May 22, 2018

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

RE: RIN 0938-AT41 – Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold

Dear Administrator Verma,

Thank you for the opportunity to comment on the Department's proposed rule, *Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold*. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals, by advocating, educating and litigating at the federal and state level.

We write with strong objection to the proposed changes to the existing regulations on equal access. The proposed rule would significantly weaken CMS's ability to monitor and enforce access to covered services in state Medicaid programs, by exempting many states and most rate cuts from rigorous reporting requirements. Moreover, the changes would be operative before CMS has had a chance to evaluate whether the current regulatory scheme is effective for addressing access. We urge CMS not to make major changes to the rule at this time.

I. CMS must monitor access in Medicaid.

As background, state Medicaid programs must set payment rates to ensure provider participation such that Medicaid services are available at least as readily as they are for people who are not in Medicaid. *See* 42 U.S.C. § 1396a(a)(30)(A). Over the years, beneficiaries and providers used this legal requirement, known as the "equal access provision," to hold states accountable when they cut Medicaid provider payment rates, or allowed rates to stagnate such that access to covered Medicaid services was diminished. In 2015, however, the Supreme Court ruled in *Armstrong v. Exceptional Child* that providers could not enforce the equal access provision in federal court, admonishing them to seek administrative recourse from CMS instead.

State Medicaid programs have long struggled to provide adequate access to covered Medicaid services.[1] Regularly beset by budget pressures, many states have cut Medicaid provider reimbursement rates significantly, leaving providers a thin profit margin and making it difficult for those Medicaid programs to attract a sufficient number and mix of providers to ensure that beneficiaries can access needed services.[2] After the Supreme Court's decision in *Armstrong v. Independent Living Centers,* there is little recourse to address reimbursement rate and access shortcomings in federal court, even where there is a clear violation of the Medicaid Act. Thus, CMS's role in monitoring and enforcing the Medicaid Act's equal access provision is more important than ever.

II. Provider payment rates are a crucial component in determining access.

Provider payment rates are not the only determinant of access to care. But the research confirms what common sense tells us, and what the Medicaid statute requires: payment rates do matter, so much so that they must be "sufficient to enlist enough providers so that care and services are available under the [state Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A).

There is evidence that reductions in Medicaid provider payment rates result in diminished access. One study found that provider payment reductions led to a significant increase in

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[1] *See, e.g.,* THOMAS C. BUCHMUELLER *ET AL.*, NAT'L BUR. ECON. RES., THE EFFECT OF MEDICAID PAYMENT RATES ON ACCESS TO DENTAL CARE AMONG CHILDREN 28 (2013), http://www.nber.org/papers/w19218.pdf.

[2] *See, e.g.,* STEPHEN ZUCKERMAN & DANA GOIN, THE URBAN INST., HOW MUCH WILL MEDICAID PHYSICIAN FEES FOR PRIMARY CARE RISE IN 2013? EVIDENCE FROM A 2012 SURVEY OF MEDICAID PHYSICIAN FEES at 7 (2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf; Sandra L. Decker, *In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFF. 1673 (2012).

the likelihood that a Medicaid enrollee had no provider visits in the last year.[3] In addition, the study found that payment reductions led Medicaid enrollees to seek more care in hospital outpatient departments instead of physicians' offices.[4] Decreases in payment significantly increase the likelihood that Medicaid enrollees are diagnosed with pregnancy complications, asthma, hypertension, abdominal pain, and urinary tract infection in an emergency department instead of a physician's office.[5]

There is also evidence that increases in Medicaid provider payments result in improved access. The increase in Medicaid payment rates for primary care providers to Medicare levels in 2013 and 2014 improved some measures of access to care. A "secret shopper" study in 10 states found that the availability of Medicaid primary care appointments increased by 7.7 percentage points after the reimbursement increase.[6] The study also found that states with larger reimbursement increases tended to have larger increases in appointment availability.[7] Research also shows that this primary care "bump" was particularly important for children. After the payment increase, office-based primary care pediatricians increased their rates of Medicaid participation.[8]

III. Now is not the appropriate time to change the rule.

CMS asserts that—after reviewing only one cycle of states' Access Monitoring Review Plans—it has sufficient experience to partially excuse states from the requirements imposed just three years ago. CMS provides no evidence to support this assertion, and, on its face, it is not compelling. Since the final equal access rule was promulgated three years ago, CMS does not appear to have made significant strides in enforcing the equal access provision. The rules required Medicaid programs to submit Access Monitoring Review Plans to CMS by October 1, 2016. *See* 42 C.F.R. § 447.203(b)(5)(i). But as of April, 2018, two states and three territories do not have plans posted on CMS's public website.[9] Nor has CMS made any public reports about its analysis of the plans that have been submitted, or what corrective action, if any, CMS required states to make.

