PARTNERSHIP FOR MEDICAID HOME-BASED CARE

September 13, 2019

Submitted electronically via:
http://www.regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-2406-P2: Methods for Assuring Access to Covered Medicaid Services—Rescission

Dear Administrator Verma:

The Partnership for Medicaid Home-Based Care (PMHC) is pleased to submit these comments on CMS-2406-P2 relating to a proposed rescission to Medicaid access to care documentation. PMHC has long endeavored to serve as a resource to the Centers for Medicaid and Medicaid Agency (CMS), and we hope the comments offered here will likewise be of value to your important work.

Since its founding in 2015, PMHC has been dedicated to its mission of advancing the delivery of high-quality, cost-effective Medicaid home-based care and services. Our members bring to this important quest their experience as home care providers, associations, managed care organizations, and technology providers. While such a diverse membership is somewhat unique, our members have come together due to a shared commitment to support legislative and regulatory efforts that improve the quality, accessibility, and integrity of home and community-based care and services in Medicaid.

It is because we take this commitment so seriously that we are writing today to express our grave concern with the potential consequences of the changes proposed in this rule. As we expressed in a similar fashion last year, we clearly recognize the Administration's desire to be responsive to state-level concerns relating to regulatory burden. In fact, we support regulatory reform that improves effectiveness and efficiency, as we believe our recent response to the Patients over Paperwork request for information demonstrates. However, that support does not extend to instances when changes contemplated for the purpose of regulatory relief would instead have negative consequences on access to care, its quality, its cost, or patient safety.

We respectfully submit that the rescission proposed here would have such negative consequences, and we therefore urge that it be withdrawn for reconsideration.

As affirmed by the text in this proposed rule, "Section 1902(a)(30)(A) of the Social Security Act (the Act) requires states to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." As you know, this "equal access" rule has been in place since its promulgation by CMS in 2015, following a Supreme Court ruling.

Since then, states have been required to submit information to CMS so it may determine if proposed fee-for-service (FFS) payment cuts would reduce access to care to an extent violative of the "equal access" requirement. Importantly, this assessment is conducted for services that are vital to the health of Medicaid clients, including primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services, and home care services.

Last year, this requirement faced the risk of substantial weakening when it was proposed that states be exempted from access to care assessments if Medicaid managed care plans provided 85 percent or more of the total Medicaid services delivered in the state. We spoke out against this proposal, expressing our grave concern that states would no longer document the sufficiency of their FFS payments to assure access to Medicaid-covered care and services. We are grateful this message was heard and applaud CMS for deciding not to finalize the proposed exemption.

With this proposed rule, however, we are concerned that CMS may be introducing uncertainty in an area of vital importance to vulnerable Americans and their healthcare providers. For example, the proposed rule states that in place of the data currently submitted by states via the AMRPs "similar information can be presented by states through the SPA submission process to demonstrate compliance with the statute…" We would certainly hope for this to be the case, but the lack of any requirement that it be so is a cause for genuine concern.

Similarly, the Agency suggests in this proposed rule that if it is finalized, "we would expect to issue subregulatory guidance concurrently with the publication of the final rule through a letter to State Medicaid Directors to provide information on data and analysis that states will submit with SPAs to support compliance with section 1902(a)(30)(A) of the Act." The proposed rule goes on to say that "[s]uch data *might* include: rate comparisons; ratios of participating providers to total providers in the geographic area; ratios of participating providers to beneficiaries in the geographic area; available transportation in the geographic area; direct comparisons of access for Medicaid beneficiaries to that of the general population in the geographic area; and provider, beneficiary, and other stakeholder complaints and recommendations for resolution of such complaints." (emphasis added) Here, too, specificity sufficient to allay concerns is not provided, nor is any certainty that the aforementioned subregulatory guidance *will* be issued or that states *will* be required to include in their SPAs the important items listed here.

Finally, the proposed rule states, "We *expect* that the [subregulatory] guidance would *remind* states of their ongoing obligation to ensure sufficient payment rates and that they must demonstrate with the information they provide through SPAs that the proposed rates or rate structure would satisfy the requirements of the statute, including section 1902(a)(30)(A) of the Act." (emphasis added) With respect, the importance of the statutory compliance mentioned here cannot be understated. And yet, this proposed rule provides no guarantees of that compliance. Instead, the proposed rule only presents expectations of reminders which, while appreciated, do not convey the certainty we believe is vital.

In opting to participate in the Medicaid program, states accept responsibility for many documentation requirements; this is by no means either the only or the most comprehensive one. Having said that, we believe this documentation requirement is particularly important due both to the vulnerable status of the population served by Medicaid home and community-based services and to the proven utility of those services in helping Medicaid taxpayers avoid the high cost of institutionalization.

It is for these reasons we write to urge you to withdraw this proposal to allow for further consideration. If that step is not taken, we secondarily urge the Agency to embed in any final rule much greater specificity concerning the data submission and statutory compliance processes discussed above. With sufficient clarity and certainty, the Administration's goal of regulatory relief can be met without concurrent loss of patient access, patient safety, or cost savings; without it, we fear this policy change could cause severe human, clinical, and fiscal harm.

On behalf of the Partnership for Medicaid Home-Based Care, I would like to thank you again for this opportunity to provide our comments and recommendations. If we can be of a resource to you, please do not hesitate to call on us.

Sincerely,

David J. Totaro, Chair

cc: Members, Partnership for Medicaid Home-Based Care