September 10, 2019

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Ms. Seema Verma.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission; Docket No. CMS-2406-P2; RIN 0938-AT41

Dear Secretary Azar and Ms. Verma:

The National Health Law Program (NHeLP) appreciates the opportunity to comment on the proposed rescission of the rules implementing the Medicaid Equal Access provision. For over fifty years, NHeLP has worked to improve health access and quality through education, advocacy and litigation on behalf of low-income and underserved individuals.

We write with strong objection to the proposed changes to the existing regulations on equal access. Given both our history and current experience working with Medicaid beneficiaries and beneficiary advocates around the country to ensure that they have real access to the services they need, we are especially concerned with the proposal to rescind the current rules without enacting any replacement mechanism for monitoring access to covered services in Medicaid. Rescinding the current regulations

would significantly weaken CMS's ability to achieve its statutorily mandated role of monitoring and enforcing access to covered services in state Medicaid programs.[1] This would leave the agency without sufficient information to understand whether Medicaid programs are delivering covered services to beneficiaries. Moreover, the rescission would be operative before CMS has had the chance to evaluate whether the current regulatory scheme is effective for addressing access or to establish an alternative method for monitoring access. We urge CMS not to rescind the current regulations, but instead establish a process to review the current regulatory scheme and make updates as appropriate.

The existing regulations implement the Secretary's duty under the Medicaid Act to enforce the requirements of the Social Security Act § 1902(a)(30)(A), commonly known as the "equal access" provision of the Medicaid Act. Before CMS promulgated the current regulations, the absence of clear guidance on how CMS monitored and enforced the equal access provision was a long-standing problem. Moreover, the need for standards and monitoring protocol remain especially critical after *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015). Rescinding the current regulations will not eliminate an unnecessary administrative burden, but it will eliminate effective oversight of states' compliance with their obligation to provide equal access to Medicaid services.

I. CMS should not rescind the current rule

a. The current regulations were designed to respond to the Supreme Court's holding that equal access be enforced by CMS rather than the courts.

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.[2] This requirement is commonly known as the "equal access" provision. State Medicaid programs have long struggled to provide adequate access to covered Medicaid services.[3] 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.[4] As a result, providers and

[1] Throughout these comments, we will refer collectively to the Medicaid programs administered by states, territories, and the District of Columbia as "state Medicaid programs."
[2] 42 U.S.C. § 1396a(a)(30)(A).
[3] *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.
[4] *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* 7 (2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf; Sandra L. Decker, *In 2011*

beneficiaries filed numerous lawsuits over the years alleging violations of the equal access provision.[5]

In 2011, recognizing the need for additional oversight and guidance, CMS promulgated regulations to implement the Medicaid Act's equal access provision.[6] While the proposed rule was pending, on March 31, 2015, the Supreme Court ruled 5-4 in *Armstrong v. Exceptional Child Care Ctr.* that providers do not have a right to sue state Medicaid programs in federal court to enforce the equal access provision.[7] After the Supreme Court's decision, 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. The Court admonished the parties in the case to seek administrative recourse from CMS instead.[8]

Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help, 31 HEALTH AFF. 1673 (2012).

[5] *See, e.g., Visiting Nurse Ass'n of North Shore v. Bullen*, 93 F. 3d 997 (1st Cir. 1996); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F. 3d 908 (5th Cir. 2000); *Arkansas Medical Soc., v. Reynolds*, 6 F. 3d 519 (8th Cir. 1993); *Clark v. Coye*, 60 F. 3d 600 (9th Cir. 1995).

[6] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (May 6, 2011) (proposed rule); s*ee also* Memorandum from Byron Gross and Jane Perkins, NHeLP, *et al*., to Cindy Mann, Director, Centers for Medicare & Medicaid Services, *Suggestions for Development of Proposed Regulations Implementing 42 U.S.C. § 1396a(a)(30)(A)* (Feb. 11, 2011), https://healthlaw.org/resource/suggestions-for-development-of-proposed-regulations-on-provider-ratesetting.

