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NATIONAL HEALTH LAW PROGRAM

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Re: File Code CMS-2328-P
Medicaid Program: Methods for Assuring Access to covered Medicaid Services

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Dear Sir or Madam:

Writing on behalf of itself and the undersigned organizations, the National Health Law Program (NHeLP) appreciates the opportunity to comment on the Proposed Rule entitled "Medicaid Program: Methods for Assuring Access to Covered Medicaid Services," published in the Federal Register on May 6, 2011 (76 Fed. Reg. 26,342).

Founded in 1970, NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. As such, the availability of sufficient access to health care providers and services by Medicaid enrollees is central to NHeLP's mission. The regulations governing setting of provider reimbursement rates by states, and CMS's oversight of that process, are a critical part of assuring that our clients receive quality health care services.

The necessity of strong CMS oversight of Medicaid rate-setting by the states is extremely important, now more than ever. Historically, lawsuits by private parties, both Medicaid enrollees and providers, have kept some pressure on the states to keep them from slashing provider rates to meet budgetary objectives without considering the impact on access to care. With private enforcement of 42 U.S.C. § 1396a(a)(30)(A) ("Section (30)(A)") at risk due to the pending *Douglas v. Independent Living Center* case at the Supreme Court, CMS's role in assuring that the mandates of this Medicaid Act provision are met by the states will be all the more critical. CMS will have to provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to assure that there is sufficient provider participation so that Medicaid enrollees can access necessary services.

Comments made in the Preamble to the proposed regulation make it clear that states are not currently following the mandates of Section (30)(A), which makes strong federal oversight critical. The Preamble indicates that, when CMS has sought clarification on states' process for determining that access standards are

met, it has become clear that states are not taking the determination seriously. The Preamble states: "When asked for additional detail on the methodology that States used to determine compliance with the access requirement, only a few Sates indicated that they relied upon actual data to make a determination." (76 Fed. Reg. at 26,348). Clearly, such determinations must be made on actual data, or they are meaningless. This confirms that a strongly enhanced regulatory framework is needed to ensure state compliance.

General Comments on Proposed Regulations

NHeLP supports CMS's efforts to make states more accountable for assuring that there is sufficient access to quality services for their Medicaid populations, both when proposing provider rate reductions and also on an ongoing basis to make sure that rates are not falling below levels necessary to assure adequate provider participation. NHeLP also strongly supports provisions that assure the public the opportunity to review and comment on proposed rate reductions before they are submitted for CMS review. However, NHeLP believes that the regulations, as proposed, do not provide for sufficiently clear criteria for measuring access and should be strengthened. Otherwise, the regulations will not even begin to resemble a federal enforcement scheme. The proposed regulations should be modified to set clear standards against which the agency will measure access to care in state Medicaid programs and should set uniform measures of access for which states must collect data. Further, NHeLP disagrees with CMS's position that the regulations implementing Section (30)(A) should not be applicable to Medicaid managed care rates. Finally, NHeLP believes it is very important for the regulations to clearly state that (1) no State Plan Amendments lowering rates may be implemented prior to CMS review and approval, and (2) public notice and comment provisions apply to rate reductions enacted by state legislatures. These various points are discussed below.

Importance of Clarifying That SPAs Cannot Be Implemented Prior to CMS Approval

Historically, CMS has been reluctant to undertake any strong enforcement actions if a state has set rates too low in violation of Section (30)(A). In the context of a proposed rate reduction, CMS does have a clear enforcement option, which is to deny a SPA request. However, states have, in the past, chosen to implement rate reductions without waiting for CMS action on their SPA requests, essentially thumbing their noses at the CMS review process.

