Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 13, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2406–P2
P.O. Box 8016
Baltimore, MD 21244–8016
Submitted electronically via http://www.regulations.gov

REF: CMS-2406-P2

RE: Medicaid Program; Methods for Insuring Access to Covered Medicaid Services – Rescission, 84 Fed. Reg. 33722 (July 15, 2019)

Dear Administrator Verma,

The Catholic Health Association of the United States, the national leadership organization of the Catholic health ministry, representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organization across the continuum of care appreciates the opportunity to comment on the Center for Medicare & Medicaid Services' (CMS's) July 15 proposed rule, "Methods for Insuring Access to Covered Medicaid Services – Rescission." **While we recognize CMS' ongoing attention to reducing unnecessary regulatory burdens for both states and providers, CHA opposes the proposed changes and strongly urges you not to finalize the rule.** Simply rescinding the current rules without proposing an alternative regulatory approach to monitoring access will jeopardize beneficiaries' access to care and also could impact providers who serve Medicaid beneficiaries.

Medicaid is a crucial element of our nation's safety net and provides essential health care services to working families, children, the elderly and the disabled, many of whom would be uninsured and without access to health care in the absence of a strong and vital Medicaid program. It is imperative that people who rely on Medicaid have timely access to the care they need, which is why it is so important that state and federal financing for Medicaid is sufficient to provide adequate payment to Medicaid providers.

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that states pay Medicaid providers an amount "sufficient to enlist enough providers so that care and services are available…at least to the extent that such care and services are available to the general population in the geographic area." States and CMS have a shared responsibility

under the law for ensuring compliance. In 2015, the U.S. Supreme Court in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378, held that Medicaid providers and beneficiaries do not have a private right of action to challenge states' Medicaid payment rates in federal courts under the federal access standard. That decision left CMS as the sole source of oversight of the adequacy of state Medicaid rates. The current CMS regulations, finalized in 2015, have provided an effective structure for monitoring rates, including by promoting transparency in rate development and approval.

States are now required to undertake access monitoring review plans (AMRPs) for certain Medicaid services at least every three years as well as when they submit state plan amendments to reduce or restructure rates. States must engage in a public process, with input from beneficiaries and providers, to periodically examine payment adequacy and access, which provides a comprehensive record enabling CMS to monitor access to care within the fee-for-service (FFS) environment. CMS' proposed rule would eliminate the requirement for states to provide AMRPs without simultaneously proposing any replacement, leaving only the statutory directive to ensure access as the operative federal rule. Although CMS indicates its intent to develop a new outcomes-driven strategy to monitor access, rescinding the current rules without proposing a robust regulatory alternative would jeopardize access to essential services.

Therefore, CHA is concerned that the proposal if finalized would leave Medicaid without a regulatory structure and process for states and CMS to carry out their access monitoring obligations, raising questions about how the program will ensure ongoing adequacy of payment rates to ensure beneficiary access. The only regulatory text that would remain (at 42 CFR 447.204) is language that mirrors the statutory requirement found at 1902(a)(30)(A), along with a longstanding requirement (at 42 CFR 447.203) that state agencies maintain documentation of payment rates and make those records available to HHS upon request.

Rather than requiring regular, ongoing monitoring through AMRPs, it appears from the Information Bulletin issued alongside the proposed rule that CMS expects that states would demonstrate compliance with statutory access requirements by including a range of information when they submit payment State Plan Amendments (SPAs) to change FFS rates. Many of the anticipated metrics described in the Informational Bulletin are relevant measures of access but we are concerned about the lack of a standardized process for public input from beneficiaries, providers and other stakeholders. Without assuring opportunities for beneficiaries, providers, and other stakeholders to comment on whether rates are sufficient to promote access, states may not have the information they need to identify access barriers. CMS, too, would not have comprehensive information about how rates impact access.

Moreover, the proposed rule and the accompanying Informational Bulletin do not specifically address the steps states are expected to take to monitor access when states are

not proposing rate changes and rates have not been modified for a number of years. This is a large gap that CMS should address. As health care costs rise, rate changes are sometimes necessary to assure ongoing access. CHA is concerned that without the current every three-year AMRP requirements, some rates could fall behind and threaten access. The current regulatory structure includes essential procedural protections that should be maintained. In developing new monitoring approaches CMS should ensure adequate oversight of all payment rates, not just rates that states are seeking to adjust.

CMS indicates it plans to convene workgroups and technical expert panels to consider effective approaches to ensuring beneficiary access in both the fee-for-service and managed care program. CHA would welcome an opportunity to participate in such discussions and to inform any future access monitoring plans. **In the meantime, however, and for the reasons discussed, we must express our opposition to the rescission proposal and ask CMS not finalize it.**

Thank you for the opportunity to comment on this rule. If you have any questions about our comments, please contact Kathy Curran at kcurran@chausa.org or (202) 721-6312.

Sincerely,

Lisa A. Smith
Vice President
Advocacy and Public Policy