[7] 135 S. Ct. 1378, 1388 (2015). Lower courts have interpreted this holding expansively to preclude claims on equal access. *See, e.g., Providence Pediatric Med. DayCare, Inc. v. Alaigh*, No. 10-2799 (NLH/KMW), 2015 WL 3970049, at *9 (D.N.J. June 30, 2015) ("*Armstrong* makes clear that Plaintiffs cannot bring their claims in Counts I, II and III through the Supremacy Clause. Moreover, *Armstrong* is dispositive of those claims based upon Defendants' alleged violations of § 30(A). Because there is no private right of enforcement of § 30(A), judgment must be entered in favor of Defendants as to Count I to the extent Plaintiffs allege a violation of § 30(A)"). Some courts have suggested that the decision precludes remedies that address Medicaid rates, even when the plaintiffs did not bring a cause of action under the equal access provision. *See, e.g., O.B. v. Norwood*, 838 F.3d 837, 842 (7th Cir. 2016). In addition, post-Armstrong, state courts have limited the availability of state law claims and remedies for cases involving provider rate cuts as well. *See, e.g., Santa Rosa Memorial Hospital, Inc. v. Kent*, 25 Cal. App. 5th 811, 822 (Cal. Ct. App. 2018) ("Plaintiffs contend, and the trial court ruled, that *Armstrong* precludes private enforcement of section 30(A) only in federal court. We disagree. All of the reasoning in *Armstrong* applies equally to proceedings in state as well as federal courts."); *Alaska State Hosp. and Nursing Home Ass'n v. Alaska Dept. of Health & Soc. Servs.*, No. 3AN-19-08244 CI at *9 (Alaska Sup. Ct. Aug. 30, 2019) (order granting preliminary injunction), https://s3-us-west-2.amazonaws.com/ktoo/2019/09/3AN-19-08244CI.pdf.

[8] *See* 135 S. Ct. at 1385.

Following the Court's decision in *Armstrong*, on November 2, 2015, CMS issued a final rule implementing the regulations.[9] In addition, CMS issued a separate Request for Information (RFI) seeking input on development of standards for beneficiary access to covered services.[10] In the preamble to the Access Rule, CMS acknowledged that the *Armstrong* case "underscored the primacy of CMS's role in ensuring access."[11]

The final rule requires each state Medicaid agency to develop an Access Monitoring Review Plan that is available to the public and submitted to CMS every three years. Each state's Access Monitoring Review Plan presents the agency's analysis as to whether beneficiaries have sufficient access to care. States have the flexibility to decide which data sources, methodologies, and measures to use in conducting their analyses, but they must include an analysis of access for each of the rule's listed core service types. The rule also requires states in developing their Access Monitoring Review Plan to consider relevant provider and beneficiary information, including input from the medical care advisory committees and from "ongoing mechanisms for beneficiary and provider input on access to care."[12] The mechanisms include hotlines, surveys, ombudsman, review of grievance and appeals data, and input on proposed rate reductions or restructurings. States are required to "promptly respond to public input . . . with an appropriate investigation, analysis, and response."[13] In short, the Access Rule requires that state Medicaid agencies consider the access implications of changes in provider payment rates and take beneficiary and provider input into account in deciding what payment policies to adopt. Repealing the equal access regulations would eliminate this accountability mechanism. Notably, when it originally promulgated the rule, CMS emphasized that the regulatory scheme would "strengthen CMS review and enforcement capabilities. . . [by the] development of needed information to monitor and measure Medicaid access to care."[14]

b. 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

[9] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,575 (Nov. 2, 2015) (Final Rule) (codified at 42 C.F.R. §§ 447.203-05).
[10] Medicaid Program: Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program, 80 Fed. Reg. 67,377 (Nov. 2, 2015).
[11] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67,579.
[12] 42 C.F.R. § 447.203(b)(7)(i).
[13] *Id.* § 447.203(b)(7)(ii).
[14] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67,578.

