Nov. 1, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Re: Need to Prioritize Investments in the Health Care Workforce to Ensure Access to Care for Medicaid Beneficiaries

Dear Administrator Brooks-LaSure:

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition of health care providers, safety net health plans, counties, and labor—the undersigned organizations write to provide feedback on priorities for implementing the Centers for Medicare & Medicaid Services' (CMS') recently finalized regulations for ensuring access to care in Medicaid fee-for-service (FFS) and managed care delivery systems.[1,2] Overall, we urge states and CMS to prioritize investments in the health care workforce, because having enough providers who accept Medicaid patients is a critical first step towards meeting our shared goals of ensuring timely access to care.

As you know, Medicaid serves as a lifeline for tens of millions of Americans and plays an important role in providing access to necessary health services that include maternity care, pediatric services, behavioral health services, primary and dental care, and long-term services and support. Medicaid beneficiaries are among our nation's most economically disadvantaged populations, and they deserve the same access to care as the general population.

To achieve this goal, the statute requires that Medicaid payments to providers be sufficient to ensure this access and that capitation rates to health plans be actuarially sound.[3] Historically, beneficiaries and providers could enforce these standards in federal courts, but in 2015, the Supreme Court limited this right.[4] As a result, CMS is uniquely responsible for ensuring that state Medicaid payment policies provide the access to care Medicaid beneficiaries deserve.

Despite the requirement that Medicaid patients have the same access to care as other patients in their geographic area, Medicaid payment rates often are far below those of other payers. As a result, clinicians are generally much less likely to accept new Medicaid patients than patients covered by other payers.[5] Federally qualified health centers, essential hospitals, and clinicians who serve a safety net role in their communities choose to serve Medicaid patients despite the financial loss because of their commitment to serve all regardless of their ability to pay. However, their financial viability is threatened when state Medicaid programs undervalue the care they provide.

We appreciate CMS' recent efforts to correct these long-standing challenges by updating federal regulations to oversee Medicaid payment rates and ensure access to care in both FFS and managed care delivery systems. We support many of the long-term goals of these new rules, such as improving data available to assess access challenges and allowing states to pay Medicaid providers the same rate as other payers. We also appreciate many of the efforts in these rules to improve access to Medicaid home- and community-based services (HCBS), improve beneficiary access to information about their coverage, and incorporate feedback from beneficiaries in Medicaid policy development, which are outside the scope of this letter.

For states and CMS to implement these new rules successfully, policymakers must properly consider the relationship between Medicaid payments and access. The goal of improving timely access to care can be achieved only if there are enough providers available to accept Medicaid patients. Medicaid payment policies are the primary tool that state programs and CMS can use to invest in the Medicaid workforce. For the greatest return on this investment, states need the flexibility to direct payments to safety net providers and to leverage all available Medicaid policy levers to invest in training, recruiting, and retaining the Medicaid workforce.

In practice, a workforce-first approach to implementing these new rules means that CMS should prioritize data collection to monitor current workforce challenges and the evaluation of payment rates against appropriate benchmarks before penalizing health plans or providers for factors outside of their control. CMS can help set these priorities by providing targeted technical assistance in priority areas and preserving states' ability to use all available tools to support safety net providers in the way that works best for their state. Setting these priorities not only would help inform data-driven policy decisions but also help reduce burdens on state Medicaid programs that are currently overwhelmed by the number of new federal requirements.[6]

To help inform CMS' implementation of the new rules, this letter discusses key priorities identified by members of the Partnership for Medicaid. We stand ready to continue to work with CMS to figure out how states, health plans, and providers can collaborate to meet our shared access goals.

Need for Robust Data on Access to Inform Policy

The first step to improving access to care for Medicaid patients is collecting data on current access challenges. We appreciate many of the new data requirements in the new rules, including improved collection of data on beneficiary experiences of care, HCBS waiting lists, and other factors affecting access to care. However, we note that implementing these new requirements will impose an additional administrative burden on states and may need to be phased in accordingly.

As CMS continues to develop its access monitoring systems, we hope that it will heed the recommendations from the Medicaid and CHIP Payment and Access Commission (MACPAC) to "actively solicit and incorporate input from key stakeholders."[7] In particular, we note the need for clear guidance on how measures are defined and the need to interpret access measures in the appropriate context. CMS should also consider ways to strengthen measures of access across all three domains recommended by MACPAC: provider availability and other measures of potential access, realized access, and beneficiary perceptions and experiences.

Need to Consider Workforce Data When Implementing Wait Time Standards

We share CMS' commitment to ensuring that access to services covered by Medicaid is timely and comparable with access available to patients covered by other payers. However, when states and CMS

implement this requirement, it will be important to consider the broader context of current workforce challenges and not penalize health plans or providers for factors outside of their control.

CMS should consider the experience of implementing wait time standards in the marketplace and use the data collected through secret shopper surveys to determine whether there are enough providers to meet these new requirements. If workforce gaps are identified for particular provider types or geographic areas, states and CMS should focus on efforts to support Medicaid providers and strengthen the Medicaid workforce before imposing penalties on health plans. This approach ultimately would be more effective at meeting our shared goals of ensuring timely access to care for all Medicaid beneficiaries.

