UnityPoint Health

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September 12, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2406–P2
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS–2406–P2 – Medicare Program; Methods for Assuring Access to Covered Medicaid Services—Rescission; published in Vol. 84, No. 135 Federal Register 33722-33732 on July 15, 2019.

Submitted electronically via www.regulations.gov

Dear Administrator Verma:

UnityPoint Health ("UPH") appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule to establish two mandatory specialty care models. Through more than 30,000 employees, our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, western Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Health Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program as well as providers from the Pioneer ACO Model.

UnityPoint Health respectfully offers the following comments to the proposed regulatory framework.

GENERAL PROVISIONS

CMS is proposing to remove the regulatory text that sets forth the current required process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with the Medicaid statute. Specifically, this would eliminate the requirement for state Medicaid programs to maintain and update access monitoring review plans.

Comment: While this proposal retains the requirement in 42 CFR §447.203(a) for states to maintain

documentation of payment rates and make that available to CMS upon request, it eliminates the regulatory framework underlying this requirement. **We oppose this change as premature and encourage CMS to maintain the current regulatory framework which sets a standardized approach to evaluating payment policy relative to beneficiary access to care.**

First, we question why CMS would encourage a nonstandard approach that does not permit cross state comparisons for determining access to Medicaid. This rule suggests that states may demonstrate sufficiency of payment rates via "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." We find it interesting that CMS would grant "states flexibility to select the types of data they would use to demonstrate the sufficiency of payment rates," yet similar parameters are not available for health plans seeking to provide network adequacy for Medicare Advantage. **Should CMS grant this proposed flexibility for Medicaid access to vulnerable populations, we would encourage CMS to apply this to MA adequacy as well.** Generally, providing flexibility on how MA adequacy is achieved could even the playing field for highly integrated delivery systems when compared to more loosely affiliated large health plans. Assuming definitional flexibility, we believe this approach to MA is an opportunity to provide alternative evidence to show that highly integrated delivery systems can provide superior care to beneficiaries in situations where access and geography are an issue based on current network regulations. In fact, we believe that similar network adequacy flexibility would incentivize delivery systems and health plans to be innovative in their approach to serving those areas, rather than simply excluding them as would be required today.

Second, we believe that, in principle, **CMS should be establishing a standardized method for measuring access for the Medicaid population across all states**. As a nonprofit, integrated healthcare system with a multiple state presence, Medicaid is an important payer and its payment rates have significantly lagged behind other public and private payers. The eliminated framework specifically set forth that states monitor access to (1) Primary care; (2) physician specialist services; (3) behavioral health services; (4) pre- and post-natal obstetric services; (5) home health services; (6) services subject to a proposed payment rate reduction or restructuring; (7) services with a significantly higher volume of beneficiary, provider or other stakeholder access complaints; and (8) additional types of services selected by the state. Access monitoring review plans are particularly useful for rural areas, which already face workforce shortages as evidenced by designated HPSAs and MUAs, and these plans squarely connect reimbursement rates to workforce shortages. Even for states with a low percentages of FFS beneficiaries, this access gut-check helps to assure that payment rates have not contributed to barriers to care for FFS Medicaid patients.

Third, **we believe this rule is premature** as proposed substitutes have not been enacted and are not able to be enforced. CMS justifies in part the elimination of the access monitoring review plans (based in regulations and a rule-making process) due to a future a CMS guidance related to a SPA and a separate data-driven access strategy, both of which have yet to be released. The details of the guidance and strategy are unknown, and these sub-regulatory processes are not subject to public rule-making. We would encourage CMS to delay this rule until these "substituted" processes are made

public and can be evaluated on their merits.

Fourth, **the SPA process to support compliance with section 1902(a)(30)(A) of the Social Security Act[1] is not an equivalent** to the proposed elimination of the access monitoring review plans. The SPA does not specifically target the issue of access, or does it trigger a recurrent specific analyses of vital services lines or those services subject to high volumes of access complaints or payment restructures.

Fifth, **we do not believe that CMS has correctly captured the administrative burden to CMS** of this non-standardized approach. By eliminating a specific framework, CMS evaluation and review will require more time and effort on an individual basis to review differentiated documentation.

We are pleased to provide comments to the proposed regulation and its impact on our integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs
UnityPoint Health

[1] Section 1902 (a)(30)(A) of the Social Security Act (the Act) requires that state Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care."