Illinois Health and Hospital Association

May 22, 2018

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 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; Proposed Rule (*Federal Register,* Vol. 83, No. 57, March 23, 2018)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule concerning revisions to Methods for Assuring Access to Covered Medicaid Services-Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold. IHA has strong concerns with these proposed changes and presents the following comments for your consideration.

CMS proposes to exempt states from these requirements if they have high Medicaid managed care penetration or if they intend to make "nominal" provider payment rate reductions**. IHA urges CMS to withdraw these proposed changes, as they would put beneficiary access to care at risk by removing an important oversight function. IHA shares CMS' goal of reducing the regulatory burden on the health care system, but we strongly believe that we must selectively target burden that is duplicative, provides no value, or does harm. While CMS' proposed changes are intended to address concerns states have raised regarding administrative burden, they overlook the critical role CMS and states play in ensuring provider rates are sufficient to ensure beneficiaries' access to care.**

<u>DOCUMENTATION OF ACCESS TO CARE AND SERVICES PAYMENT RATES</u>
All Medicaid rate changes, including reductions to fee-for-service rates, affect Managed Care Organizations' (MCOs') capitation rates. Rate reductions to specific services are usually passed along to the service provider. IHA does not agree with the provision that states with at least 85 percent of beneficiaries enrolled in MCOs would not be required to meet the requirements specified in 42 CFR 447.203 (b)(1) through (6).

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When the final rule was issued, IHA commented how extremely disappointed we were that CMS did not apply the access review requirements to managed care entities. With the increased presence of mandatory managed care, we believe it is important that states ensure that managed care entities are providing Medicaid clients access to care and not impeding it through operational tactics resulting in non-payment to providers. The current rule already falls short in its service review of what is needed to ensure states provide beneficiaries with access to all essential services and that providers receive reasonable payment for the services provided. The proposed rule specifies that for states with more than 85 percent of their beneficiaries enrolled in Medicaid managed care organizations, including 1115 Waiver populations enrolled in comprehensive risk contracts, states would be exempt from most access monitoring requirements. States would still need to submit alternative data and analysis to CMS assuring the agency that any proposal to reduce or restructure Medicaid payments would not affect beneficiary access to covered services. **IHA proposes that this alternative and certification methodology be specified in this rule and be uniform for all states.**

States proposing to reduce Medicaid payment rates by less than four percent in overall service category spending during a state fiscal year (and six percent over two consecutive years) would be exempt from the current rule access analysis. **IHA strongly opposes these proposed thresholds for determining when states must submit the access monitoring review plan. Rate reductions of less than four percent have significant impacts on providers which could lead to access issues for Medicaid beneficiaries, including those enrolled in Medicaid managed care.**

The Emergency Medical Treatment and Labor Act (EMTALA) requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. In the case of hospitals, EMTALA places an added requirement on hospitals regardless of the Medicaid rates being paid by Medicaid MCOs or the state for care provided to beneficiaries. EMTALA does not permit hospitals to elect who to serve, which results in operational costs.

<u>MEDICAID PROVIDER PARTICIPATION AND PUBLIC PROCESS TO INFORM ACCESS AND CARE</u>
The regulation has been changed to exempt states with managed care enrollment of at least 85 percent, or in the case of rate reductions of no more than four percent, to complete a monitoring of access review. IHA believes states should be held accountable to assure there are enough providers for beneficiaries, at least to the extent those services are provided to the general public. For states with a large volume of beneficiaries enrolled in Medicaid managed care, are states to determine network adequacy?

We are very concerned that this proposed rule may erode certain important requirements that states document whether payment reductions would affect access. As stated earlier, rate reductions to fee-for-service rates are also incorporated into Medicaid managed care capitation rates and passed along to the provider.

CONCLUSION

IHA is deeply concerned that CMS' proposals to amend the current access review requirements for states do not strike the right balance between protecting beneficiaries' access to services and relieving states from administrative burden. CMS' oversight of state Medicaid provider payment changes and the implications for access is the last safeguard remaining to ensure access to covered services for vulnerable Medicaid populations. **Therefore, IHA strongly urges CMS to withdraw this proposed rule.**

Ms. Verma, thank you again for the opportunity to comment.

Sincerely,

A.J. Wilhelmi
President & CEO