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Health Policy and Advocacy*

December 22, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

***Subject: Final Rule with Comment Period: CMS 2328-FC/RIN 0938-AQ54 Medicaid Program:
Methods for Assuring Access to Covered Medicaid Services (Vol. 80, No. 211, November 2, 2015)***

Dear Acting Administrator Slavitt:

On behalf of our nearly 400 hospitals and health system members, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) final rule with comment period that aims to provide for a transparent data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered services consistent with section 1902(a)(30)(A) of the Social Security Act and to address issues raised by that process. The final rule is particularly relevant in light of the Supreme Court decision earlier this year in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) that limits providers' and beneficiaries' ability to take legal action to supplement CMS review and enforcement of section 1902(a)(30)(A) of the Act in federal court and to ensure beneficiary access to covered services.

CHA is supportive of the final rule's goals to: (1) measure and link beneficiaries' needs and utilization of services with availability of care and providers; (2) increase beneficiaries' involvement through multiple feedback mechanisms; and (3) increase stakeholder, provider and beneficiary engagement when considering proposed changes to Medicaid fee-for-service payments rates that could potentially impact beneficiaries' ability to obtain care. To support these three goals, the final rule requires states to develop an access review plan that sets out the data elements and other information to be used to ensure beneficiary access to mandatory and optional services; to establish new procedures to review the effects on beneficiary access of proposed rate reductions and payment restructuring; and to implement ongoing access monitoring reviews of key services, and additional services upon a state's discretion.

While CHA is supportive of the above stated goals, we are extremely disappointed that CMS has chosen to exclude hospital services and hospital-based services, except for labor delivery, as core services in this critical review process. Failing to include such services means that Medicaid beneficiaries may not be assured timely access to high-quality health care services, as states will be permitted to continue to cut funds for core services with little federal oversight. CHA recommends that CMS expand the list of core services required of state access monitoring review plans to include hospital services as detailed below. CMS could accomplish this in two ways:

1. CMS can respond to this final rule with comment by expeditiously reissuing the final rule to include hospital services.
2. CMS could withdraw the final rule and reissue it as a proposed rule for public comment.

Regardless of CMS' choice, it is extremely important that the agency take action. For the past three decades, California hospitals have been subjected to Medi-Cal rate reductions and limitations that have been solely budget driven and with little to no supporting analysis. Our hospitals have often found themselves with no recourse other than to seek relief through the courts to ensure adequate rates. Due to the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, California hospitals will no longer have the ability to challenge Medicaid rates and ensure that Medi-Cal beneficiaries have access to vital health care services.

I. Access Monitoring Review Plan

Core Services (Section 447.204(5))

CHA urges CMS to include hospital services —**such as hospital inpatient/outpatient, long-term acute care hospital, and inpatient psychiatric services — as well as skilled nursing services and hospital-based post-acute care services like inpatient rehabilitation** in the core services that must be reviewed by the state at least once every three years. Currently, the regulations would only require hospital services related to labor and delivery to be considered. The omission of hospital services ignores the vital and unique role hospitals play in ensuring access to high-quality health care services for Medicaid beneficiaries. Hospitals treat the most acute illnesses and provide a unique set of services that are essential in delivering high quality care to Medi-Cal beneficiaries across California. Without the hospital and the additional services that it provides across the continuum of care, many communities, particularly California's rural communities, would not have access to a health care provider.

Greater oversight is needed to preserve access to hospital and related hospital-based post-acute care services. According to 2014 calendar year data from the California Office of Statewide Health Planning and Development, 29.3 percent of the 3.4 million hospital inpatient stays in California were paid by Medi-Cal. Between 2013 and 2014, the first year of coverage expansion under the ACA, inpatient discharges for Medi-Cal fee-for-service patients increased by 7.7 percent; inpatient discharges for Medi-Cal managed care patients increased by 32.5 percent. Emergency room visits by this population increased by more than 1 million, largely because Medi-Cal patients do not have access to a regular source of care. Data also suggests that the newly enrolled are using services at a greater rate than when they were uninsured. While the shift appears favorable for hospitals, it is important to note that the Medi-Cal program only pays hospitals about 70 percent of the actual cost of providing care – leaving an annual loss of about \$6 billion. Hospitals, quite simply, are a vital component of California's health care safety net, providing high-quality health care services benefitting all Californians — insured and uninsured alike.

II. Stakeholder Engagement

Mechanisms for Ongoing Beneficiary and Provider Input (Section 447.204(7))

CHA appreciates that in the final rule, CMS requires states to implement ongoing mechanisms for beneficiary and provider input on access to care (through hotlines, surveys, ombudsman, review of

grievance and appeals data, or another equivalent mechanism). States are also required to promptly respond to public input, maintain a record of data on public input and how the states responded to this input, and to make this information available to CMS upon request. **To strengthen these accountability requirements, CHA recommends that states be required to submit this information to CMS on an annual basis. Further, we believe CMS should require direct solicitation of providers on their experience in obtaining care for beneficiaries. Often, the challenges of access are masked because the hospital continues to provide care when there is no available access to the next level of care. A more complete approach to understanding beneficiary access is needed; we appreciate CMS' efforts to collect that information through its recently released request.**

Timely access to high-quality health care services is crucial for the over 12.5 million Californians – including approximately one-half of the state's children – who rely on the Medi-Cal program. Under the Affordable Care Act, nearly one in three Californians now depends on the Medi-Cal program for all of their health care needs. Additionally, over 1.4 million individuals have obtained health coverage through our state-based marketplace, Covered California, a population that is anticipated to churn between the Medi-Cal program due to income fluctuations throughout the year. State Medicaid programs' ability to live up to the original commitment of Congress in enacting the Medicaid Act is as critical now as it has ever been. Medicaid expansion and reliance on Medicaid programs as a key element of the ACA magnify the importance of both ensuring sufficient access and capacity in the broader delivery system and maintaining the health care safety net that is critical in serving all Californians — particularly those with unmet health care needs.

CHA appreciates the opportunity to comment on the final rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Amber Kemp, vice president, health care coverage, at akemp@calhospital.org or (916) 552-7543.

Sincerely,

/s/

Alyssa Keefe
Vice President, Federal Regulatory Affairs