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[3] Sandra L. Decker, *Changes in Medicaid Physician Fees and Patterns of Ambulatory Care*, 46 INQUIRY 291 (2009).
[4] *See id.* at 303.
[5] *Id.*
[6] Daniel Polsky et al., *Appointment Availability after Increases in Medicaid Payments for Primary Care*, 372 NEW ENGLAND J. MED. 537, 537 (2015), https://www.nejm.org/doi/full/10.1056/NEJMsa1413299.
[7] *Id.* at 539.
[8] Suk-fong S. Tang et al*., Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians*, 141 PEDIATRICS 2570 (2018).
[9] *See* Ctrs. Medicare & Medicaid Servs., Access Monitoring Review Plans, https://www.medicaid.gov/medicaid/access-to-care/review-plans/index.html (last visited May 22, 2018).

Moreover, our own review of the initial Access Monitoring Review Plans that are posted reveals significant deficiencies. For example, the Kentucky document published on CMS's website is not an actual Access Monitoring Review Plan containing fee-for-service data and analysis, but instead a Request for Proposal to outside agencies to conduct such an analysis.[10] Neither Louisiana nor Kansas cover any of the areas mandated by the current regulations in their Access Monitoring Review Plans, and instead focus their reporting entirely on their managed care programs, making it impossible to tell whether there are fee-for-service access issues.[11] Hawaii's four-page report contains only general demographic information about the populations who receive services fee-for-service, a description of the state's case management program, and a list of facilities with which the state contracts and summarily concludes: "Analysis of the data and information contained in this report show that Hawaii Medicaid beneficiaries have access to healthcare that is similar to that of the general population in Hawaii."[12]

In addition, while CMS has approved SPAs that reduced rates since the regulations went into effect, the analysis submitted by states in support of those SPA proposals is not published on its access monitoring website, or with the SPA approval. The approval letters appear to simply take the state at its word that access will not be reduced as a result of proposed rate cuts, but do not indicate that CMS has performed any independent analysis to ensure that proposed cuts will not reduce beneficiary access to covered services.[13]

We urge CMS make more information about its monitoring and enforcement efforts publicly available. At a minimum, CMS should ensure that states provide Access Monitoring Review Plans as required by the regulations, and review states' submissions to ensure that they are complete and accurate. In addition, we request that CMS publish any metrics it is using to evaluate state's reports and proposed SPAs that would reduce rates, and any corrective action it has required states to make. This kind of evidence is vital to assuring beneficiaries

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[10] KENTUCKY DEP'T MEDICAID SERVS., ACCESS TO CARE FINAL RULE (2016).
[11] LOUISIANA DEP'T HEALTH, ACCESS MONITORING REVIEW FRAMEWORK (2016); KANSAS DEP'T HEALTH & ENVIRON., MEDICAID SERVICE ACCESS MONITORING PLAN – OCTOBER 2016 (2016).
[12] STATE OF HAWAII, MEDICAID ACCESS MONITORING REVIEW PLAN 2016 at 2 (2016).
[13] *See, e.g.,* Letter from Richard C. Allen, Ctrs. Medicare & Medicaid Servs., to Marie Matthews, Mont. Dep't Pub. Health & Hum. Servs. (Mar. 8, 2018) (approving a 2.99% reduction in rates for Optometrist services, noting that the state has assured CMS that "the change in reimbursement . . . is not expected to have an effect on access to care for Medicaid beneficiaries" and noting that since 2016 beneficiary utilization and provider enrollment for the benefit have been "consistent," without analysis as to whether consistent enrollment is connected to the current payment rate), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-17-0028.pdf; Letter from Kristin Fan, Ctrs. Medicare & Medicaid Servs., to Allison Taylor, In. Fam. Soc. Servs. Admin (Sep. 27, 2017) (approving a continued 3% reduction in inpatient hospital rates and asserting that stakeholder "comments did not suggest a loss of access to care" without further analysis), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-17-004.pdf.

that CMS's current efforts to monitor access to Medicaid services are working and sufficient. It is premature to make changes to the regulations before the public has had a chance to determine whether the current regulatory scheme is adequate to protect the needs of Medicaid beneficiaries, and to ensure that they have access to covered services.