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."[15]

Numerous studies have linked reductions in Medicaid provider payment rates to diminished access. One study found that provider payment reductions led to a significant increase in the likelihood that a Medicaid enrollee had no provider visits in the last year.[16] In addition, the study found that payment reductions led Medicaid enrollees to seek more care in hospital outpatient departments instead of physicians' offices.[17] 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.[18] From our own experiences working with advocates in 50 states, we know that low-income people can experience particular barriers to obtaining specialty care, including orthopedic and psychiatric care.

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.[19] The study also found that states with larger reimbursement increases tended to have larger increases in appointment availability.[20] 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.[21]

c. Rescinding the current regulations at this juncture is premature.

To date, CMS has reviewed only one cycle of states' Access Monitoring Review Plans under the requirements imposed less than four years ago. Moreover, since the final equal access rule was promulgated, CMS does not appear to have made significant strides in enforcing the equal access provision. The rules required Medicaid programs to submit Access Monitoring

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[15] 42 U.S.C. § 1396a(a)(30)(A).
[16] Sandra L. Decker, *Changes in Medicaid Physician Fees and Patterns of Ambulatory Care*, 46 INQUIRY 291 (2009).
[17] *See id.* at 303.
[18] *Id.*
[19] 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.
[20] *Id.* at 539.
[21] Suk-fong S. Tang et al., *Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians*, 141 PEDIATRICS 2570 (2018).

Review Plans to CMS by October 1, 2016. *See* 42 C.F.R. § 447.203(b)(5)(i). In the preamble to this proposed revision CMS claims that it has "received AMRP submissions from all states."[22] But as of September 2019, two states and three territories do not have plans posted on the public website it cites.[23] 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. Under the current regulatory scheme, states must submit their second reports by October 1, 2019. We are aware of many states and territories that are currently compiling and analyzing information in order to complete those reports on time.

As CMS acknowledges in the preamble to this proposal, when it proposed to amend the current regulatory scheme last year to allow states to be exempt from reporting in certain instances, this proposal prompted serious concerns among the stakeholders who submitted comments.[24] Yet CMS does not suggest that the majority of commenters, if any, suggested that the appropriate response to that proposal, or to concerns about the current regulatory scheme, was to get rid of any regulations governing equal access all together. Rescinding the rule in its entirely uses a bomb, when a scalpel is warranted. As discussed in more detail below, we agree that the current regulations could be improved to ensure that CMS can effectively monitor access in Medicaid and take appropriate enforcement action when there are access problems. But simply rescinding the current rule without establishing an alternate method of assuring access, will not achieve this goal.

Indeed, even under the current regulatory scheme, CMS could be doing more to monitor and enforce the equal access provision of the Medicaid Act. Our own review of the initial Access Monitoring Review Plans that are posted on CMS's website reveals significant deficiencies. For example, the Kentucky document 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.[25] 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.[26] Hawaii's four-page report contains only

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[22] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. 33722, 33723 (Jul. 15, 2019).
[23] *See* Ctrs. Medicare & Medicaid Servs., Access Monitoring Review Plans, https://www.medicaid.gov/medicaid/access-to-care/review-plans/index.html (last visited Aug. 22, 2019).
[24] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. at 33723.
[25] Kentucky Dep't Medicaid Servs., *Access to Care Final Rule* (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/ky-amrp-16.pdf.
[26] Louisiana Dep't Health, *Access Monitoring Review Framework* (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/la-amrp-16.pdf; Kansas

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."[27]

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.[28]

Despite these shortcomings, the current reporting process has been helpful in identifying access gaps in state Medicaid programs and in encouraging states to improve their own methods of monitoring access. For example, the District of Columbia identified potential issues with access to psychiatrists and dermatologists in its Medicaid program and pledged to monitor access more closely in these areas.[29] Illinois established a website and hotline for reporting on access issues to allow the Medicaid agency to better track and monitor access issues going forward.[30] The U.S. Virgin Islands pledged to launch its first survey of Medicaid beneficiaries to inform its analysis of access for its next access monitoring report.[31] Wyoming identified gaps in

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Dep't Health & Environ., *Medicaid Service Access Monitoring Plan – October 2016* (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/ks-amrp-16.pdf.

