September 13, 2019

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

Subject: Proposed Rule: CMS 2406-P2/RIN 0938–AT41 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission (Vol. 84, No. 135, July 15, 2019)

Dear Administrator Verma:

The California Hospital Association, the California Association of Public Hospitals and Health Systems, Private Essential Access Community Hospitals, Inc., the California Children's Hospital Association, and the District Hospital Leadership Forum appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule referenced above. This rule would remove the regulatory text that sets forth the required process for states to document whether Medicaid payments in fee-for-service (FFS) systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act (the Act).

These requirements include requiring states to develop and submit to CMS an access monitoring review plan (AMRP) for certain Medicaid services that is updated at least every three years. Additionally, the current rule requires that, when states submit a state plan amendment (SPA) to reduce or restructure provider payment rates, they must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid payment rates on beneficiary access to care. CMS indicates it is proposing to rescind the requirements because states have raised concerns over the associated administrative burden.

Our organizations respectfully oppose rescinding these requirements. We have outlined below our concerns about 1) the importance of monitoring access for vulnerable populations served by fee-for-service (FFS) delivery systems; 2) how changes to FFS reimbursement impact managed care reimbursement; 3) the importance of provider participation and a public process to inform access to care; and 4) the need for greater CMS oversight of state Medicaid programs.

I. Importance of Monitoring Access for Vulnerable Populations Served by FFS Delivery Systems

We respectfully request that CMS not rescind the rule provisions designed to assure access for the vulnerable populations served by FFS delivery systems. In the proposed rule, CMS provides an overview of state feedback on the administrative burden of the regulatory requirements associated with the "relatively small population in fee-for-service," sharing that states provided feedback that "these populations are often so small or require such specialized care that their needs may not be meaningfully compared to the general population."

Of the 13 million Californians enrolled in Medi-Cal – California's Medicaid program – in state fiscal year 2018-19, nearly 2.4 million of these individuals (over 18 percent) were served by the FFS delivery system. These include high-cost individuals enrolled in both Medi-Cal and Medicare (dually eligible individuals), those temporarily placed in FFS for approximately three months while they wait to receive informational materials and complete their Medi-Cal managed care health plan selection, and share-of-cost individuals.

The populations covered by Medi-Cal FFS in California are some of the most vulnerable, including children and adolescents with medically complex conditions and disabilities, individuals with breast and cervical cancer and tuberculosis, pregnant women, and low-income seniors. DHCS data reveal:

- The distribution of ages in the FFS population is very different than that of the managed care population. The median age for Medi-Cal's FFS population (36) is 15 years older than for the Medi-Cal managed care population (21). Individuals participating in Medi-Cal's FFS delivery system had a slightly smaller proportion of children ages 0-18 and adults ages 19-64 compared to the managed care population. Conversely, FFS participants had a larger proportion of individuals ages 65 and older compared to their managed care counterparts.

- Dually eligible individuals — who comprise 88 percent of the aged eligibility group and 31 percent of the disabled eligibility group — represent 10 percent of the FFS population. In terms of spending, Medi-Cal's aged population represents 9 percent of the overall population but accounts for 35 percent of total Medi-Cal spending. Similarly, Medi-Cal's disabled population constitutes 10 percent of the overall Medi-Cal population and accounts for 35 percent of overall spending, according to an October 2016 DHCS report.

- When compared to Medi-Cal's managed care delivery system participants, Medi-Cal's FFS participants are more likely to be female.

Considering that California's FFS population is greater than the entire Medicaid program in many states — such as Colorado, Massachusetts, Oregon, and Washington, to name a few — our organizations believe strongly that the vulnerable populations served by FFS delivery systems should be subject to an equal assurance of access and CMS oversight as their managed care enrollee counterparts.

II. Changes to FFS Reimbursement Impact Managed Care Reimbursement

We appreciate that CMS removed the initially proposed rule whereby states with at least 85 percent of their Medicaid population enrolled in managed care plans would be exempt from the regulatory requirements in §§ 447.203(b)(1) through (6) and 447.204(a) through (c), and providing states an exemption for proposing nominal rate reductions. As shared in our May 2018 comments, CMS' oversight with the access and monitoring reports is an important mechanism in ensuring California is held accountable for adequate provider reimbursement. Even though California's Medicaid FFS population represents only 20 percent of total Medicaid enrollment in California, the importance of properly establishing and updating FFS rates plays a significant role in reimbursement for providers serving all 13 million Medi-Cal members.

In California, many of the Medi-Cal managed care plans enter into network provider agreements whereby they reference the published FFS rate schedule as a marker for reimbursement under the contract. However, because over 10 million beneficiaries are enrolled in the Medi-Cal managed care delivery system — with 24 separate managed care plans that span 58 counties — not all providers have entered into network provider agreements that cover the entire state. While providers believe there are adequate reimbursement protections in place via the state's CMS-approved contracts with the Medi-Cal managed care plans, and federally under 42 U.S.C. section 1396u-2(b)(2)(D) — the "Rogers Amendment" — any non-network providers receiving reimbursement for emergency services, or post-stabilization services, would be based upon the FFS rate schedule/methodology.

