental payment programs to improve payment for physicians and practitioners with the objective of improving access to services for vulnerable communities. These supplemental payment programs often support physicians and other practitioners at public academic teaching hospitals and rural hospitals serving vulnerable communities. As such, changes in UPL payments for physicians and practitioners could particularly limit beneficiary access to tertiary and quaternary services, as well as all hospital services in rural communities.

CONCLUSION

The proposed rule has significant changes that will critically harm vulnerable communities and threatens rural hospitals' ability to care for the people in their communities. As you are aware, safety net providers in rural areas anchor the local economy, so when the hospital fails, the entire community - employers, schools, and churches – fails, too. The proposed rule impedes the Medicaid program's core mission of providing access to health care services to Medicaid beneficiaries. The proposed rule undermines the state Medicaid programs and adversely impacts the vulnerable population who rely on the program. NRHA is not supportive of this change and urges the agency to alter significantly or withdraw the proposal. Our priority is to protect access to health services for the more than 75 million Medicaid beneficiaries who make up a significant portion of rural patients. We look forward to working with the agency to explore reasonable transparency measures that ensure accountability in Medicaid state financing and payment policies without risking access to care for Medicaid beneficiaries and their broader communities. If you would like additional information, please contact NRHA Government Affairs and Policy Manager, Max Isaacoff at misaacoff@nrharural.org or 202-639-0550.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association