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

Re: Proposed Rule, Medicaid Program: Methods for Assuring Access to Cover Medicaid Services - Exceptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold (CMS-2406-P)

Dear Administrator Verma,

Thank you for the opportunity to comment on the Proposed Rule Medicaid Program: Methods for Assuring Access to Cover Medicaid Services - Exceptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold CMS-2406-P. As health care advocates who have come together to speak up for patients and health care consumers, we would like to express our strong opposition to this proposed rule.

The Medicaid Program: Methods of Assuring Access to Cover Medicaid Services rule, also known as the "equal access" rule, was finalized in 2015 to ensure equal access for all Medicaid fee-for-service (FFS) beneficiaries compared to the general public with other types of health insurance. The rule requires states to monitor that the services provided through Medicaid FFS and any changes that are made to the program continue to provide enrollees with meaningful access to the care they need through capturing access and payment data as part of an access monitoring review plan (AMRP) which needs to be updated at least once every three years and submitted to CMS.

While the proposed rule seeks to reduce the administrative burden for states and is well-intentioned, it will ultimately reduce access to essential health care services for some of the most vulnerable Medicaid FFS consumers, including the disabled, mentally ill, or those with a substance use disorder, by doing away with important reporting requirements and by allowing a significant reduction of provider rates over time.

We are particularly concerned with the following provisions that would take effect if the proposed rule is approved in its current state:

- **Reducing Access and Transparency for Medicaid FFS Beneficiaries**: The proposed rule would make exemptions for states with more than 85 percent of their Medicaid beneficiary populations enrolled in managed care organizations (MCOs) from being required to develop and submit triannual AMRPs. Currently, this would apply to 18 states[1] AZ, DC, FL, HI, IA, KS, KY, LA, MD, NE, NJ, NM, OH, OR, RI, TN, TX, and WA. This number is likely to increase as more states move to MCO systems.

[1] https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems

These states could seek approval for cuts in FFS provider payments without seeking input from the beneficiaries or providers who would be affected by those changes. Those states would also not be required to submit an analysis based on the AMRP of the effects these cuts would have on patient access to care. Although this removes an administrative requirement for states, doing away with a transparent public process for beneficiaries and providers would make it more difficult for the affected parties to know about the rate cuts before they are implemented and allow them a chance to comment on how the cuts may affect access to care.

The proposed rule reiterates that states continue to have a responsibility to monitor access consistent with the Medicaid statute, but the method it proposes to do so is not likely to be effective. States would not be required to monitor or certify the effects of reduced rates on consumers or providers, except in the cases when, at the states' discretion and determination, these proposed rate cuts may decrease access. In those cases, they would be required to provide an analysis and certification of their own choosing. The loosening of the reporting and compliance requirements, as well as deregulating their format, would make it difficult for CMS to determine whether states are complying with the "equal access" requirement. Furthermore, allowing states to determine whether their proposed cuts "decrease access" disincentives states from reporting, as they have no oversight or requirement to submit those reports.

This proposed rule would also decrease access to key services, such as mental health and substance use treatment, as they are carved out from the MCO system in some states. In those cases, consumers are able to access those services through the FFS system, but the proposed changes mean that states will no longer need to submit AMRPs for such services, which could make it more difficult to access these services.

- **Weakening Medicaid Access for All**: Although the proposed rule would still require states with lower MCO populations to develop and update AMRPs, this reporting would be significantly reduced. This is because under the proposed rule, states implementing "nominal rate reductions" would not be required to seek enrollee and provider input on proposed cuts on access. The proposed rule defines what constitutes a "nominal rate reduction" as 4 percent in a state fiscal year or 6 percent over two consecutive fiscal years, which it says would be "unlikely to result in diminished access."

  As described above, states would have to submit an alternative analysis when submitting state plan amendments that would reduce or restructure rates in circumstances that the state itself determines may diminish access to care. States therefore would submit reports at their discretion, without basing them in AMRP findings, which could diminish access.

  Through loosened reporting requirements and without the ability to monitor the effects of rate reductions long-term, these "nominal rate reductions" would undoubtedly become the go-to option for states seeking to cut their Medicaid costs.

  Additionally, while a reduction of 6 percent over two years may seem "nominal," such cuts add up over time. In Illinois, for example, the state did not raise rates for pediatric in-

home nursing services for many years, which resulted in shortages of nurses and unnecessary risks to children, including institutionalization, medical complications and decreased quality of life[2]. Through decreased payment rates to providers, including specialists who are able to care for vulnerable disabled, mentally ill and substance use disorder populations, this proposed rule would significantly reduce patient access to essential services.

Although the 2015 “equal access” rule had its shortcomings since it only required states to measure access and rates for FFS and not managed care or waiver programs, it created a structure to ensure consumers were provided with an adequate level of care as part of the Medicaid program. The new proposed rule would scale back the progress of the previous rule and reduce the information CMS receives from states when they implement changes to payment rates to ensure that the Medicaid FFS population continues to have access to quality care. This would ultimately lead to reduced access to providers, further exacerbating Medicaid beneficiary access issues.

We firmly believe that if approved in its current form, this rule will hurt patients across the United States. We are asking that you add more rigorous requirements or retract this proposal and protect consumer access to quality care through ensuring satisfactory reporting requirements for all states, guaranteeing thorough CMS review of the reporting provided by states and assuring sufficient provider rates.

If you have any questions, please don’t hesitate to contact us.

Thank you,

Consumers for Quality Care

MANA, A National Latina Organization

First Focus

Black Women’s Health Imperative

National Minority Quality Forum

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[2] http://www.healthlaw.org/news/press-releases/487-ob-norwood