



August 14, 2019

Administrator Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2406-P2  
P.O. Box 8013  
Baltimore, MD 21244-1850

RE: CMS-2406-P2- Methods to Insuring Access to Covered Medicaid Services

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

Dear Administrator Verma,

Trinity Health appreciates your continued interest in reducing burden for hospitals, physicians, patients, and states while improving the quality of care, decreasing cost, and ensuring patients and their providers are able to make the best choices possible for care. Trinity Health is committed to public policies that ensure affordable, high quality, people-centered care for all. Our comments on the CMS proposal to rescind the 2015 “Medicaid Program; Methods for Assuring Access to Covered Medicaid Services” final rule illustrate our commitment to policies that ensure equity in access to comprehensive, affordable health care while meeting a state’s unique needs.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Our People-Centered Health System puts the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns \$1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models (APMs). Further, we have provided care for more than one million patients who have gained Medicaid coverage since 2014 and we celebrate their health improvements and see the economic benefits of this coverage in our communities.

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.

CMS is proposing to rescind a final rule that requires states to develop and submit to CMS an access monitoring review plan (AMRP), as well as certain access analysis when proposing to reduce or restructure Medicaid provider payment rates, to ensure provider rates are sufficient for beneficiary access to care. This proposed rule is part of a broader CMS goal to reduce administrative burden for states and develop a comprehensive approach to monitoring access across Medicaid delivery systems. **Trinity Health supports efforts to reduce burden and increased state flexibility; however, we offer the following recommendations to ensure adequate access to services for this vulnerable population and state adherence to Section 1902(a)(30)(A).**

Maintain opportunity for public input on state Medicaid payment rate changes

Under existing regulations, states must consider the data collected through AMRPs and solicit input on the potential impact of changes on beneficiary access to care prior to reducing or restructuring Medicaid payment rates. In addition, an analysis of information and concerns expressed through input from stakeholders must be submitted to CMS along with the State Plan Amendment (SPA). **Trinity Health is concerned changes to this process could significantly reduce opportunity for stakeholder input.**

The proposed rule highlights that while AMRPs can serve as an overall structure for states to monitor access data, including after rate reductions or restructurings, similar information can be presented by states through the SPA submission process to demonstrate compliance with the statute without the need to develop and maintain AMRPs as currently required by regulation. **Trinity Health urges CMS to maintain the requirement that any changes to payment rates that could affect access be subject to a public comment opportunity.**

Federal statute does not require public comment for SPAs—if a state makes changes in statewide methods and standards for setting payment rates through a SPA, it must provide public *notice* of the changes but no comment period is required. To ensure transparency, incorporate broad stakeholder perspective, and guard against unintended consequences, any proposed changes to Medicaid payment that would reduce or restructure rates should be subject to public comment.

Maintain mechanism for continued beneficiary and provider input

In addition to the public comment requirement referenced above, current regulation requires states to have a mechanism (e.g. hotline, survey, etc.) through which providers and beneficiaries can provide continued input on access to care. Existing requirements also outline a process through which states must address any identified deficiencies to access.

**Trinity Health recommends states be required to maintain a process through which stakeholders can offer feedback on access to care, and CMS should maintain minimum standards—such as timeline and potential approaches—for addressing access to care issues.**

Maintain process for monitoring access to care outside of SPA submission

Under current requirements, states must have procedures to monitor continued access to care after implementation of a SPA that includes a service rate reduction or payment restructuring. This continued monitoring is incredibly important, as it can identify issues with access early.

**Trinity Health urges CMS to require states maintain a process for continued monitoring of access to care.**

Ensure standardized structure for monitoring access to covered Medicaid services

The proposed rule would rescind the only codified regulatory requirements for assessing and ensuring access across providers within Medicaid fee-for-service. CMS indicates it plans to develop an aligned methodology for analyzing access across the program in partnership with states and other stakeholders. Further, CMS notes it will release sub-regulatory guidance outlining information states would need to submit with a SPA to support compliance with 1902(a)(30)A) and expects to give states flexibility to select types of data that could be used to demonstrate sufficiency of payment rates.

**Trinity Health supports CMS efforts to reduce administrative burden for states; however, it is important CMS maintain baseline standards for ensuring access to care. At a minimum, states should be required to provide data that can be easily accessed by all stakeholders, including beneficiaries, providers, and physicians, and demonstrates the following: 1) ratio of providers to Medicaid beneficiaries, 2) sufficiency of payments, 3) adequacy for providers and services based on network adequacy standards similar to CMS requirements for Medicare Advantage Organizations, and 4) appointment availability (i.e. establishing a minimum standard for third available appointment or another similar metric).**

Ensure broad stakeholder engagement for development of new access monitoring strategy

In the CMS Informational Bulletin released concurrently with the proposed rule, CMS commits to working with the National Association of Medicaid Directors to identify potential states to participate in technical expert panels (TEPs) and ongoing working groups to support its strategy to monitor access across fee-for-service, managed care and home and community based waivers.

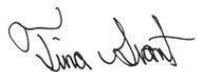
**It is critical CMS ensure beneficiaries, providers and other essential stakeholders are included in the TEPs and workgroups. Trinity Health would happily participate in this effort.**

Conclusion

Trinity Health thanks CMS for the opportunity to respond to this proposed rule. As our comments indicate, we care deeply about access to care and support and state flexibility—we want to ensure the proposed changes successfully accomplish both of these goals. We look

forward to working with you on these policies. If you have questions on our comments, please feel free to contact me at [granttw@trinity-health.org](mailto:granttw@trinity-health.org) or 734-343-1375.

Sincerely,

A handwritten signature in black ink that reads "Tina Weatherwax Grant". The signature is written in a cursive, flowing style.

Tina Weatherwax Grant, JD  
Vice President, Public Policy and Advocacy  
Trinity Health