July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Via electronic submission

RE: CMS–2442–P; Medicaid Program: Ensuring Access to Medicaid Services

Administrator Brooks-LaSure:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities – and their more than 45,000 employees – as they strive to provide health care and community services for all Arkansans. On behalf of our member hospitals, I appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed rule update (CMS-2442-P) to the Medicaid fee-for-service (FFS) program. We commend CMS for its dedication to enhancing access to care, improving quality and health outcomes, and addressing health equity concerns. Nevertheless, it is imperative that any impact this proposed rule has on Arkansas Medicaid beneficiaries, and the providers that serve them, must positively impact access and quality of care.

In recent months, the Medicaid enrollment landscape has undergone significant changes, posing challenges for Arkansas's Department of Human Services staff, beneficiaries, and health care providers. In December 2022, the Consolidated Appropriations Act of 2022 granted states the authority to initiate the redetermination process on April 1, 2023, which had been temporarily halted in March 2020 due to the Families First Coronavirus Response Act. In Arkansas, the state legislature took a

proactive approach by creating a state law – Act 780 of 2021 – that requires the Arkansas Department of Human Services to complete eligibility redetermination within six months. As of May 2023, Medicaid provided health benefits to 1.066 million Arkansans, representing over one-third of the state's population. Among these beneficiaries, the Arkansas Health and Opportunity for Me (ARHOME) program provides coverage to 312,860 beneficiaries, while traditional Medicaid covers 307,510 adults and 446,171 children. An additional 55,000 Medicaid beneficiaries are covered by the Provider-Led Arkansas Shared Savings Entity (PASSE) program. Alarmingly, within the past two months alone, more than 78,500 Medicaid[1] beneficiaries have lost their coverage, and we anticipate a significant surge in this number in the upcoming months.

Payment Rate Transparency, Analysis, and Rate Reduction

As is true for most states, Medicaid has historically reimbursed hospitals at significantly lower rates than the cost of providing care. In fact, Arkansas Medicaid rates for inpatient hospital care have not increased since 2007. Arkansas Medicaid rates for outpatient hospital services last changed in 1992, and that rate was a decrease. Those rates have fallen far below the excess costs of labor, supplies, drugs, and other expenses – all of which have been exacerbated by record-setting inflation.

Acknowledging these deficiencies, CMS provided guidance on the use of supplemental funding in the State Medicaid Manual Transmittal as early as 1991. The supplemental programs were approved by CMS to improve funding flexibility, minimize payment parity, encourage provider participation, and address budgetary concerns from state partners. In 2009, Arkansas took the opportunity offered by CMS's flexibility to create the Hospital Assessment Fee Act – amended in 2011 – to maximize Medicaid reimbursement under the Upper Payment Limit (UPL). The assessment funding has significantly offset the negative operating margins for Arkansas hospitals. In 2015, the AHA commissioned a report to analyze the reimbursement rates for Medicaid claims in Arkansas. In the report, the researchers found that Medicaid reimburses providers at 52% the cost of services. The UPL supplemental funding improves the reimbursement rate to 78%, but it still falls 22% short of the cost to provide health care services.

[1] Medicaid beneficiary data was extracted from the Arkansas Department of Health's Monthly Enrollment and Expenditures Report.

We do appreciate the value of CMS publishing fee-for-service rates for all health care services. Adding this level of transparency can help inform policymakers and stakeholders that these rates do not adequately reimburse the cost of services to our Medicaid patients and can further aid evaluation of the impact of provider payment on beneficiary access to care. Research using data from the National Health Interview Survey has found that an increase in Medicaid reimbursement led to increased utilization of health care services and improved health outcomes. As Arkansas remains near the bottom of health outcomes measures, quite simply, Arkansas's hospitals cannot afford more decreases from any payor.

Medicaid Advisory Committee (MACs and BAGs)

We appreciate the proposed enhancements and restructured framework for the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG). These committees play crucial roles in offering valuable input, recommendations, and feedback to ensure the viability and effectiveness of the Arkansas Medicaid program. The inclusion of representatives from the Medicaid beneficiary population on both the MAC and BAG will help to ensure that Arkansas's Medicaid program effectively addresses the needs of its beneficiary population. The ultimate objective is to enhance health outcomes while fostering transparency and accountability in the decision-making processes of the state's Medicaid program. We support CMS's continued commitment to ensuring that beneficiaries and relevant stakeholders have a voice in the dispersion of Medicaid services.

Home- and Community-Based Services

While we do generally support efforts to enhance quality and oversight measures, such as the publication of average hourly rates, waiting lists for home- and community-based services (HCBS), and quality and compliance measures, it is crucial for CMS to minimize the administrative burden associated with these publications. Health care facilities face complex administrative tasks and a multitude of reporting requirements. Our health care systems already generate an excessive amount of documentation to validate services provided to Medicaid patients. These reporting mandates reduce the availability of financial resources that could otherwise be utilized to improve access to – and the quality of – services offered by our esteemed members. Therefore, we respectfully request that CMS conduct a thorough review of existing reporting requirements to determine the most efficient and effective mechanisms for conducting these

assessments and, thereby, alleviate the financial and workforce strains associated with maintaining these reporting mandates.

Thank you for your consideration of our comments and others from the hospital community about these proposed changes.

Sincerely,

Bo Ryall
President and CEO
Arkansas Hospital Association

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