Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

July 5, 2011

Donald M. Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to http://www.regulations.gov

Re: CMS-2328-P: Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (May 6, 2011)

Dear Dr. Berwick:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, I welcome the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on May 6, 2011 on Methods for Assuring Access to Covered Medicaid Services.

CHA represents the largest not-for-profit provider of health care services in the nation. One in every 6 patients in the United States is cared for in a Catholic hospital each year, and many of those patients rely upon Medicaid to pay for their care. Medicaid provides health coverage for more than 67 million individuals. They include children and adults in low-income families, the elderly, and the disabled, many of whom would be uninsured in the absence of a strong and vital Medicaid program. Medicaid is also a major source of financing for long-term care and a primary funding source for America's safety net institutions, including many Catholic hospitals that serve a disproportionate share of the low-income, uninsured, and underinsured in their communities every day.

The health and well-being of millions depends on keeping the Medicaid program strong and vibrant. We recognize that states are facing significant economic challenges in these times and many are struggling to meet their commitments under the program. However, having a Medicaid card is meaningless if there is not adequate access to providers who will accept Medicaid. This is why the provider payment provision of the Medicaid Act, 42 U.S.C. Section 1902(a)(30)(A), provides that Medicaid rates must be "consistent with efficiency, economy and quality of care"

and must be "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." Providing adequate reimbursement is essential to ensure the ability of hospitals and long-term care facilities to continue to serve Medicaid beneficiaries with high quality care.

The proposed rule is an important step in ensuring that beneficiaries have access to needed services. The overall focus on a standardized state review process and transparency for beneficiaries and stakeholders when states propose reductions in provider payments is highly appropriate, and we also support the requirement of ongoing state monitoring of access. We do have several suggestions, however, that we urge CMS to adopt to improve the ability of the proposed rule to achieve the goal of ensuring beneficiary access.

Access Reviews

CMS proposes to require states to perform Medicaid access to care reviews using a three-part framework recommend by the Medicaid and CHIP Payment and Access Commission (MACPAC) in its March 2011 Report to Congress. In assessing access to care, states would be required to consider: (1) the extent to which enrollee needs are met; (2) the availability of care and providers; and (3) changes in beneficiary utilization of covered services.

While these are appropriate and important factors to include, we believe a critical element is missing and should be added as a fourth prong: **States should also be required to perform provider cost studies to examine whether payment rates bear a reasonable relationship to provider costs** (consistent with the position taken by the U.S. Ninth Circuit Court of Appeals in *Orthopaedic Hospital v. Belshe*, 103 F. 3d 1491 (1997), cert. denied, 522 U.S. 1044 (1998)). First, MACPAC itself acknowledges that its report is preliminary and that the proposed framework does not directly address hospital, ancillary, long-term care or other services, focusing instead on primary and specialty care providers. Second, the situation is different for hospitals than other providers. Hospitals which participate in Medicare and have emergency departments are subject to legal requirements to screen and treat emergency patients without regard to their ability to pay, and many hospitals, including Catholic hospitals, treat anyone presenting in their ED as part of their mission of service. Given this, the proposed availability and utilization prongs are less relevant measures of beneficiary access to hospital care. Finally, while perhaps not solely determinative, payment adequacy is obviously directly related to a hospital's ability to continue to provide care to those in need of its services and should be included as key element of an access review.

The proposed access review is to include a comparison of Medicaid payment rates to those made by Medicare or commercial payers. We recommend that such a comparison be part of a new cost study prong, so that **states' cost studies compare their Medicaid payments to those made by Medicare and commercial payers**. When conducting access reviews, the proposed rule directs them to include all base and supplemental payments. Medicaid disproportionate share

hospital (DSH) payments reflect not only Medicaid shortfalls but also the uncompensated care provided to uninsured individuals**. Medicaid DSH payments should be excluded when a state conducts an access review.**

CHA supports the requirement that states conduct ongoing access reviews for each Medicaid service, and not just reviews in connection with a rate reduction proposal**. However we recommend that the reviews occur every three years, rather than every five years as proposed**. This will ensure a more prompt initial review of all services, and will allow states, beneficiaries and stakeholders to keep a closer watch on the effect of payment rates on access into the future.

When Rate Reductions Are Proposed

Under the proposed rule, states wishing to reduce provider payments must submit an access review completed in the previous 12 months with a State Plan Amendment (SPA) for a rate reduction and must have procedures to monitor access to care after implementation of a rate reduction. When access problems arise, states must submit corrective action plans to CMS. CHA supports all of these proposals, but also strongly recommends a change in the language concerning SPA submissions.

The proposed requirement to include an access review with an SPA applies if the SPA "would reduce provider payment rates or restructure provider payments in circumstances when the changes could result in access issues." T**he phrase "in circumstances when the changes could result in access issues" is confusing and should be dropped. We believe any proposed rate reduction or provider payment restructuring that could result in rate reductions should be accompanied by an access review.**

Similarly, elsewhere in the proposal CMS invites comments on whether to drop the word "significant" from the current requirement that states give public notice of "any significant proposed change in … methods and standards for setting payment rates for services." We agree the term is vague and believe that the public should be notified of any change in payment rates, methods and standards. **Therefore we recommend the word "significant" be dropped.**

We also support the requirement for states to solicit and consider input from beneficiaries and stakeholders on how a contemplated payment reduction will affect beneficiary access, and to do so before submitting the SPA to CMS. For this consultation to be meaningful, interested parties must have access to the states' methods and analysis. **We urge CMS to require states to make the access review and payment data public in a manner that allows interested parties to comment on the proposed rate reduction.**

Finally, **CMS should clarify that proposed rate reductions may not be implemented until CMS has approved an SPA accompanied by an access review demonstrating compliance with regulatory and legislative access protections.**

Opportunities for Ongoing Input to States and CMS

Under the proposed rule, states would be required to create ways for beneficiaries to provide them with ongoing input on access to care, through for example surveys, hotlines, and ombudsmen. CHA believes it is important for beneficiaries to have voice in Medicaid policy and supports this proposal. **In addition, CHA believes CMS should also require states to solicit ongoing input from providers, advocates and other stakeholders.**

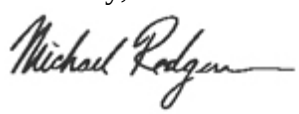
CHA strongly recommends that the proposed rule also establish a mechanism for stakeholders to communicate directly with CMS on Medicaid access and payment sufficiency. There needs to be a way for beneficiaries and providers, as well as other stakeholders, to provide input on payment and access issues directly to CMS as well as to state agencies. Any such mechanism should enable communication both during an SPA rate review process and on a continuing basis.

Access and Medicaid Managed Care

CMS states that the proposed rule will not apply to managed care arrangements, but that it is considering future action to address access issues in managed care systems. CHA believes it is vitally important that Medicaid managed care beneficiaries receive the same protections with respect to access to services as do beneficiaries in fee for service plans. According to MACPAC, approximately 49 million people receive care through some form of Medicaid managed care. While we appreciate that CMS is looking into access issues in Medicaid managed care**, we recommend that CMS apply the access review requirements to payments by managed care organizations to providers.**

Thank you for the opportunity to comment on the Medicaid provider access proposed rule. We share CMS' commitment to ensuring that all patients who receive their care through Medicaid have access to the services and providers they need. We look forward to a continued partnership to strengthen and improve Medicaid for the people the program serves. If you have any questions about these comments, please do not hesitate to contact me or Kathy Curran, senior director, public policy, at 202-721-6300.

Sincerely,



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