Eliminating or reducing the safeguards established under the current rule for states to document and report publicly whether their Medicaid payments are sufficient to ensure beneficiaries have access to covered services will eliminate the transparency and provider assurances that FFS rates will not be negatively and arbitrarily impacted by the Medicaid agencies. **For the reasons stated above, it is important to recognize these existing protections impact more than just providers within the FFS delivery system.**

III. Importance of Provider Participation and a Public Process to Inform Access to Care

Our organizations are disappointed that CMS is proposing to rescind the ongoing mechanisms for beneficiary and provider input on access to care associated with the current AMRP requirements. The current process requires states to undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid payment rates on beneficiary access to care. These requirements are incredibly relevant to providers in light of the Supreme Court decision 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 the Act in federal court, and to ensure beneficiary access to covered services.

CMS indicated in its July 11 CMCS Informational Bulletin that it is committed to developing a new data-driven strategy to understand access to care in the Medicaid program across FFS and managed care delivery systems, as well as in home and community-based services (HCBS) waiver programs. CMS also indicates the new strategy will focus on a more uniform and comprehensive methodology for analyzing Medicaid access data for all states and will be led by CMS working in partnership with states. CMS plans to convene workgroups and technical expert panels that include key state and federal stakeholders in the upcoming months, specifically working with the National Association of Medicaid Directors to identify states that would be interested in partnering by participating in technical expert panels and ongoing working groups. CMS was silent on engagement with the beneficiary and provider community.

In addition, CMS further indicates in the proposed rule that, if the regulatory amendments in the proposed rule are finalized, it expects to issue subregulatory guidance concurrently with the publication of the final rule through a letter to state Medicaid directors about data and analysis that states will submit with SPAs to support compliance with the Act.

A critical excluded element from the proposed process above is a mechanism for beneficiary and provider input into the subregulatory guidance that CMS will issue concurrently with the publication of the final rule. Our organizations request that CMS include beneficiary and provider community representatives in this process. **Any process to develop a streamlined, comprehensive approach to**

monitoring access across Medicaid delivery systems should allow for the meaningful participation of Medicaid beneficiaries, providers, and other stakeholders — an essential component for enhancing transparency and assisting CMS in its review of states complying with statutory requirements.

IV. Need for Greater CMS Oversight of State Medicaid Programs

Our experience in California teaches us that it is extremely important for CMS to have effective tools to enforce its rules for state Medicaid programs. The California State Auditor continues to document instances in which our state Medicaid agency provided ineffective program oversight, affecting access to care for millions of Medi-Cal beneficiaries.

In 2019 audits requested by the California Joint Legislative Audit Committee, the California State Auditor released two reports about the California Department of Health Care Services' (DHCS) – California's state Medicaid agency – oversight of care provided to Medi-Cal beneficiaries.

In an August 2019 report titled *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care*, the audit revealed:

- The Regional Model health plans – health plans administering managed care to Medi-Cal beneficiaries in 18 rural California counties – have not provided all Medi-Cal beneficiaries with adequate access to care.
    - DHCS did not enforce state requirements that limit the distances health plans may direct their Medi-Cal beneficiaries to travel to receive health care. Some beneficiaries were required to travel hundreds of miles.
    - DHCS failed to hold Regional Model health plans accountable for improving beneficiaries' access to care.
- Regional Model beneficiaries have generally received a lower quality of care than beneficiaries in other areas of the state.
- DHCS did not adequately educate the Regional Model counties about the options available to them regarding their transition to managed care.
    - DHCS did not assist Regional Model counties that wanted to create or join a county organized health system, which may have provided its beneficiaries with better access to care.

In a March 2019 report titled *Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*, the audit revealed:

- An annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services.
- Many of the state's children do not have adequate access to Medi-Cal providers who can deliver required pediatric preventive services.
- Limited provider access is due, in part, to low Medi-Cal reimbursement rates.
- States with higher utilization rates offer financial incentive programs that California could implement, but it would likely require additional funding.
- DHCS delegates responsibilities to ensure access and use of children's preventive services to managed care plans, but it does not provide effective guidance and oversight.

- It does not provide adequate information to plans, providers, and beneficiaries about the services it expects children to receive.
- It does not ensure that plans regularly identify and address underutilization of children's preventive services.
- It has not followed up on plans' efforts to mitigate cultural disparities in the usage of preventive services.

It is concerning that these audits highlight significant deficiencies in DHCS' oversight of the care provided to Medi-Cal managed care beneficiaries. We appreciate that the state has since taken steps to address many of the concerns brought to light by these reports and believe that the current AMRP and public notice process offer the same opportunities to provide oversight and monitoring of the Medi-Cal FFS program, and to identify opportunities to improve access to care for vulnerable populations.

Our organizations remain supportive of the goals of the current rule developed 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 FFS payments rates that could potentially impact beneficiaries' ability to obtain care. The expansion of Medicaid and reliance on the Medi-Cal program to cover our most vulnerable magnify the importance of ensuring sufficient access and capacity in the broader delivery system and to maintain a health care safety net that is critical in serving all Californians — particularly those with unmet health care needs.

We appreciate the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact Alyssa Keefe, vice president, federal regulatory affairs, California Hospital Association, at akeefe@calhospital.org or (202) 488-4688; or Amber Kemp, vice president, health care coverage, California Hospital Association, at akemp@calhospital.org or (916) 552-7543.

Sincerely,

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California Association of Public Hospitals & Health Systems
California Children's Hospital Association
District Hospital Leadership Forum
Private Essential Access Community Hospitals, Inc.