



July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) Ensuring Access to Medicaid Services proposed rule. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

I. Background

Medicaid is an important source of coverage for rural residents and payer for rural providers. About one quarter of rural adults under 65 are covered by Medicaid.¹ Rural residents are more likely to be low-income and unemployed² and for individuals that are employed, rural employers are less likely to provide insurance.³ Thus Medicaid fills in gaps in coverage and access in rural America.

II. Provisions of the Proposed Regulations

A. Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)

NRHA supports CMS' proposal to create a new Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG). We agree that a wide range of perspectives and experiences

¹ Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, RURAL POLICY RESEARCH INSTITUTE, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH, (Oct. 2022), 12, <https://rupri.public-health.uiowa.edu/publications/other/Rural%20Insurance%20Chartbook.pdf>.

² Julia Foutz, Samantha Artiga, & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAMILY FOUNDATION, Apr. 25, 2017, <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>.

³ CENTER FOR BUDGET AND POLICY PRIORITIES, *Medicaid Works for People in Rural Communities* (Jan. 19, 2018) <https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities>.

should be reflected in both groups, especially individuals with lived experiences. We applaud CMS' proposals to codify this in § 431.12 by requiring that 25% of MAC members come from the BAG and requiring broad industry representation on the MAC, including clinicians, advocacy groups, managed care plans, and other state agencies.

Additionally, NRHA supports mandating that states create a BAG consisting of individuals with Medicaid experience. Diverse voices, from current beneficiaries to caregivers of those enrolled in Medicaid, should be represented on the BAG.

NRHA suggests that CMS include geographic representation requirements in the proposed regulations where appropriate. Diverse industry perspectives and lived experiences are crucial to ensuring adequate representation on the MAC and BAG, but we believe that there is room for other elements. In the preamble CMS notes that states should take into account their demographics when selecting MAC and BAG members, including balancing representation according to geographic areas. NRHA urges CMS to include stronger language to guarantee that geography is fairly reflected. Without being overly prescriptive at the federal level, CMS should ensure that there is rural representation on both groups that is proportional to the rural population in each state.

B. Home and Community-Based Services (HCBS)

HCBS are important for rural populations. Rural populations tend to be older than urban populations and this trend will likely continue as the overall U.S. population rapidly ages.⁴ Rural residents would benefit tremendously from greater access to HCBS not only because of the proportion of older adults but because they typically see higher incidences of disease or disability and struggle with barriers including transportation and distance. In addition, HCBS can keep rural residents in their home and community to receive care rather than in an institution, such as a nursing home, where they are likely farther from their families and support systems.

However, uptake of HCBS may be slower in rural communities compared to other areas. There are several barriers that may cause this disparity in the availability or use of HCBS. First, affordability may be a factor for both patients and HCBS agencies.⁵ Given the sparse population in rural areas it may not be feasible for HCBS agencies to operate and could be difficult to recruit HCBS direct care workers to live and work in the area. Additionally, access to information on HCBS waivers may be limited because of the rural communications infrastructure.⁶ For example, if HCBS are available in a rural area, residents may not have the resources to know about them or find them because of lack of broadband or internet access.⁷ Despite the challenges of HCBS in rural areas, **NRHA supports efforts by CMS to expand and improve HCBS, with a particular focus on better integration for rural beneficiaries.**

⁴ Kim Parker, et al., *Demographic and economic trends in urban, suburban and rural communities*, Pew Research Center, May 22, 2018, <https://www.pewresearch.org/social-trends/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/>; Jonathan Vespa, *The Graying of America: More Older Adults Than Kids by 2035*, U.S. Census Bureau (Mar. 13, 2018) <https://www.census.gov/library/stories/2018/03/graying-america.html>.

⁵ Daniel Siconolfi, et al., *Rural-urban disparities in access to home- and community based services and supports: Stakeholder perspectives from 14 states*, 20 J. AM. MED. DIR. ASSOC. 503, 506 (2019) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6451868/>.

⁶ *Id.* at 505.

⁷ *Id.*

5. HCBS Payment Adequacy (§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

The direct care workforce is integral to providing HCBS. Medicaid serves as the largest payer of HCBS, paying for about two-thirds of HCBS in 2020.⁸ Furthermore, state 1915(c) waivers are the single largest source of HCBS spending.⁹ Thus, Medicaid serves an important role in assuring availability of and access to these services, in addition to adequate working conditions for direct care workers providing HCBS. One way to continue increasing access to HCBS is to improve the historically low wages that direct care workers receive to reduce turnover and attract more high-quality employees.¹⁰

NRHA recognizes the importance of adequate payment for direct care workers. Rural areas feel national workforce shortages and challenges more acutely as it is generally more difficult to recruit professionals to rural communities. On the other hand, CMS must assure that the majority of HCBS fee-for-service and managed care payments go to direct care worker compensation does not detract from the provision of critical services by HCBS providers. **We believe that higher payment rates are needed to make sure direct care workers actually receive higher wages** while HCBS organizations can continue to provide all necessary services.

8. HCBS Quality Measure Set (§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v))

NRHA applauds CMS' inclusion of rural/urban stratification at § 441.312(d)(7). However, NRHA encourages CMS to include stronger language that requires rural/urban stratification of certain measures in the HCBS Quality Measure Set, including for the subset of measures that must be stratified by certain factors. Currently, the language at (d)(7) provides an illustrative, not mandatory, list of factors for which certain measures must be stratified. NRHA believes it is important to ensure that the subset of measures that must be stratified include rural/urban status as well as race, ethnicity, and language.

