Congress of the United States

Washington, DC 20510

July 5, 2016

The Honorable Sylvia Matthews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

As Ranking Members of the relevant committees of jurisdiction, we have the responsibility and privilege of protecting the rights of the more than 70 million Americans who receive health care under Medicaid and CHIP. We write to you today in regards to final regulatory action issued by the Centers for Medicare & Medicaid Services (CMS) in November entitled, *Medicaid Program; Methods for Assuring Access of Covered Medicaid Services,* 80 Fed. Reg. 67576 (Nov. 2, 2015).

First and foremost, we would like to thank you for responding to our June 2015 letter calling for final action on the rule. As implementation commences, we urge the agency to make certain that principles designed to ensure that beneficiaries receive equal access to care are coordinated and applicable across the program—in both fee-for-service and managed care arrangements, and demonstration and wavier programs. We look forward to working with you on this effort.

However, we also remain concerned that upon review of the final rule, equal access to the full range of benefits in the program has not been addressed, including essential services such as hospital and home-and-community-based services (HCBS). Accordingly, we urge CMS to reexamine its selected service categories and include essential services such as hospital and home-and-community-based services as part of any systematic ongoing access review process. The equal access regulation will function as the primary regulatory interpretation of the law under Section 1902(a)(30)(A), and as such, the full array of services in the program should be included.

Section 1902(a)(30)(A) of the Social Security Act requires that payments to providers be "consistent with efficiency, economy, and quality of care" and "sufficient" to ensure that Medicaid recipients have equivalent access to services as privately insured patients. The release of the final rule is especially timely in light of last year's U.S. Supreme Court decision holding that providers cannot sue in federal court to enforce adequate Medicaid payment rates.

Accordingly, the access review process outlined in the final rule is critical to ensuring redress for all beneficiaries and providers to enforce their rights under the Medicaid statute.

When the regulation was first proposed in 2011, CMS included a provision requiring states to perform an access review for all Medicaid covered services every five years. However, in the final rule, CMS significantly limited the scope of the service categories subject to the required ongoing review. In the preamble of the rule, CMS notes that services selected are those that are both in high demand and commonly used by Medicaid beneficiaries, yet high-volume services such as hospital and HCBS care are notably missing from the subset of services subject to ongoing reviews as outlined in the final rule.

Again, we are pleased that CMS has advanced their 2011 rulemaking to provide thoughtful guidance for states on how to provide access to an array of important Medicaid services. However, with millions of Americans around the nation covered by Medicaid and millions more gaining eligibility for Medicaid benefits, we remain concerned that failure to conduct ongoing oversight of the full array of services, particularly hospital and home-and-community-based care, may create a dangerous precedent that could undermine beneficiary access to care.

Sincerely,

Ron Wyden
Ranking Member
Senate Finance Committee

Frank Pallone, Jr.
Ranking Member
House Energy & Commerce Committee

cc. Victoria Wachino, Director, CMS Center for Medicaid and CHIP Services