IV. CMS must not change the rule to exempt states with high managed care penetration.

NHeLP opposes the proposed change to exempt states with high managed care penetration rates, defined as states where at least 85% of Medicaid beneficiaries are enrolled in a managed care plan. NHeLP has long opposed CMS's limiting the equal access regulations to fee-for-service Medicaid.[14] As we have previously stated, The § 1902(a)(30)(A) requirement is a broad Medicaid state plan requirement – like many others in § 1902(a). When Congress intends to exempt Medicaid managed care from foundational § 1902(a) requirements, Congress does so explicitly. For example, in § 1932(a)(1)(A), the statute explicitly authorizes state plans to include managed care "notwithstanding paragraph… (23)(A) of section 1902(a)" (the freedom of choice provision). No exemption like the explicit one for (a)(23)(A) exists anywhere in the statute for (a)(30)(A), and HHS has no authority to create such an exemption on behalf of Congress. Rather than declining to review states with high managed care penetration rates, CMS should review provider rates paid in Medicaid managed care programs.

Even putting aside the question of reviewing provider rates paid in managed care programs, the proposal to exempt states with high managed care penetration rates would effectively ignore access problems for beneficiaries who remain in fee-for-service delivery systems in those states. CMS does not provide any justification for the proposed exemption, aside from noting that several states complained about the administrative burden associated with creating an Access Monitoring Review Plan. But there are several other steps CMS could take to assist states in creating their plans without exempting them from rigorous monitoring of access in their Medicaid programs, such as providing templates that states could use to report the requested data, and providing technical assistance to states to assist their compliance.

Moreover, this proposal threatens significant harm to beneficiaries. As CMS notes in the preamble to the proposed rule, a recent Kaiser study found that 18 states (including the

[14] *See* Letter from Jane Perkins, Legal Dir., Nat'l Health Law Prog., to Ctrs. Medicare & Medicaid Servs. (Jan. 4, 2016), http://www.healthlaw.org/publications/search-publications/nhelp-equal-access-regulation-comments; Letter from Byron J. Gross & Jane Perkins, Nat'l Health Law Prog., to Ctrs. Medicare & Medicaid Servs. (June 11, 2011), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-proposed-rule-governing-medicaid-rate-setting; *see also* Sara Rosenbaum, *Medicaid And Access To Care: The CMS Equal Access Rule*, HEALTH AFF. BLOG, Nov. 19, 2015, https://www.healthaffairs.org/do/10.1377/hblog20151119.051847/full/.

District of Columbia) have managed care penetration above 85%.[15] Our analysis of the Access Monitoring Review Plans submitted by those states in 2016 suggests that over 4 million Medicaid beneficiaries receive care from fee-for-service Medicaid in those states. In many of those states, those beneficiaries have high health care needs and are most likely to be negatively impacted by access problems in Medicaid fee-for-service. For example, in Maryland, Ohio, and Oregon, all states with overall managed care enrollment above 85%, all or some dual-eligibles continue to receive services through fee-for-service Medicaid.[16] Dual-eligibles tend to be a population with a particularly high need for services, especially for services not covered by Medicare such as dental and behavioral health services. And, in Florida, Maryland, and Oregon, all states with over 85% managed care penetration, women with breast and cervical cancer enrolled in Medicaid through the Breast and Cervical Cancer Treatment program receive their care fee-for-service.[17] People with cancer are another high-need population.

