



THE PARTNERSHIP FOR MEDICAID

May 22, 2018

Ms. Seema Verma, MPH
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2406-P
P.O. Box 8016
Baltimore, MD 21244-8016
Submitted electronically to <http://www.regulations.gov>

Dear Administrator Verma,

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 appreciate the opportunity to respond to *CMS-2406-P Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*. While we recognize the Centers for Medicare & Medicaid Services (CMS) seeks to ease unnecessary administrative burden for state Medicaid agencies, we are deeply concerned by the proposed changes to the reporting and documentation requirements that states must provide to demonstrate access to care for Medicaid beneficiaries enrolled in fee-for-service (FFS). We urge CMS to fully implement the existing access requirements before proposing changes and to base any changes on strong data and analyses that take into account the range of populations and services remaining in FFS and capture nuances in payment rates across states and services.

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 supports. It is critical that beneficiaries access high quality, necessary services when they need them, and this is especially true for those on Medicaid who have a disability or a chronic or complex health condition. Delays in accessing needed treatments and services can lead to poorer outcomes and unnecessary costs to the health care system, and federal oversight is needed to ensure the Medicaid program is serving our nation's most vulnerable.

The Partnership for Medicaid strongly believes that federal and state financing of Medicaid-covered services should be sufficient to ensure that Medicaid enrollees have timely access to high quality, necessary care. This includes ensuring payments to safety net providers and plans are adequate and, where relevant, actuarially sound in order to ensure access to meet the same goal. In addition, any proposals that make changes to Medicaid and program requirements should balance state flexibility and innovation with necessary federal standards to protect patients. This is true regardless of whether Medicaid is delivered through FFS or managed care. We believe the proposed rule weakens enforcement of requirements that ensure access to care and does not strike the right balance between state flexibility and beneficiary protections.

The existing regulatory access monitoring requirements are the only means of meaningful oversight and enforcement of the equal access provision of the Medicaid statute. This provision

requires Medicaid provider payments be “consistent with efficiency, economy, and quality of care...and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”¹ The federal government is responsible for enforcing this provision, and we are concerned the rule proposes exemptions that leave access to care in some states and for particular service categories unchecked and that are not supported by data and information.

The access monitoring requirements enacted under the 2015 rule were a positive first step to ensure beneficiaries can access needed services. States were first required to submit an access monitoring review plan (AMRP) by October 1, 2016, and we are only a year and a half into the rule’s implementation. The initial AMRP’s submitted by states vary in quality and how access is measured. We should build on this first step and improve our understanding of access in the states before loosening up monitoring requirements. Any changes should not take a one size fits all approach and be based on data and analyses.

The rule proposes to exempt states with high levels of managed care enrollment from submitting an AMRP and complying with additional requirements, but the rule does not justify why an 85 percent threshold was selected nor does it take into consideration the populations or services remaining in FFS. While states are increasingly shifting Medicaid delivery to managed care, the populations remaining in FFS are often the most vulnerable beneficiaries, such as individuals with complex health care needs and dual eligibles. States also often carve out certain services from managed care altogether, such as behavioral health and long-term services and supports. The proposed rule does not include any review of the services and populations remaining in FFS in states that would be exempt. We are concerned the exemption threshold is arbitrary and leaves many beneficiaries vulnerable to access challenges.

The rule also proposes to exempt states from demonstrating access and seeking stakeholder input when implementing “nominal” reductions, but the rule does not state why a 4 percent annual or 6 percent reduction over two years was selected as a “nominal” reduction. Such reductions can have different implications depending on the state or service and their current rate levels, and these implications may not be “nominal” depending on the circumstance. The proposed rule does not provide information or analyses on the implications of these thresholds across states or services to demonstrate what can be consistently considered as nominal. We are also concerned that the rule does not provide additional information on the acceptable forms of alternative analyses states may provide. It is critical that CMS monitor rate reductions to ensure high levels of access to quality care, and to ensure that beneficiaries and providers are able to provide input on the implications of rate reductions.

We are also concerned the proposed rule will have implications beyond FFS. States often look to FFS as a benchmark for capitation payments to managed care entities, making FFS rates relevant in determining whether payments to plans are actuarially sound. Insufficient rates under FFS can also undermine access in managed care, and it is important that FFS rates are evaluated to ensure access for all beneficiaries, regardless of how their benefits are delivered.

¹ 42 U.S.C. § 1396a(a)(30)(A)

We urge CMS to identify opportunities to improve access to care, including promoting payment parity between Medicaid and Medicare when appropriate. Medicaid payment rates for many providers are often far below what Medicare pays for comparable services. Low Medicaid rates can affect provider participation and create barriers to health care access for beneficiaries. It is critical CMS look for ways to ensure strong access to care and promoting payment equity is one step that can be taken to protect beneficiary access.

The federal government must serve as a strong steward of the Medicaid program in order to ensure Medicaid beneficiaries have access to high quality, necessary services, and the existing access review requirements are the primary means of enforcement. We believe the proposed rule suggests changes that are premature and not based on sufficient data and experience. We urge CMS to fully implement the existing access requirements. Additionally, we strongly believe any future changes be based on strong data and analyses that take into account the range of populations and services remaining in FFS and capture nuances in payment rates among unique state Medicaid programs.

We appreciate the opportunity to provide comments on the proposed rule, and we look forward to working with CMS to ensure all Medicaid beneficiaries have access to range of services and providers. If you have any questions, please contact Shannon Lovejoy at the Children's Hospital Association, First Co-Chair of the Partnership for Medicaid, at (202) 753-5385 or shannon.lovejoy@childrenshospitals.org.

Sincerely,

American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Dental Association
American Dental Education Association
American Health Care Association/National Center for Assisted Living
America's Essential Hospitals
Catholic Health Association of the United States
Children's Hospital Association
Easterseals
The Jewish Federations of North America
National Association of Community Health Centers
National Association of Counties
National Association of Pediatric Nurse Practitioners
National Council for Behavioral Health
National Health Care for the Homeless Council
National Hispanic Medical Association