AMERICA'S ESSENTIAL HOSPITALS

December 21, 2015

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

Ref: CMS-2328-NC: Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Process for Access to Care in the Medicaid Program

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on this Centers for Medicare & Medicaid Services (CMS) request for information (RFI) on core measures and metrics of beneficiary access to care in Medicaid and thresholds and goals for improving program access. America's Essential Hospitals supports CMS' work to identify measures and metrics that appropriately assess Medicaid beneficiaries' access to care.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our roughly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half of their inpatient and outpatient care to Medicaid and uninsured patients. Through their integrated health systems, members of America's Essential Hospitals offer primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health and substance abuse services, and wraparound services vital to vulnerable patients.

Essential hospitals play a unique and critical role in the Medicaid delivery system. Given our largely low-income, vulnerable patient populations, we are distinctly positioned to make a real and lasting impact on the lives and well-being of the most disadvantaged among us. We have the expertise, passion,

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and commitment to apply and adapt proven models of care to the benefit of our patients, and to pioneer new models to meet their specialized needs.

In its RFI, CMS solicits feedback to inform potential development of standards to assess beneficiary access to covered services under Medicaid. As CMS moves forward with developing thresholds and goals to inform and improve access in the program, we ask the agency to consider the following comments.

1. CMS should consider access measures that are relevant for the full range of services critical to the Medicaid population.

As CMS develops standards to assess beneficiary access to covered services, the agency should look at measures that are relevant for all services—*especially* hospital services. Measures should demonstrate an appropriate range of available preventative, primary care, and specialty services; and a sufficient number, mix, and geographic distribution of providers to meet the needs of all Medicaid patients in a service area. Without adequate access, enrollees would not receive primary and specialty care vital to positive health outcomes.

Measures also should focus on issues particularly relevant to the Medicaid population. In state reviews, CMS should include relevant measures that identify patients' ability to receive social support, such as language services, other culturally competent care, transportation services, and access to after-hours care. These types of services are especially important to Medicaid beneficiaries. Reviewing these factors will help protect essential providers from rate changes that hinder their ability to provide the full range of care to vulnerable patients.

2. CMS should identify a set of uniform measures for states to collect.

In addition to developing measurement standards that capture meaningful access to covered services, CMS should identify a set of uniform measures for which states must collect data. This will enable CMS to compare data across states and develop a better understanding of measures that particularly impact access. CMS could still provide flexibility to states to satisfy the access monitoring review requirements using other measures, but the burden would be on the state to demonstrate the strength of its alternative measures.

In its role as first co-chair of The Partnership for Medicaid, America's Essential Hospitals has encouraged the adoption of uniform measures and access to care summary indicators. The Partnership has developed a quality reporting framework and process aimed at improving health care quality and reducing costs in Medicaid. The Partnership for Medicaid is a nonpartisan, national coalition of 23 organizations representing hospitals, physicians and other health care providers, safety net health plans, counties, and labor. The

coalition's goal is to preserve and improve Medicaid. As outlined in further detail in the attached proposal, the Partnership urges adoption of a four-step process for comprehensive state reporting and accountability, to include these components:

- federal reporting infrastructure
- a succinct common reporting set
- federal incentives to report
- mandatory reporting by all states

America's Essential Hospitals urges CMS to consider key aspects of this proposal as it works to develop a system that establishes a baseline for identifying access gaps and institutes a standardized measurement method.

3. CMS should ensure any measures used for comparisons of payment include the cost of services.

For comparing payment rates, CMS should consider measures that assess whether the payment rates cover providers' average costs. CMS should also clarify that cost should be calculated as the agency has defined it—i.e., through a Medicare cost reporting methodology, consistent with standards for other parts of the Medicaid program. This will help to ensure that the definition of cost is not manipulated to create the appearance of sufficient payment rates.

4. CMS should apply any measures used to determine adequacy of fee-for-service (FFS) payment rates to managed care payment rates.

CMS seeks comment on comparisons or measures that would inform managed care rate adequacy. Inclusion of such comparisons or measures is critically important, as more than 70 percent of Medicaid enrollees are in some form of managed care,[1] and states are increasingly looking to Medicaid managed care as a way to limit costs. Managed care capitation rates must support plan payments to providers sufficient to ensure access at least equivalent to that available to the general population. Too often, current Medicaid managed care rates result in less access to services for beneficiaries.

As states continue to increase use of managed care for their Medicaid populations, it is vital that plans are paid rates that are sufficient to provide not just access to these services, but equal access, as the statute requires. As such, CMS should ensure states accurately account for the costs associated with providing care to guarantee that payment rates are actuarially sound and preserve access to providers. The development of actuarially sound rates

[1] Kaiser Family Foundation. State Health Facts: Total Medicaid Managed Care Enrollment, 2013. http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/. Accessed November 2015.

should include, as part of the base data, the assumption of provider payment rates that meet the (a)(30)(A) standard.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at eomalley@essentialhospitals.org or 202-585-0127.