Our analysis of the Access Monitoring Review Plans submitted by high managed care penetration states in 2016 suggests that well over 600,000 children receive fee-for-service Medicaid in those states, many of whom are children with special health care needs. Children in general tend to have more frequent recommended physician visits and immunizations compared to adults, and that it is even more the case for those children who have special health care needs.[18]

The exemption for states with high managed care penetration will also disproportionately impact Native American Medicaid beneficiaries. Our analysis of the Access Monitoring Review Plans of high managed care penetration states indicates that over 200,000 fee-for-

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[15] Kaiser Family Found., Share of Medicaid Population Covered under Different Delivery Systems as of July 1, 2017, https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 22, 2018).

[16] *See* MARYLAND DEP'T HEALTH & MENTAL HYGIENE, ACCESS MONITORING REVIEW PLAN FOR THE STATE OF MARYLAND 2 (2016); OHIO DEP'T MEDICAID, OHIO ACCESS MONITORING REVIEW PLAN 5 (2016); OREGON HEALTH AUTH., OREGON ACCESS MONITORING REVIEW PLAN 9(2016); *see also* MATHMATICA POLICY RES., CTRS. . MEDICARE & MEDICAID SERVS, MEDICAID MANAGED CARE ENROLLMENT AND PROGRAM CHARACTERISTICS, 2015 at 22 (2016), https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2015-medicaid-managed-care-enrollment-report.pdf.

[17] STATE OF FLORIDA, MEDICAID ACCESS MONITORING REVIEW PLAN 7 (2016); MARYLAND DEP'T HEALTH & MENTAL HYGIENE, *supra* note 16, at 2.

[18] *See, e.g.*, INST. ON MED., AMERICA'S CHILDREN: HEALTH INSURANCE AND ACCESS TO CARE (Margaret Edmunds & Mollymath J. Coye, eds., 1998); MICHAEL CROCETTI ET AL., CHARACTERISTICS OF CHILDREN ELIGIBLE FOR PUBLIC HEALTH INSURANCE BUT NOT ENROLLED 5 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4586284/pdf/nihms721798.pdf; Paul W. Newacheck *et al., An Epidemiologic Profile of Children With Special Health Care Needs*, 102 PEDIATRICS 117 (1998).

service Medicaid enrollees are Native American. In New Mexico, nearly all of the fee-for-service population is composed of Native American enrollees.[19] In Arizona and Washington, more than half of full service Medicaid fee-for-service enrollees are Native American.[20] Access is particularly important for Native American Medicaid beneficiaries since Native Americans have "long experienced lower health status when compared with other Americans. . . [including l]ower life expectancy and the disproportionate disease burden."[21]

Long-standing research has established that Medicaid beneficiaries with higher health care needs or chronic conditions are already more likely to experience access problems than their comparatively healthy counterparts.[22] Thus, while CMS asserts in the preamble to the rule that the impact of cuts to fee-for-service rates in states with high managed care penetration is "low relative to the overall program administration because most of the state's beneficiaries are enrolled with a comprehensive managed care entity," this assertion misses the point. Even if a relatively low proportion of beneficiaries experience access problems after a rate cut, the state has still violated its obligations under the Medicaid Act. If the access problems are concentrated among high-need and vulnerable beneficiaries, including seniors, people with disabilities, children, and Native Americans, that should draw more scrutiny from CMS, not less.

If those states need only submit their own analysis and self-certification that services are accessible in their fee-for-service programs, it will be difficult for CMS to understand where there are access problems and address them. Vulnerable Medicaid beneficiaries who continue to receive services on a fee-for-service basis could face diminished access without any meaningful oversight or opportunity for redress.

Moreover, exempting states with high managed care penetration will provide no oversight of services carved-out from managed care and delivered on a fee-for-service basis. As of 2015, twenty-two states (including six states with managed care penetration rates at or above 85%) still carved out all or some of their dental services from their Medicaid