In our view, the law is clear, as determined by the United States Court of Appeals for the Ninth Circuit, that State Plan Amendments, including those proposing rate-setting adjustments, cannot be implemented until approved by CMS (though the regulations, at Section 447.256(c), currently permit implementation retroactive to the beginning of the quarter during which the SPA is submitted.) *See Exeter Memorial Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998). Further, CMS has recently issued guidance to the states confirming that implementation is not permitted prior to SPA approvals. *See* State Medicaid Directors Letter #10-020, October 1, 2010. However, this has not been sufficient to prevent states from implementing rate reductions prior to CMS review, as evidenced by California's actions in recent years. In fact, California has specifically taken the position that it is free to go ahead and implement rate reductions prior to CMS approval, taking the position that the *Exeter* decision does not apply to post-Boren Amendment rate setting. Thus, to assure that CMS's authority to review and deny SPA requests

has meaning, CMS should amend the regulations to absolutely clarify that SPAs that include rate reductions cannot be implemented until CMS has an opportunity to review and make a decision on the SPA.

Rate Reductions Done Through Legislative Enactments

Much of the litigation under the repealed Boren Amendment applied to rate reductions or rate freezes adopted by state Medicaid agencies. There are only a few reported decisions that deal clearly with rate reductions or freezes enacted by State legislatures. However, such reductions are increasingly common, as in the rate reductions at issue in *Independent Living Center* and related cases. Although there is case authority for applying notice and comment requirements to legislatively enacted rate reductions, the lack of extensive authority has allowed states to ignore the Supremacy Clause of the Constitution and take the position that legislatively enacted rate-setting is somehow subject to more relaxed federal requirements than rate-setting done by the state agency. The revised regulations should assure that states cannot avoid any of the requirements of Section (30)(A) and its implementing regulations by having rate-setting done directly by the legislature. Further, all public notice and comment requirements, including those for institutional rate setting as set forth in the current version of 42 U.S.C. § 1396a(a)(13)(A), which replaced the Boren Amendment, must apply equally to rate-setting done by the legislature. There should be no assumption that legislative rate-setting *per se* satisfies public comment requirements, since rate-setting may be done by state legislatures, sometimes in behind close door sessions, without full opportunities for public comment.

Application to Managed Care Payments

In the Preamble, CMS asserts that Section (30)(A) discusses "access to care for all Medicaid services paid through a State plan under fee-for-service and [does] not extend to services provided through managed care arrangements." Thus, CMS has made the proposed regulations inapplicable to managed care rates. NHeLP disagrees with this decision and urges CMS to apply the regulations to managed care plans.

Over 70 percent of Medicaid enrollees in the country are now enrolled in some form of managed care, with well over half of these in managed care organizations (as opposed to primary care case management programs). [Kaiser Family Found., Feb. 2010] Despite legal requirements that capitation payments made by states to plans be "actuarially sound" NHeLP staff consistently receive requests for consulting assistance from consumer-based organizations and for legal assistance from Medicaid enrollees complaining of the failure of managed care organizations to maintain adequate networks of providers, particularly specialty care providers and dentists. Indeed, many managed care organizations, while receiving capitation payments from the state, pay their providers on a fee-for-service basis. We know from experience that payments to these providers can be low, and we suspect that the inadequate provider networks are, at least in part, the results of these low provider rates paid by the MCOs. The capitation paid to the MCO should not operate as a barrier to shield the MCOs fee-for-service payments to participating providers from the protections of Section (30)(A). However successfully the proposed regulations are enforced, they will not assure adequate access to the majority of Medicaid enrollees if benchmarks for access and CMS oversight are not applied to managed care plans.

NHeLP recognizes that another provision of the Medicaid Act, 42 U.S.C. § 1396b(m)(2)(A), and Part 438 of the Regulations set a standard of actuarial soundness for capitation payments under managed care risk arrangements. However, there is nothing in Section (30)(A) that would exempt its requirement that rates be adequate to assure access to services from applying to the rates that managed care plans pay to providers. Both requirements are applicable and, together, should act to assure that managed care plans receive adequate capitation payments from states and that managed care plans that are acting as the states' agents in providing care to enrollees should pay adequate rates to the providers in their networks to assure adequate access.

