



Charles N. Kahn III
President and CEO

May 22, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2406-P; Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold; 83 *F.R.* 12696 (March 23, 2018)

Submitted electronically to www.regulations.gov

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching full-service community hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) about the referenced Notice of Proposed Rulemaking on the Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold (Proposed Rule). **As described in detail below, the FAH urges CMS to not finalize the proposed changes to access monitoring requirements because they would disproportionately impact vulnerable Medicaid beneficiaries, potentially subject providers of services for those beneficiaries with unsustainable rate reductions, and would represent a significant loss of information integral to CMS’s oversight of the program.**

The Federation urges CMS to withdraw the proposed amendments that would exempt states from requirements that they take certain actions to assure that Medicaid payments are “consistent with efficiency, economy, and quality of care and are 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” as required under federal Medicaid statute.¹ We believe that assuring access to Medicaid services is critically important as Medicaid provides almost 70 million people with health coverage – coverage that is only meaningful if beneficiaries have access to care through participating providers that are paid at levels adequate to support participation in the Medicaid program.²

The Proposed Rule, if finalized, would make several major changes to Medicaid program requirements. First, it would provide an exemption to certain specifications for states’ access monitoring review plans (AMRP) for FFS services when those states have comprehensive, risk-based Medicaid managed care enrollment that is above 85% of their total Medicaid population. Under 42 CFR 447.203(b), states are required to submit an access monitoring review plan (AMRP) for FFS services that includes an analysis of access that takes into account information obtained through a public process; and compares Medicaid payment rates to other public and private health insurer payment rates for at least primary care services (including those provided by a physician, FQHC, dental care, physician specialist services, behavioral health care, pre-and post-natal services, and home health). When a state reduces rates or restructures them in ways that could diminish access, it must add those services to the AMRP and monitor for a period of 3 years. AMRP monitoring must also be conducted for services for which CMS has received a significantly higher than usual volume of complaints.

Second, the rule would provide an exemption from special monitoring provisions when certain states make rate reductions or restructure rates in ways that could impact access. The exemptions would apply for rate reductions that CMS believes are “nominal.” Under the proposed rule, states would not need to undertake ongoing access monitoring when it imposes reductions or (restructures rates) where the overall rate reduction is 4% or less of overall spending within the specific state plan service category for a single state fiscal year and 6% or less over 2 consecutive state fiscal years. Those states would also no longer need to engage in a public process for considering feedback on rate reductions. (States meeting the 85% managed care enrollment threshold would also be exempted from these requirements.)

Both groups of states would be subject to alternate access monitoring specifications under the proposed rule. In lieu of existing monitoring specifications, states would be required to submit an alternative analysis with supporting data, the details of which would largely be left to states to determine.

Finally, states proposing rate reductions in excess of the 4%/6% thresholds would no longer have to provide CMS with an analysis of the impact of their proposed rate changes on access. Instead, those states would be required to provide CMS with an assurance that *current* access is in accordance with statutory requirements.

¹ Section 1902(a)(30)(A) of the Social Security Act.

² January 2018 Medicaid and CHIP Enrollment Data Highlights, <https://www.medicaid.gov/medicaid/programinformation/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

Disproportionate Impact on Vulnerable Beneficiaries

As many as 18 states would be exempt from AMRP provisions because at least 85% of their Medicaid enrollees are enrolled in comprehensive Medicaid managed care plans.³ Most states, even those with very high rates of managed care enrollment, often exclude certain categories of particularly vulnerable groups from managed care plans. In those states, Medicaid benefits for people with physical, mental or intellectual disabilities or who are elderly are largely delivered through the FFS system. Consequently, the adequacy of FFS rates, even in states with large managed care populations, are critical for assuring access to care for certain populations who receive most of their Medicaid benefits via the FFS delivery system. In the FAH's view, current regulations are the minimum requirements in assuring states carefully consider the impact of states' policies on access. They require data, comparisons across different types of insurers and geographic areas, ongoing monitoring of rate changes and public feedback. Those activities continue to be critical for enrollees who receive their care through FFS. **We urge CMS to not finalize the exemptions for states with high managed care enrollment.**

“Nominal” Rate Reductions

Under the Proposed Rule, states implementing rate reductions below 4% in one year and 6% over two years would be exempt from access monitoring requirements and they would not need to seek public input on those rate reductions. In the preamble to the proposed rule, CMS indicates that its proposed threshold for rate reductions or rate restructuring of 4% in a year; and 6% over two years represent “nominal” changes. But such changes, if implemented in consecutive years, are far from nominal. **If finalized, this threshold would allow a state to implement a 12% rate reduction over a period of 4 years or a 16% rate reduction over a period of 5 years without requirements for ongoing monitoring of the impact of the rate changes on access services.** Nor would those states be required to consider public input. Under the Proposed Rule, reductions amounting to hundreds of millions of dollars could be implemented without ongoing monitoring and without public comment. **We believe that the imposition of rate reductions of those magnitudes is far from “nominal” and the results of such reductions could be devastating for ensuring beneficiaries in the FFS delivery system have access to Medicaid services.**

Reductions in payment rates for Medicaid fee-for-service providers can also have a magnifying effect on providers in a state's managed care delivery system. Medicaid managed care capitation payments are often set based on fee-for-service rates. Consequently, if finalized, states would be permitted to implement rate reductions of potentially considerable magnitude that would impact both their most vulnerable fee-for-service populations as well as their managed care populations without any significant ongoing monitoring or public feedback.

Medicaid is already well-established as having some of the lowest provider payment rates⁴ and these exemptions would apply whether or not access for those particular services are

³ <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴ Government Accountability Office. Medicaid payment: comparisons of selected services under fee-for service, managed care, and private insurance. July 2014. <https://www.gao.gov/assets/670/664782.pdf> Accessed

already compromised. Many states' Medicaid rates are already set well below the cost of care for enrollees and Medicaid rates continue to be a prime target when states look for budgetary savings. Absent other effective remedies and in light of a recent Supreme Court decision⁵, beneficiaries and providers are left to depend on CMS to enforce state compliance with statutory access requirements via regulations. **The exemptions from access regulations provided to states under the proposed rule would effectively eliminate one of the few remaining avenues for ensuring access to Medicaid services.**

Loss of Information

Under the proposed rule, states meeting the high managed care enrollment thresholds would no longer have to provide to CMS certain types of information, data or assumptions regarding its evaluation of access, including comparisons of rates among payers, analyses of access within geographic areas, and projections of the impact of rate reductions on access. In lieu of those components of existing AMRP requirements, states would be asked to provide CMS with an alternative analysis, the details, methodology, components, data for data for which are largely left to states' discretion. The new rules would represent a major loss of information that may otherwise be used by CMS for overseeing the Medicaid program and assuring the programs are operated consistent with statutory requirements to assure access.

Thank you for the opportunity to comment, should you have questions please do not hesitate to contact me or Paul Kidwell of my staff at (202) 624-1500.

Sincerely,



April 4, 2018.

⁵ Armstrong v. Exceptional Child Center, Inc.