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[19] NEW MEXICO MEDICAID, ACCESS MONITORING REVIEW PLAN FOR FEE-FOR-SERVICE RECIPIENTS 11 (2016).
[20] ARIZONA HEALTH CARE COST CONTAIN. SYS., 2016 ACCESS MONITORING REVIEW PLAN 3 (2016); WASHINGTON STATE HEALTH CARE AUTH., FEE FOR SERVICE ACCESS MONITORING REVIEW PLAN 7 (2016).
[21] Indian Health Servs., Disparities, https://www.ihs.gov/newsroom/factsheets/disparities (last visited May 7, 2018).
[22] *See, e.g.,* SHARON K. LONG *ET AL.,* URBAN INST. NATIONAL FINDINGS ON ACCESS TO HEALTH CARE AND SERVICE USE FOR NON-ELDERLY ADULTS ENROLLED IN MEDICAID 3 (2012), https://www.macpac.gov/wp-content/uploads/2015/01/Contractor-Report-No_2.pdf; Karen Davis *et al., Access to Health Care for the Poor: Does the Gap Remain?*, 2 ANN. REV. PUB. HEALTH 159, 160 (1981).

managed care program and delivered them on a fee-for-service basis.[23] Yet access to primary care dental services is one of the areas that states are required to monitor under the regulations. Allowing a state that enrolls the majority of beneficiaries in a managed care plan to forgo rigorous monitoring and reporting of access to carved-out dental services that are delivered fee-for-service could obscure serious access problems.

In addition, at least one high managed care penetration state, Maryland, carves out substance use disorder treatment and specialty mental health services on a fee-for-service basis.[24] Given CMS's attention to Medicaid's role in the ongoing opioid crisis, allowing states to forgo reporting on access to opioid treatment and other substance use treatment services seems particularly counter-intuitive, especially since, again, access to behavioral health services is an area of focus in the current regulations.

Another high managed care penetration state, Nevada, delivers Medicaid services to people in rural and frontier regions of the state on a fee-for-service basis.[25] CMS just recently announcement that it is undertaking a specific focus on "[e]nsuring access to high-quality health care to all Americans in rural settings."[26] Allowing state Medicaid Programs to forgo rigorous monitoring of access to health care in rural regions is odds with this goal. CMS should not adopt the proposed change.

In the preamble to the rule, CMS invites comment as to whether it should consider an even lower threshold of managed care penetration for exemption from the reporting provisions of the rule. CMS suggests it would entertain exempting states with only 75% managed care penetration. For the reasons stated above, NHeLP vehemently opposes lowering the threshold. Lowering the threshold to 80% or 75% would exempt at least five or ten additional states, respectively, and would allow access for millions more Medicaid beneficiaries to go unchecked. We reiterate that no state should be exempt from monitoring and reporting—CMS should not increase the number of states that could be exempt.

V. CMS should not allow states to cut 4% in one year or 6% in two years without reporting or scrutiny.

NHeLP also opposes CMS's proposal to define cuts of 4% in one year or 6% in two years as "nominal" and therefore not subject to reporting and scrutiny. CMS asserts in the preamble that, in its experience, it has found that rates at these levels do not impact

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[23] MATHMATICA POLICY RES., *supra* note 16, at 90-323.
[24] MARYLAND DEP'T HEALTH & MENTAL HYGIENE, *supra* note 16, at 3.
[25] NEVADA DEP'T HEALTH & HUM. SERVS., A PLAN TO MONITOR HEALTHCARE ACCESS FOR NEVADA MEDICAID BENEFICIARIES 5 (2016).
[26] CTRS. MEDICARE & MEDICAID SERVS., RURAL HEALTH STRATEGY 2 (2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.

access. But CMS fails to specify what experience it draws on, and its assertion is inconsistent with the literature on the relationship between rates and access.

Moreover, CMS's proposal fails to account for rates that have failed to keep up with inflation over time. When states fail to raise their rates as costs increase, and the rates paid by other payers increase, the rates stagnate, which may be equivalent to a cut of well over 4%. One study found that between 2008 and 2012, while Medicaid rates rose by an average of 5%, they still fell relative to Medicare rates—from 72% of Medicare to only 66%.[27] The fact that Medicaid rates are failing to keep up with inflation suggests that CMS should do more monitoring of rates, even when states are not proposing to cut them, not allow states to make cuts without scrutiny.

