

September 12, 2019

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

RE: CMS–2406–P2, Medicaid Program: Methods for Assuring Access to Covered Medicaid Services – Rescission; Proposed Rule (Vol. 84, No. 135), July 15, 2019.

Dear Ms. Verma:

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, 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 rescind 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.

The AHA is deeply disappointed that CMS has chosen to rescind the current regulatory requirements for states to assess their Medicaid provider payments to determine if such payments affect beneficiary access to care. By removing this important oversight function, CMS’s proposal would put beneficiary access to care at greater risk. While the AHA shares CMS’s goal of reducing the regulatory burden on the health care system, we believe that it is paramount that burden reduction efforts selectively target those burdens that are harmful, duplicative or provide no value. This proposed rule fails to meet this criteria. It would leave the Medicaid program without a regulatory structure and process for the states and CMS to assess the adequacy of payment rates to ensure beneficiary access. We therefore request the agency to withdraw this rescission.

While CMS justifies this rescission as its effort to address concerns states have raised regarding administrative burden, the agency overlooks the critical role 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 federal statute.² Following the court's decision, CMS issued its final rule, in 2015, to provide a framework for states to assess the implications of providers' rates on access. In 2018, CMS proposed to amend this regulatory framework for states to document and monitor access with new review procedures for proposed rate changes in the Medicaid FFS program. The 2018 proposed rule was never finalized and instead CMS now proposes to rescind the federal requirements in their entirety. The safeguards embedded in the current regulatory requirements, established in 2015, are all that remain to hold federal and state governments accountable to ensure access for vulnerable populations covered by Medicaid. CMS's rescission would strip providers and beneficiaries of these safeguards and leave them with no means to raise concerns with either the state or CMS.

CMS cites states' concerns about administrative burden and notes that a number of states raised concerns over the resources needed to monitor implications of payment decisions on access for a "relatively small population in fee-for-service."³ This overlooks the significant populations in 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% 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.⁴ A state's concern over regulatory burden should not obviate the need to have safeguards in place to protect these vulnerable populations receiving their care through FFS arrangements.

It also is important to note that provider payment changes happen yearly, largely in response to state budgetary issues. The Kaiser Commission on Medicaid and the Uninsured in its survey of state Medicaid programs provides invaluable information about provider rate changes in any given year. For example, in fiscal year (FY) 2018, 33 states restricted inpatient hospital payments by cutting or freezing payments.⁵ The Kaiser report further noted that most inpatient payment restrictions during this period were payment freezes. On a national level, the AHA Annual Survey, provides another

¹ https://www.supremecourt.gov/opinions/14pdf/14-15_d10e.pdf

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

³ Federal Register, Vol. 84, No. 135, P 33723. <https://www.govinfo.gov/content/pkg/FR-2019-07-15/pdf/2019-14943.pdf>

⁴ Report to Congress on Medicaid and CHIP, March 2017, Medicaid and CHIP Payment and Access Commission, p. 135.

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>.

barometer to changes in state payment policy. The Medicaid payment shortfall for hospitals amounted to \$22.9 billion in 2017,⁶ the most recent year for which data are available. This means that Medicaid paid only 87 cents for every dollar spent treating Medicaid patients – a shortfall that is in addition to the \$38.4 billion of uncompensated care hospitals provided that year to those without insurance.⁷ These data sources underscore the chronic underpayment in the Medicaid program and the need to monitor how payment affects access to care for vulnerable Medicaid populations.

CMS issued an **Informational Bulletin** on the same day it released its proposed rule. The bulletin outlines the agency's future plans to monitor access in Medicaid. In this communication to state Medicaid programs, the agency suggests its intent to develop a new access strategy that would examine the best approach to monitoring access to meet the federal statutory requirements, as well as align monitoring across FFS and managed care delivery systems. To help develop this new strategy, CMS says it will convene workgroups and technical expert panels that include state and federal stakeholders. The AHA does not believe that the approach outlined in the CMS bulletin is sufficient to justify rescinding the current regulatory framework. **We recommend that CMS move forward with this approach to seek stakeholder input regarding an access strategy before making changes to the current regulatory structure. We further recommend that it is essential that CMS reach beyond key state and federal stakeholders in this process and include beneficiaries and the providers that serve them in the development of a future access monitoring strategy.**

CONCLUSION

The AHA is deeply concerned that CMS has chosen to abandon access review and monitoring requirements. 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 to rescind the current regulatory requirements.

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/

Ashley B. Thompson
Senior Vice President Public Policy Analysis and Development

⁶ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, January 2019

⁷ American Hospital Association, Underpayment by Medicare and Medicaid, Fact Sheet, January 2019.