C. Documentation of Access to Care and Service Payment Rates (§ 447.203).

NRHA supports provisions to make payment more transparent for enrollees. NRHA applauds CMS' work on this front. **NRHA encourages CMS to adopt payment rate transparency proposals.** NRHA also supports implementing the payment rate provisions in January 2026. We believe that this is sufficient time to comply after Medicaid eligibility redeterminations end in 2024.

NRHA further appreciates that state Medicaid offices must publish payment rates if they vary based upon certain factors, such as geography (rural vs. urban), population (pediatric vs. adult), and provider type. Ensuring that rural enrollees have access to information that reflects their circumstances is essential.

⁸ Molly O'Malley Watts, Alice Burns, & Meghana Ammula, *Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey*, Kaiser Family Foundation, Nov. 28, 2022, <https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/>.

⁹ *Id.*

¹⁰ Medicaid and CHIP Payment Access Commission, *State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages* (Mar. 2022), 4, <https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf>.

However, NRHA notes that publishing payment rates solely on a state Medicaid agency's website may not be accessible to all rural enrollees. Rural residents are less likely to have broadband access at home which makes retrieving internet resources more difficult.¹¹ Households with lower incomes are less likely to have broadband access, with 40% of low-income households lacking an internet subscription across both urban and rural communities.¹² This likely includes many Medicaid enrollees given income-related eligibility requirements.¹³ Even for households with internet access, computer or tablet ownership is lower than in urban populations and the broadband that is available may not be affordable.¹⁴ For these reasons, NRHA believes that rural enrollees are less likely to access this information on a state agency website and encourages additional forms of information sharing.

NRHA also supports the comparative analysis with Medicare payment rates for E/M CPT/HCPCS codes. NRHA agrees with CMS' proposal to publish the analyses for primary care, obstetrical and gynecological (OBGYN) services, and outpatient behavioral health services as these are incredibly important for preventative care and improved health outcomes. Of note, rural hospitals are increasingly forced to close their labor and delivery units due to financial vulnerability, workforce shortages, and low Medicaid reimbursement rates.¹⁵ Additionally, we hope that Medicaid payment rates may improve relative to Medicare because of the proposed transparency requirements.

NRHA suggests that CMS include psychotherapy codes for the comparative analysis of outpatient behavioral health payment rates. While E/M codes are appropriate for the other categories of providers, they do not reflect the types of providers that rural enrollees often use to access care. E/M codes are only available to limited behavioral health providers, like psychiatrists, which are severely lacking in rural areas.¹⁶ CMS should add psychotherapy codes so that psychologists, social workers, and counselors are covered by payment rate transparency. Rural communities often heavily rely upon these providers for behavioral health care.

The proposed interested parties' advisory group for Medicaid payment rates should also include Medicaid enrolled practitioners that provide primary care, OBGYN, and outpatient behavioral health services. NRHA agrees that direct care workers and beneficiaries must be represented on the advisory group but urges CMS to go further. Including these providers would align with the payment

¹¹ Emily A. Vogels, *Some digital divides persist between rural, urban and suburban America*, PEW RESEARCH CENTER, Aug. 19, 2021, <https://www.pewresearch.org/short-reads/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/>.

¹² Cynthia J. Sieck, et al., *Digital inclusion as a social determinant of health*, NPJ DIGITAL MAGAZINE, March 17, 2021, https://www.nature.com/articles/s41746-021-00413-8?mc_cid=714c29799f&mc_eid=98117185bf&mc_cid=113a62c674&mc_eid=bce6925769.

¹³ *Id.*

¹⁴ Vogels, *supra* note 12.; Jeremy Cannon, *Health care's role in rural economic development: How broadband can improve health outcomes*, National Rural Health Association, Feb. 2023, [https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2023/NRHA-Policy-Brief-Final-Draft-Healthcare-s-Role-in-Rural-Economic-Development-\(Broadband\)-\(3\).pdf](https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2023/NRHA-Policy-Brief-Final-Draft-Healthcare-s-Role-in-Rural-Economic-Development-(Broadband)-(3).pdf).

¹⁵ Roni Caryn Rabin, *Rural Hospitals Are Shuttering Their Maternity Units*, NEW YORK TIMES, Feb. 26, 2023, <https://www.nytimes.com/2023/02/26/health/rural-hospitals-pregnancy-childbirth.html>.

¹⁶ C. Holly A. Andrilla, et al., *Geographic Variation in the Supply of Selected Behavioral Health Providers*, 54 AM. J. OF PREVENTIVE MEDICINE S199, S200 (2018) (65% of nonmetro counties lacked a psychiatrist compared to 27% of metro counties).



rate transparency requirements in this subsection and bring another important perspective to the group.

3. State Analysis Procedures for Rate Reduction or Restructuring (§ 447.203(c))

NRHA is highly supportive of the proposed process to make states perform an access analysis whenever an SPA to reduce provider payments is submitted. Medicaid payments to providers are often lower than both private payer and Medicare rates, which can lead to provider reluctance to accept Medicaid patients. This issue combined with provider shortages across the board in rural areas¹⁷ makes access a prominent barrier to health care access for rural enrollees. **We also support the proposal to set reduced to restructured payment rates at least 80% of the Medicare rate for comparable services.** Aligning Medicaid payment rates closer to Medicare rates is an important step towards incentivizing more rural providers to care for Medicaid enrollees.

NRHA thanks CMS for the opportunity to comment on this proposed rule. We look forward to working together in the future to continue improving access to care for rural Medicaid enrollees. If you have any questions or would like further information, please contact NRHA's Regulatory Affairs Manager Alexa McKinley (amckinley@ruralhealth.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray, textured background.

Alan Morgan
Chief Executive Officer
National Rural Health Association

¹⁷ Medicaid and CHIP Payment Access Commission, Medicaid and Rural Health (April 2021), 2-4, <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf>.