For example, in California the state cut rates effective 2009 from $11.41 (the rate established since at least 2001) to $11.30 for CPT code 99201 (office/outpatient visit, new patient).[28] The Medicare non-facility rate that year for Los Angeles, CA (the biggest population center in the state) was $41.62.[29] Thus, in 2009, California's rate for this CPT code was already only 27% of the Medicare rate. In the nine years since then, putting aside the two years when California temporarily increased primary care rates in compliance with the ACA, California's rate has remained the same. Medicare's rate, on the other hand, has increased to $50.26. Thus, California's rate for this code has dropped to only 22% of the Medicare rate. But under CMS's proposal, California could propose to cut another 4% of the rate, bringing the rate for this code to only $10.84, or 21% of the current Medicare rate, without providing any justification or reporting on the cut. Over two years, it could reduce the rate to $10.62, without providing any particular reporting to CMS. One study determined that dental rates would have to increase by 4% to improve access for children.[30] Allowing states instead to continually cut as the cost of providing care increases is likely to exacerbate access issues; thus it is vital that states report on even cuts as small as 1 or 2%.

Even putting aside the question of stagnation, a 4 or 6% cut is not nominal even in absolute terms when it is applied to rates that are already low. For example, Maryland Medicaid currently pays $54, or 42% of the Medicare rate for debridement / wound care. A 4% cut

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[27] *See* ZUCKERMAN & GOIN, *supra* note 2, at 6-7.
[28] *See* Cal. Dep't Health Care Servs., Medi-Cal Rates, https://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp (last visited May 1, 2018); *see also* CAL. WELF. & INST. CODE § 14105.191.
[29] *See* Ctrs. Medicare & Medicaid Servs., Physician Fee Schedule Search, https://www.cms.gov/apps/physician-fee-schedule/overview.aspx (last visited May 1, 2018). The rate was somewhat lower in less densely populated parts of the state, and somewhat higher in the Bay Area. *See id.*
[30] Sandra L. Decker, *Medicaid Payment Levels to Dentists and Access to Dental Care Among Children and Adolescents*, 306 J. Am. Med. Ass'n 187 (2011).

would reduce that to just over 40% of the Medicare rate; a 6% cut would reduce it below 40% of Medicare—only $50.76. Similarly, Washington State Medicaid currently pays just $12.62 for a behavioral health assessment, about 60% of the Medicare rate of $21.23. A 4% reduction would lower the rate to $12.12, and a 6% reduction to only $11.86—just over 55% of the Medicare rate. Cuts at this level are highly likely to result in access issues, since Medicaid providers are already operating on thin margins to accept the reduced rates.

In addition, by limiting the timeframe for consideration of consecutive cuts to two years, the proposal will allow deep cumulative cuts. Under the proposal, state Medicaid programs would be permitted to cut as much as 10% in just four years without scrutiny—a cut of that proportion that cannot be considered nominal under any metrics. Moreover, the effect of cumulative cuts is particularly harmful in Medicaid programs, since the rates are already low.

Finally, CMS proposes to allows “nominal” cuts to entire Medicaid "service categories," which the preamble defines as "those generally defined under section 1905(a)(1) through (29) of the Act . . . and other applicable sections that specify categories of services eligible for medical assistance under the State plan." Defining a 4% cut to a “service category” as nominal creates a particular risk of harm. For example, the “service category” in 1905(a)(4) includes nursing facility services, EPSDT, family planning services and supplies, and tobacco cessation counseling and pharmacotherapy for pregnant women. The regulations would permit most states to cut rates for EPSDT, family planning, and tobacco cessation counseling for pregnant women by as much as 90% while keeping funding for nursing facilities flat and still not exceed the 4% threshold for the service category as a whole because those services involve far less spending than spending on nursing facilities.

Even if CMS intends each of the components of (a)(4) to be defined as its own "service category," that definition is still too broad. Under such a read, the regulation would make EPSDT a "service category.” But there is a broad and expansive range of services that fall into EPSDT, including some institutional care. Again, given that EPSDT is composed of a range of services, under CMS’s proposal, a state would be able to cut payments to a single EPSDT practitioner type by 90% without reaching 4% for the service category as a whole. These examples illustrate that, ultimately, the safe harbor concept is unworkable. CMS should not adopt the proposed changes, but should instead continue to require states to submit documentation and provide ongoing monitoring of all rate cuts.

VI. It is appropriate to amend the rule to require states making cuts to establish a baseline rather than forecast the impact of cuts in future.