Applying the Section (30)(A) requirement to states in relation to their managed care plans is particularly important in light of the insufficient job that CMS has been apparently doing in reviewing the actuarial soundness of states' managed care rates. *See* GAO Report, *MEDICAID MANAGED CARE: CMS's Oversight of States' Rate Setting Needs Improvement,* August 2010. The GAO stated in its report:

> CMS's regulations do not include standards for the type, amount, or age of the data used to set rates, and states are not required to report to CMS on the quality of the data. When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability.

Thus, in addition to including managed care within the purview of the Section (30)(A), CMS should also revise its part 438 regulations to set forth clearer standards for managed care rate review. Finally, we are alarmed that excluding managed care organizations from meeting the requirements of Section (30)(A) would establish a dangerous precedent for allowing other Medicaid consumer protections to be ignored in the future.

Proposed Revisions to § 447.203 – Documentation of access to care and service payment rates.

NHeLP applauds CMS for requiring that states complete periodic access review of their payment structures regardless of whether they are in the process of revising their rates. In many cases states have gone for years and years without adjusting rates and have evaded CMS review because no SPA requests came before CMS. It is absolutely critical that this concept remain in the final regulations.

§ 447.203(b)(1) *Access review data requirements.*

CMS has not set specific standards or guidelines for achievement of the access requirement or specific data that must be collected, analyzed and disclosed by the states, but instead has adopted the framework set forth in the March 2011 report by the Medicaid and CHIP Payment and Access Commission (MACPAC) as guiding principles for states' analysis of the Section (30)(A) requirements. NHeLP does not believe that this somewhat vague framework gives sufficient

guidance to states for doing the required analysis or that it gives sufficient guidance to CMS regional offices for their review of state Medicaid rates.

The MACPAC report is only a preliminary discussion of what should go into an effective review and analysis of adequate enrollee access. MACPAC has indicated that it plans to develop a set of measures that can be used to determine current access levels and to track access levels moving forward, but it has not yet developed such measures. Moreover, MACPAC has specifically indicated that the general framework it has set forth applies only to primary and specialty care providers (i.e., physicians), but not to hospital, ancillary, long-term care or other services. Thus, it is not even clear that the general framework put forth by MACPAC will ultimately be considered by MACPAC to be appropriate, let alone appropriate for all the varied types of Medicaid rates that are covered by the Section (30)(A) requirements. It is clear that whatever regulations it issues, CMS will want to follow up and review them when MACPAC completes its work. However, CMS should not hold up finalizing the regulations until then, but should issue some more specific guidance for now, which can always be revisited at a later date.

While MACPAC will undoubtedly eventually come up with access measures that will be worth considering, CMS has enough experience with these issues to provide clear measures now. As CMS and its predecessor HCFA have recognized over the years, no single factor will consistently and reliably measure access. Therefore, the federal policies have recognized that it is preferable to look to a variety of factors relating to the health care delivery system itself—such as the number of participating physicians, geographic location, travel time and waiting time—as well as factors indicating whether potential access has become realized access, such as utilization rates, reported health care needs, and satisfaction with care. For example, in 2001, CMS required states to provide Plans of Action regarding dental rates, which had been identified as being extremely inadequate. *See* State Medicaid Directors Letter #01-010, January 18, 2001. In that SMDL, CMS suggested a number of access/rate measures that states could use, e.g. that Medicaid rates for dentists should be set at least at the 75th percentile of fees charged by dentists in the state to assure adequate access. CMS could use this measure, or similar measures for which it may have data, in the interim until MACPAC comes up with more updated measures. (Almost all of the states submitted an action plan, thus evidencing the ability of state programs to respond to CMS's leadership.) In its approvals of numerous section 1115 demonstration projects in the 1990s, the federal agency consistently required each approved state to meet specific appointment scheduling and travel distance times as measures of adequate access and provider participation. Between 1990 and 1993, then-HCFA distributed State Medicaid Manual provisions that included standards for implementing the section 6402 of the OBRA 1989. And while the OBRA provision was later repealed, the access standards framed by HCFA are still relevant (e.g. at least 50% of pediatric practitioners, 100% if there is only one such practitioner in a county or geographic area—participate fully in Medicaid). Clearly, the agency has a history of requiring states to meet access guidelines, and it should build upon, rather than walk away from, those standards now.

