September 13, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission, RIN:0938-AT41

Dear Administrator Verma:

Thank you for the opportunity to comment on the proposed rule, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission."

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including many who rely on Medicaid as their primary source of healthcare coverage. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Centers for Medicare and Medicaid Services (CMS) to utilize the collective insight and experience our patients and organizations offer in response to the proposed rule.

In March of 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy

and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit package.

The proposed rule would rescind the regulation that CMS issued in November 2015 to enforce the provisions at 1902(a)(30)(A) of the Social Security Act to ensure that provider reimbursement rates are sufficient to provide adequate access to treatments and services for all Medicaid enrollees. The 2015 final rule established a process for states to submit access monitoring review plans (AMRP) every three years, conduct an access review when submitting proposed reductions in payment rates to CMS and monitor Medicaid patients' access to care if rate changes are approved. Our organizations are deeply concerned that the proposal to rescind this rule would threaten patients' access to care in the Medicaid program by eliminating this accountability mechanism, and we urge CMS to withdraw the proposal and keep the final 2015 rule in place.

Proposed Rule Jeopardizes Access to Care in Medicaid

Our organizations believe that access to care for all populations served by the Medicaid program should be regularly and thoroughly monitored in order to hold states accountable for ensuring enrollees have appropriate access to covered services. If CMS moves forward with this proposal to rescind the 2015 final rule, our organizations are concerned that access to critical services would not be adequately protected for enrollees in the Medicaid program.

Patients with serious and chronic conditions need access to a wide range of primary care providers and specialists. The 2015 final rule requires states to monitor and report on patient access across a range of critical services – including primary care services, physician specialist services, behavioral health services, prenatal and postnatal obstetric services, and home health services – that are important for patients with serious and chronic conditions who need access to a variety of providers to help them best manage their conditions. Our organizations are concerned that access to all of these critical categories of care would not be monitored and protected if CMS moves forward with rescinding the 2015 final rule.

Research has shown that Medicaid beneficiaries with higher healthcare needs or chronic conditions already have greater problems accessing care.[1] By rescinding the 2015 final rule, which establishes a process for monitoring access for individuals who receive services on a fee-for-service (FFS) basis, it will be even more challenging for CMS to understand and address barriers to accessing care for vulnerable populations typically served through a FFS model. These populations include children with special healthcare needs, individuals with disabilities and the elderly.

Additionally, monitoring access within FFS is important in ensuring access for patients enrolled in both FFS and Medicaid Managed care organization (MCOs), as FFS payment rates have an outsized impact across the Medicaid system. FFS payment rates are often used to determine the size of the capitation payments that MCOs receive. Some states also use FFS provider payment rates as a floor for the rates that MCOs pay providers under their plans. Therefore, rescinding the 2015 final rule would negatively affect access for patients in MCOs as well.

Proposed Rule Reduces Transparency Prior to Rate Setting

Rescinding the 2015 final rule would mean that states and the public would not know whether there is sufficient access to key services before making critical decisions about Medicaid reimbursement rates for participating providers. Without this important information, rate reductions could lead to patients losing access to providers with whom they have longstanding relationships, experiencing longer wait times, or losing access to providers in their community altogether — leading to an inability to manage

conditions and worse health outcomes for people with serious healthcare needs. These potential harms highlight the need to maintain the current rule that requires states to complete a deliberative process, including public and stakeholder input, when considering payment changes.

Proposed Rule Lacks Sufficient Evidence to Justify Drastic Reversal

Our organizations do not believe that there has been sufficient experience with the current rule for CMS to rescind it. The original rule was published in November 2015 and the initial deadline for states to submit AMRPs was October 1, 2016. Many states received extensions, and there is significant variability in the information that was submitted. States are currently scheduled to submit their second round of AMRPs on October 1, 2019. Therefore, CMS does not have sufficient information to make such a drastic change to measuring access to services within FFS Medicaid program at this time.

Proposed Rule Lacks Information on Replacement Plan

The proposed rule states that after rescinding the 2015 final rule, CMS expects to issue a letter to State Medicaid Directors about information states *may* submit with state plan amendments (SPAs) to demonstrate their compliance with section 1902(a)(30)(A) when proposing changes to providers' payment rates. Yet, the proposed rule does not contain any information about this replacement plan. Our organizations are deeply concerned that this unclear reporting process cannot adequately replace the 2015 final rule in ensuring access to care for patients with serious and chronic health conditions. We are also concerned that such a plan will no longer require states to solicit input from patients and other stakeholders when making payment changes, reducing beneficiaries' representation in decisions impacting their access to care.

While the 2015 final rule represents an important step forward in improving patients' access to care in Medicaid, access challenges still remain for the patients we represent. For example, patient struggles to access care through managed care organizations have been well documented in several states, including Iowa,[2] Kansas[3] and Texas.[4] The current rule also does not include home and community-based waiver services, which are particularly important for people with disabilities. For these reasons, rather than rescind the 2015 final rule in its entirety, our organizations urge CMS to focus on improving the current regulations by collecting input from a wide range of stakeholders, including beneficiaries; increasing the standardization of data on access to care to improve CMS's ability to monitor access across states; and establishing an approach that monitors access for all covered Medicaid services, including managed care and other services provided by a waiver. In contrast, rescinding the rule is a step in the wrong direction, taking patient access to care backwards.

Our organizations are committed to ensuring access to care in the Medicaid program and urge CMS to withdraw the proposed rule. Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
ALS Association
American Heart Association
American Liver Foundation
American Lung Association
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation

Family Voices
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen

CC: The Honorable Alex Azar, Secretary
Department of Health and Human Services

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[1] *See, e.g.,* Sharon K. Long *et al., Urban Inst. National Findings on Access to Health Care and Service Use for Non-elderly Adults Enrolled in Medicaid* 3 (2012), https://www.macpac.gov/wp-content/uploads/2015/01/Contractor-Report-No_2.pdf; Karen Davis *et al., Access to Health Care for the Poor: Does the Gap Remain?*, 2 ANN. REV. PUB. HEALTH 159, 160 (1981).

[2] Tony Leys and Stephen Gruber-Miller. (2019) 'Iowa agrees to give Medicaid management companies 8.6% raises', *Des Moines Register.* 10 July. Accessed at: https://www.desmoinesregister.com/story/news/health/2019/07/10/iowa-medicaid-privatization-managed-care-companies-amerigroup-centene-iowa-total-care-mcos-increase/1691928001/

[3]Karen Henry. *KanCare enrollees with mental illness report gaps in Medicaid managed care program.* September 20, 2019.The University of Kansas. Accessed at: https://news.ku.edu/2017/09/20/kancare-enrollees-mental-illness-report-gaps-medicaid-managed-care-program

[4] J. David McSwane and Andrew Chavez. (2018) 'Managed-care companies overstate the number of physicians available to treat the state's sickest patients', *Dallas News.* 4 June. Accessed at: https://interactives.dallasnews.com/2018/pain-and-profit/part3.html