



**American Hospital
Association®**

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May 22, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Re: CMS–2406–P, Medicaid Program: Methods for Assuring Access to Covered Medicaid Services – Exemptions for State with High Managed Care Penetration Rates and Rate Reduction Threshold; Proposed Rule (Vol. 83, No. 57), March 23, 2018.

Dear Ms. Verma:

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule to amend requirements that states assess their Medicaid fee-for-service (FFS) provider payments to determine if they are sufficient to ensure beneficiary access to covered services.

CMS proposes to exempt states from these requirements if they have high Medicaid managed care penetration or if they intend to make “nominal” provider payment rate reductions. **The AHA urges CMS to withdraw these proposed changes, as they would put beneficiary access to care at risk by removing an important oversight function. While the AHA shares CMS’s goal of reducing the regulatory burden on the health care system, we must selectively target burden that is duplicative, provides no value, or does harm. These regulatory requirements, which protect beneficiary access to care, do not meet these criteria.**

While CMS’s proposed changes are intended to address concerns states have raised regarding administrative burden, they overlook the critical role CMS and states play in ensuring provider rates are sufficient to ensure beneficiaries’ access to care. In the wake of



the U.S. Supreme Court's 2015 decision, *Armstrong v. Exceptional Child Center, Inc.*¹, which ended providers' and beneficiaries' right to challenge state Medicaid payment rates in federal court, CMS and the states have become the final arbiter to determine if provider payments are adequate to ensure access under the federal standard.² Following the court's decision, CMS issued its final rule to provide a framework for states to assess the implications of providers' rates on access. That rule, which CMS proposes to amend, established a process for states to document and monitor access, and develop review procedures for proposed rate changes in the Medicaid FFS program. The safeguards imbedded in these requirements are all that remain to hold federal and state governments accountable to ensure access for vulnerable populations covered by Medicaid.

EXEMPTION FOR STATES WITH HIGH MEDICAID MANAGED CARE PENETRATION

The AHA urges CMS to withdraw its proposal to exempt states with high Medicaid managed care enrollment from most access monitoring requirements. This proposed change, according to CMS, is intended to address states' concerns over administrative burden and would specifically exempt states with Medicaid managed care penetrations rates of 85 percent from most access monitoring requirements. Under current requirements, states must establish procedures to ensure beneficiary access to core services is not affected before CMS will approve a cut or restriction to provider rates. In addition, the following core services must be reviewed at least once every three years: primary care, physician specialist, behavioral health, pre- and post-natal obstetric (including labor and delivery), home health, and any additional services where rates have been reduced or restructured or for which the state or CMS has received a higher-than-usual volume of access complaints. While CMS proposes to exempt these states from the access monitoring requirements, it would require states to submit alternative data and analysis that any proposal to restructure or reduce a payment rate will not affect beneficiary access. CMS, however, provides no further specificity on what would constitute alternative analysis, leaving it to the states to determine.

CMS's proposal to exempt high Medicaid managed care states from access requirements overlooks significant populations in these states that remain in FFS arrangements. The Medicaid and CHIP Payment and Access Commission (MACPAC), in its March 2017 Report to Congress, noted that 55 percent of Medicaid spending was for services provided under FFS arrangements. The report further noted that the populations that remain in FFS are some of Medicaid's most vulnerable – children and adults with disabilities. For states with high managed care penetration, MACPAC noted that many services are frequently provided through FFS arrangements, including long-term care services and supports, dental services and behavioral health services.³ At MACPAC's April 2018 public meeting, the commissioners reviewed CMS's proposed rule, and MACPAC staff noted that 17 states would qualify for the proposed exemption from the access monitoring requirements based

¹ https://www.supremecourt.gov/opinions/14pdf/14-15_d1oe.pdf

² Medicaid "Equal Access" standard Sec. 1902 (a)(30)(A)

³ Report to Congress on Medicaid and CHIP, March 2017, Medicaid and CHIP Payment and Access Commission, p. 135.

on managed care penetration rates.⁴ For the vulnerable populations in these states receiving their care through FFS arrangements, this proposed exemption strips away an important federal safeguard that ensures access to covered services. The AHA urges CMS to withdraw its proposed exemption to the access and monitoring requirements and consider other means to address states' concerns regarding administrative burden.