With respect to specific data on Medicaid payments, CMS has proposed that states be required to collect data comparing Medicaid payments to average customary provider charges, but has given states an option to collect data on comparison of Medicaid rates to Medicare payment rates, commercial payment rates or Medicaid allowable costs. NHeLP believes that the other measures

are significant also and urges CMS to require that data on all three of the other measures be collected and analyzed by states. Medicaid rates are often much lower than rates paid by other payers, so comparisons to both Medicare and commercial rates are important. If Medicaid rates are far below these other payers, that is an important indication that the rates are too low and endanger access. Use of all three measures of comparison is also critical because of the significant gaps in these payers' rate structures, for example Medicare's gaps with respect to services for children and dental services.

NHeLP also believes that a comparison to costs is a critical part of any analysis of rate sufficiency and disagrees with CMS's proposal to allow states to decide whether or not costs should be analyzed. NHeLP respectfully disagrees with the following CMS statement: "Depending upon State circumstances, cost-based studies may not always be informative or necessary." Especially since CMS is taking the position that these regulations implementing Section (30)(A) do not apply to managed care arrangements, but only to fee-for-service Medicaid, it seems obvious that if providers are paid less than their cost of providing services, there arises a serious possibility that insufficient providers will agree to participate and that those who do may not be providing quality care.

The requirement that costs be analyzed should not be extremely burdensome on states, and, to the extent it presents some burden, it is a necessary one. Many institutional providers in many states already are required to file cost reports, at least for the Medicare program even if the state's Medicaid program has not required it. For those services for which cost reporting is not required, the State can perform cost studies. If data demonstrates that current Medicaid rates in a state are below the cost to the providers of providing the services, states should be required to raise rates (or prevented from reducing rates) unless they can demonstrate with other reliable data that services are sufficiently accessible to their Medicaid enrollees despite the low payment rates.

The proposed regulations at § 447.203(b)(1)(B) re "Access review Medicaid payment data" should be revised to make clear that data should be obtained and provided for each item or service separately, not for Medicaid payments in the aggregate. Thus, it would not be sufficient for a state to provide data, for example, showing that its Medicaid payments total in the aggregate 95% of Medicare payments for the same aggregate services. It is quite possible that rates are reasonable for some services, but far too low for other services; thus, it is important that data be provided for each individual type of Medicaid service.

§ 447.203(b)(2) *Access review timeframe.*

NHeLP endorses CMS's decision to require rate reviews on an ongoing basis and not just when a state decides to implement rate reductions. History has shown that many years can go by without rate adjustments by states, so that Medicaid rates can fall extremely far behind the rates paid by other payers. This is a feature of the proposed regulations that absolutely must be retained in the final regulations.

As drafted, the regulations require that each Medicaid service undergo a full access review every 5 years, beginning January 1 of the year beginning no sooner than 12 months after the effective

date of the regulations. This is too long a period for compliance. Assuming, for example, the regulations became effective in February 2012, then the 5-year review period would not begin until January 2014 and rates for some services would not be reviewed until the end of 2019, almost 9 years from now. In light of the fact that states should already have been assuring that their rate structures complied with Section (30)(A), and that CMS has discovered that states have not been taking that obligation seriously and have not been basing rates on any actual evidence, states should be required to do their rate reviews on a much more expedited basis.