Need for Meaningful Analyses of Provider Payment Rates

Provider payment rates are the primary tool that state Medicaid programs can use to improve access to care for Medicaid beneficiaries. As a result, we appreciate the new requirements for states to assess how FFS payment rates for selected services compare with external benchmarks. Like the new access monitoring requirements, these payment requirements also will impose a large administrative burden on states and may need to be phased in accordingly.

As CMS proceeds with improving the data to inform analysis of Medicaid payment rates, CMS also should use this data to ensure that safety net providers are paid adequately. In particular, we are concerned that CMS does not include requirements for states to monitor the adequacy of payments to hospitals. In addition, we are concerned that new rules do not do enough to require states to increase Medicaid payments that are too low.

Alongside efforts to increase provider payment rates, CMS should work with states to ensure that capitation rates paid to health plans remain sufficient to adequately compensate safety net providers. The statute requires that managed care capitation rates be actuarially sound, meaning that they cover all reasonable, appropriate, and attainable costs of the services covered under the contract. Despite these requirements, Medicaid managed care organization (MCO) rates have sometimes been set—or reduced—based solely on budgetary considerations. Furthermore, states frequently pay rates that are as low as actuarial soundness requirements will allow, and new services or obligations have been "carved in" without commensurate capitation increases. We request that CMS ensure that states amending contracts include increased payments for safety net providers and accordingly increase managed care capitation rates as well. Additionally, we urge CMS to reinforce guidance to states regarding actuarially sound MCO rates and retroactive rate changes to support adequate payments to providers.

Concerns about New Barriers to States' Ability to Increase Payment Rates

The new Medicaid managed care rules codify a variety of requirements related to managed care state directed payments (SDPs), a new tool that many states use to increase Medicaid provider payment rates to advance state access and quality goals. By allowing Medicaid providers to be paid the same commercial rates as other patients, SDPs help states close payment equity gaps and ensure equal access to care for all.

Unfortunately, the managed care rule imposes two new administrative barriers that may make it more difficult for some states to use SDPs to increase provider payment rates: (1) the elimination of separate payment terms, and (2) the prohibition on interim payments based on historical utilization. These provisions do not change the amount of SDPs that providers are eligible to receive, but they have the potential to add substantial administrative costs to states, health plans, and providers with no meaningful benefit for patients. Moreover, these provisions may reduce payment transparency and appear to harm safety net providers disproportionately.

These new requirements currently are scheduled to take effect in 2027, shortly after CMS expects health plans to meet new wait time standards. This approach is counterproductive because placing new barriers on payments to safety net providers will undermine new access goals. Instead, CMS should support states' ability to use all available tools to support safety net providers in the way that works best for their state.

Need to Engage Stakeholders in Efforts to Improve the Medicaid Workforce

In addition to closing gaps in payment rates between Medicaid and other payers, CMS should work with states, providers, and health plans to explore other approaches to support the Medicaid workforce. For example, CMS could explore ways to better support Medicaid graduate medical education programs and examine establishing similar programs for nursing and other health care professionals to enhance efforts to train the next generation of Medicaid providers. In addition, CMS could consider ways to better support health plans who are currently using reserve funding to invest in pathways programs for students interested in entering health care careers.

The Partnership for Medicaid stands ready to work with CMS in this important policy area. Recognizing the importance of the Medicaid workforce to our shared goals of improving Medicaid access, we recently convened a new workgroup of members to share best practices and explore new policy solutions. Ultimately, we believe that the best ideas for improving the Medicaid workforce will come from the safety net providers and health plans who are on the front lines of efforts to ensure that Medicaid beneficiaries get the access to care that they deserve.

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Overall, we appreciate CMS' efforts to ensure that Medicaid beneficiaries have access to high-quality, necessary services as required by statute. The new Medicaid access and managed care rules take many important steps to advance this goal, and we hope to continue to partner with CMS to support the data-driven workforce investments that are a necessary first step in this process. If you have questions, please contact Daniel Jones with the Partnership for Medicaid at djones@essentialhospitals.org.

Sincerely,

American College of Obstetricians and Gynecologists
America's Essential Hospitals
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Counties
National Association of Rural Health Clinics
National Council for Mental Wellbeing
National Council of Urban Indian Health
National Rural Health Association
American Nurses Association

[1] 89 Fed. Reg. 40,542.
[2] 89 Fed. Reg. 41,002.
[3] Social Security Act § 1902(a)(30)(A) and 1903(m)(2)(A)(iii).

[4] *Armstrong v. Exceptional Child Center, Inc.,* 135 S. Ct. 1378 (2015).
[5] Medicaid and CHIP Payment and Access Commission. *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey*. Washington, D.C. June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf. Accessed Aug. 26, 2024.
[6] New requirements for all state and territory Medicaid programs. National Association of Medicaid Directors. https://medicaiddirectors.org/resource/new-requirements-for-all-state-and-territory-medicaid-programs/. Washington, D.C. May 27, 2024. Accessed Aug. 27, 2024.
[7] Medicaid and CHIP Payment and Access Commission. Chapter 1: A New Medicaid Access Monitoring System. In *Report to Congress on Medicaid and CHIP*. Washington, D.C. June 2022. https://www.macpac.gov/publication/a-new-medicaid-access-monitoring-system/. Accessed Aug. 26, 2024.