NHeLP suggests that CMS decline to adopt any of the proposed changes to the rule. If CMS does make any change to the rule, however, NHeLP supports the proposed change

to § 447.204(b)(2). The rule as written appears to require states to anticipate the impact proposed rates will have on access, but provides them with no guidance as to how to make such a prediction. It appears that most states who have proposed to cut rates over the last three years have largely simply asserted that their proposed cuts will not affect access, providing little or no evidence or analysis to support their assertion.[31] This is logical, since if a state admitted that it was cutting rates in a way that it knew were likely to reduce access to services, it would essentially be admitting to a violation of the Equal Access provision. Rather than requiring states to predict the impact of cuts in the future, necessitating numerous assumptions, requiring states to establish a baseline of access to the service at issue is more likely to provide CMS with useful information about access over time, even if it does not always allow CMS to prevent access problems in advance. Moreover, by establishing a baseline of access, CMS will be able to collect information about the relationship between rates and access that can inform future decision making. We do suggest, however, that CMS provide additional guidance to states on how it should establish this baseline and what kind of data CMS will accept to illustrate existing access levels. Moreover, CMS should develop metrics to monitor access over time to ensure that if a rate cut does cause access to fall below the baseline, it is able work with the state to remedy the access issues.

VII. CMS should develop a standard reporting template and metrics that all states must use.

In the preamble to the rule, CMS notes that in the future, as informed by stakeholder feedback, it may adopt a more standardized form and content for the states' Access Monitoring Review Plans. We strongly recommend that CMS set a national core set of access to care measures and metrics, and do so in regulation, not sub-regulatory guidance. Under federal law, CMS is charged with the responsibility of enforcing the Medicaid Act; and core access measures will allow it to do so more easily and consistently. While individual states could be responsible for collecting and analyzing state-level data to evaluate compliance with national standards set by CMS, we urge CMS to require more uniformity in their reporting to allow it to more easily monitor states' efforts and enforcing compliance if the data reveals access problems. Currently, as discussed above, state access monitoring plans and processes vary significantly in their scope, their data sources, and their level of detail. It is nearly impossible to compare the states' plans to one another. A core set of measures would allow CMS to more efficiently obtain the information it needs to provide meaningful oversight of access in the Medicaid program since it could then readily apply lessons learned from engaging with one state's plan to another state. National

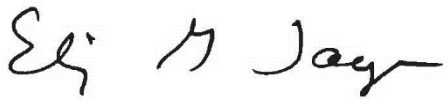
[31] *See, e.g.,* MO. DEP'T SOC. SERVS., MEDICAID FEE-FOR-SERVICE ACCESS MONITORING REVIEW PLAN 27, 28 (2018) (asserting that a 3% cut to home health and dental rates will not impact access because it will bring rates back to the rates that were in effect two years ago), https://dss.mo.gov/mhd/files/access-monitoring-review-plan.pdf.

measures are needed to ensure that standards do not vary too widely from one state to another, and that oversight by CMS is not fragmented.[32] We previously provided ample input to CMS on specific measures that it should consider including among the core measures on which states must measure and report.[33] We commend CMS to review our previous suggestions and reach out to us to discuss them further.

Conclusion

In sum, now is not the appropriate time to make changes to the rules. CMS has a central role to play in ensuring that Medicaid provides full and appropriate access to covered Medicaid services. NHeLP has serious concerns that the proposed changes will weaken beneficiary's access to covered Medicaid services. Thus, CMS should take more time and engage in more robust monitoring of beneficiary access under the existing regulatory framework before making changes. Thank you for your attention to our comments. If you have any questions or need any further information, please contact Abbi Coursolle, Senior Attorney (coursolle@healthlaw.org; (310) 736-1652)).

Sincerely,



Elizabeth G. Taylor

[32] *Cf.* SUZANNE MURRIN, DEPT. OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE 19 (2014) ("CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance."), *available at* http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.
[33] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Andy Slavitt, Ctrs. Medicare & Medicaid Servs. (Jan. 4, 2016) (responding to CMS's Request for Information (RFI)-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program), http://www.healthlaw.org/issues/medicaid/services/medicaid-access-metrics-rfi-response.