NHeLP makes the following suggestions in regard to the timing of these rate reviews:

1. For the first cycle, all rates should be reviewed by the end of the second full calendar year following the effective date of the regulations.
2. In subsequent cycles, rates should be reviewed at least every 3 years, rather than every 5 years as proposed.
3. Priority should be given to rates for primary care, specialty care and dental care, which have been disproportionately low in some states and for whose services access problems have been consistently documented. With Medicaid expansion occurring in the next few years, the existence of adequate provider networks is particularly critical so that the newly expanded population will have real access to physicians. Priority should also be given to any other services regarding which CMS has knowledge of particular access problems. Rate reviews for these services should be required to be completed by the end of the first full calendar year following the effective date of the regulations.
4. The regulations as proposed currently vaguely allow the states to review a subset of services each calendar year during the 5 year review period (which we are requesting be reduced to 3 years). This would allow the state to review a minimal number of services during the first review period and save the majority of rate reviews until the last year of the period. The regulations should require that 1/3 of services be reviewed each year, and, emphasizing the importance of physician and dental rates to access, require the rates for those services to be reviewed in the first year of each three year cycle.

The proposed regulations require that the results of the rate reviews be made public, but do not require that the reviews be posted on the internet. Putting the reviews on a web site is given only as an option. All state Medicaid agencies maintain websites, and there is no reason why the regulations should not require that the rate reviews be posted on the websites. Otherwise, this would put the burden on the public to seek the reviews through public record requests and potentially be requested to incur the cost of copying before the records could be seen. There should be as much transparency as possible.

§ 447.203(b)(3) *Special Provisions for proposed provider rate reductions or restructuring.*

NHeLP supports CMS's proposal that any SPA proposing a rate reduction should be accompanied by an access review performed within 12 months of the rate reduction. CMS should clarify the language in the proposed regulation which states that a State must submit such an access review with any SPA "that would reduce provider payment rates or restructure

provider payments in circumstances when the changes could result in access issues." The structure of this sentence is unclear as to what the clause "in circumstances when the changes could result in access issues" modifies. This language should be clarified to state that any SPA which reduces provider payment rates must be accompanied by an access review. NHeLP does not think there should be an exception for "restructuring" of provider payments, which is an unclear concept. All SPAs that reduce provider rates (whether done by simply reducing a fee schedule or by changing a methodology) should require an access review.

NHeLP also strongly supports the proposed provision that would require a state to develop procedures to monitor the impact on access when a rate reduction is approved by CMS and implemented by the state. However, NHeLP believes that the requirements in this regard should be more specific. Presumably, the state will have submitted an access review with a methodology showing sufficient access that can withstand a rate reduction, and CMS will have reviewed and approved the methodology used for the access review prior to approving the SPA. Therefore, the state should be required to use the same methodology to measure access once the rate reduction is put into place, or else there would not be a fair comparison of the impact of the rate reduction. Also, CMS should set specific timeframes for the required monitoring procedures. At a minimum, the State should be required to monitor the impact on access at 6 months, 1 year and 2 years after the rate reduction, to make sure there is no short term or longer term impact on access that may result.

§ 447.203(b)(4) *Mechanisms for ongoing input.*

NHeLP supports the requirement in the proposed rule that the states must adopt mechanisms for beneficiary input on access to care and maintain records of the input. NHeLP suggests, however, that this section be revised to provide that there should be mechanisms to allow for input not just for beneficiaries, but for all affected stakeholders, including beneficiary advocates, providers, and others. Further, the regulation should require that the input obtained shall be made available to the public.

§ 447.203(b)(5) *Addressing access questions and remediation of access issues.*

The proposed regulations provide that a state must submit a corrective action plan if it determines, through its review or monitoring procedures, that there is an access problem. NHeLP supports this concept and is comfortable with the proposal that such corrective action plan must be submitted within 90 days of discovery of the access problem and shall provide for correction to the access problem within 12 months.