EXEMPTION FOR RATE REDUCTIONS UNDER A DEFINED THRESHOLD

The AHA urges CMS to withdraw its proposed exemption for states proposing nominal rate reductions from any required access analysis. Specifically, CMS proposes to exempt states from access analysis if the reduction in Medicaid payment rates is 4 percent or less in a state fiscal year (SFY) or 6 percent or less over two SFYs. Under the proposal, states would still be required to submit an alternative analysis to CMS demonstrating compliance with federal standards but, like the exemption for high managed care states, CMS provides no detail regarding this alternative analysis – appearing to leave it to states to determine.

In this proposal, CMS largely ignores the payment variation across states. At their April 2018 public meeting, MACPAC commissioners discussed CMS's proposal to exempt nominal rate reductions from access review and analysis. Several commissioners noted that a 4 percent payment reduction (or 6 percent over two years) could have very different implications for a state with low payment rates vs. a state with high payment rates. Others noted that a reduction of 4 to 6 percent could be a significant burden for some Medicaid providers, calling into question whether rate reductions could ever be defined as nominal. For example, the Kaiser Commission on Medicaid and the Uninsured, in its most recent survey of state Medicaid programs, notes that for fiscal year (FY) 2018, 33 states restricted inpatient hospital payments by cutting or freezing such payments.⁵ The report further notes that most inpatient payment restrictions during this period were payment freezes and, as such, could possibly fall under CMS's nominal threshold of 4 to 6 percent and exclude many states from the access review requirements. On a national level, the Medicaid payment shortfall for hospitals amounted to \$20 billion in 2016,⁶ the most recent year for which data are available. This means that Medicaid paid only 88 cents for every dollar spent treating Medicaid patients – a shortfall that is in addition to the \$38.3 billion of uncompensated care hospitals provided that year to those without insurance.⁷ Given the chronic underpayment in Medicaid, provider payment rate reductions should always be subject to access review and monitoring requirements as a critical safeguard for vulnerable Medicaid populations.

⁴ Medicaid and CHIP Payment and Access Commission, April 19 2017 meeting transcript, p. 132.

<https://www.macpac.gov/wp-content/uploads/2017/07/April-2018-Meeting-Transcript.pdf>

⁵ Medicaid Moving Ahead: Results from 50 State from Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, p 45, October 2017.

<http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>

⁶ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, January 2018.

⁷ American Hospital Association, Underpayment by Medicare and Medicaid, Fact Sheet, January 2018.

RELIEF FROM PUBLIC NOTICE OF RATE REDUCTIONS

The AHA urges CMS to withdraw its proposal to allow exempt states to forgo soliciting public comment on payment changes and implications for access. CMS currently requires states to provide public notice of changes in methods and standards for setting payment rates and provide the public an opportunity to comment on the implications for access to services. The proposed rule would allow the states described above to circumvent the public notice and comment obligations altogether. The opportunity for the public to review and comment on government regulatory proposals, in general, is an important part of our democratic process. States should never be exempt from public notice-and-comment requirements when access to care is at stake. Stakeholder engagement is the cornerstone of the Medicaid access standard.

CONCLUSION

The AHA is deeply concerned that CMS's proposals to amend the current access review requirements for states do not strike the right balance between protecting beneficiaries' access to services and relieving states from administrative burden. CMS's oversight of state Medicaid provider payment changes and the implications for access is the last safeguard remaining to ensure access to covered services for vulnerable Medicaid populations. Therefore, the AHA strongly urges CMS to withdraw this proposed rule.

Thank you for the opportunity to provide comments. Please contact me if you have questions, or feel free to have a member of your team contact Molly Collins Offner, director of policy, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President