Significantly lacking here is the oversight role that CMS should be playing. It should be made clear that CMS will review the state's submitted access rate reviews within a specified time frame (preferably 90 days) and is empowered to determine that the data demonstrates an access problem that warrants corrective action. This should not be left solely to the state's discretion. If CMS determines that the state's access review demonstrates an access problem, regardless of whether the state on its own acknowledges such a problem, then CMS should require the state to develop a corrective action plan. A deadline should be provided for the state to develop such a plan in this circumstance, preferably 90 days after CMS's discovery.

Further, it should be made clear that the corrective action plan is subject to CMS's approval. If CMS disapproves the corrective action plan, then the state should be given 60 days to provide a revised plan in accordance with direction that CMS shall give to the state.

§ 447.204 *Medicaid provider participation and public process to inform access to care*.

NHeLP strongly supports the proposal requiring that states confer with beneficiaries and stakeholders prior to submission of a SPA that reduces or restructures payment rates. (We note that there is no qualification in this section that would require public input only when a "restructuring" of payment rates is likely to lead to an access problem, unlike the language used, to which NHeLP objects, when describing when an access review must be submitted to CMS with a SPA. NHeLP assumes this is intentional and fully agrees that public input should be required when any restructuring is contemplated, regardless of whether or not the state believes it will lead to an access problem.)

NHeLP believes, however, that the proposed language should be augmented to include specific timetables that will allow enough time for real and valuable public input. In the past, California, for example, when following public notice procedures regarding rate-setting, has allowed as little as five days to receive public comments. If states are not given specific minimum time frames to follow, then the public notice and comment requirement may become meaningless. We believe that states should be required to give beneficiaries and other stakeholders at least 60 days to comment on proposals to reduce or restructure provider payment rates. While public hearings may be part of the process, the opportunity to submit written comments, which must be considered and addressed by the state agency, is paramount.

Further, the proposed regulation provides that CMS "may" disapprove a SPA if it determines that the state is proposing modified rates without the required public input. Since public input is an integral and required part of the new regulatory scheme, the proposed language should be amended to state that CMS "must "disapprove the SPA if the state has not allowed for public input as contemplated by the regulations.

§ 447.205 *Public notice of changes in Statewide methods and standards for setting payment rates*.

CMS has proposed one change to § 447.205 to allow for public notice to be provided on an agency website, rather than published in a newspaper or state register. NHeLP agrees that electronic publication is an appropriate alternative for providing public notice, and, in fact, suggests that electronic publication be mandated, in light of current media use.

NHeLP believes that further revision of § 447.205 is warranted. Notably, CMS has questioned in the Preamble whether the correct standard for requiring public notice is any "significant" proposed change in a states methods and standards, as currently required, whether a specific threshold for significance should be set, or whether the adjective "significant" should be removed altogether. We believe, since, as CMS acknowledges, there is currently no clear threshold for significance, that this term is too vague and should be removed. Because Medicaid

rates have historically been so low, we believe that any reduction in rates could endanger access and quality of care, and, therefore, any reduction in rates should trigger the public notice requirements.

Moreover, we believe that § 447.205 should be amended to tie in with the public process requirement in the proposed revision to § 447.204. The revised § 447.204 will now require a public process before a SPA is submitted, and this should tie in with the requirements set forth in § 447.205 as to how notice should be given. Procedures for the timing of public notice and comment could also be placed into § 447.205 and then cross-referenced in § 447.204. Thus, public notice and comment would be required pursuant to § 447.204 whenever a SPA reducing rates is being submitted, and § 447.205 would set forth the parameters of the public notice and comment requirement. Section 447.205 would also apply in situations where rates were being reduced by states, but, because of the wording of the current State Plan, a SPA may not be required.

Conclusion

We appreciate your consideration of these comments. If you have questions or would like to discuss them with us, please do not hesitate to contact Byron Gross, NHeLP Of Counsel at (310) 204-6010, or Jane Perkins, NHeLP Legal Director at (919) 932-5640. Also, if you think it would be helpful for us to draft regulatory language that would implement our suggestions, please let us know.

Sincerely,

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