[27] State of Hawaii, *Medicaid Access Monitoring Review Plan 2016* at 2 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/hi-amrp-16.pdf.

[28] *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.

[29] District of Columbia, *Fee-for-Service Medicaid: Access Monitoring Review Plan* 6 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/dc-amrp-2016.pdf.

[30] State of Illinois, *Access Monitoring Review Plan* 5 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/il-amrp-16.pdf.

[31] U.S. Virgin Islands, *Access Monitoring Review Plan* 16 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/vi-amrp-16.pdf.

behavioral health access and pledged to continue to expand telehealth in that area to improve access to behavioral health services.[32] We expect that the second round of reports, due in October, will provide CMS and other stakeholders with more detailed and nuanced information about how access to services has changed over the last three years. CMS should use this information to inform any changes to its methods of monitoring and ensuring access to Medicaid-covered services.

Rather than rescinding the regulations, CMS should focus its efforts on ensuring that states develop and submit Access Monitoring Review Plans as required by the regulations, and it should review states' submissions to ensure that they are complete and accurate. Without the data and analysis in the Access Monitoring Review Plans, it will be more difficult for states to comply with the statutory equal access requirement and for CMS to determine whether a state is in compliance. Rather than rescinding the rule, CMS should work with states, beneficiaries, providers, advocates, and other stakeholders to understand how the current regulatory scheme is addressing access by publishing any metrics it is using to evaluate state's reports and proposed SPAs that would reduce rates, along with any corrective action it has required states to make. This kind of evidence is vital to assuring beneficiaries that CMS's current efforts to monitor access to Medicaid services are working and sufficient. It is premature to rescind the regulations before CMS and the public have 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.

d. The current regulatory requirements are not overly administratively burdensome.

CMS suggests that rescinding the current equal access regulations will relieve "unnecessary administrative burden experienced by state Medicaid agencies."[33] In the first instance, we reject the idea that Executive Order 13771, which encouraged agencies to repeal two existing regulations for every new regulation promulgated, should apply to regulations that govern access to vital health care services by low-income individuals. The stated goal of that Executive Order is to "manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations."[34] The equal access regulations impose small public expenditures but do not impose any private expense for compliance. And while the current regulations do pose a small administrative cost on states,

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[32] Wyoming Medicaid, *2016 Access Monitoring Review Plan* 5-6 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/wy-amrp-16.pdf.
[33] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. at 33,730.
[34] Reducing Regulation and Controlling Regulatory Costs, Exec. Order 13771 § 1 (Feb. 3, 2017).

that cost represents the cost of compliance with the Medicaid Act. The current regulations represent the set of procedural requirements that CMS has adopted to assist it and state Medicaid agencies to ensure compliance with the statutory access requirement. As the agency explained when publishing the current regulations, the unavailability of the federal courts after the *Armstrong* decision "underscores the need for stronger non-judicial processes to ensure access, including stronger processes at both the state and federal levels for developing data on beneficiary access and reviewing the effect on beneficiary access of changes to payment methodologies."[35] Repealing the current regulations would gut, not strengthen, those non-judicial processes.

In any event, the evidence does not demonstrate that the current regulations pose a significant administrative burden that justifies repeal. CMS's Regulatory Impact Statement estimates that repeal of the current regulations will result in a reduced reporting burden of $3,633,289, which across all states totals less than $70,000 per state—hardly a major financial burden.[36]

e. Rescinding the current rule will leave millions of Medicaid enrollees without a clear way to enforce their right to access.

Rescinding the current regulatory scheme will leave beneficiaries in fee-for-service Medicaid programs without an avenue to address access issues if their states fail to attend to them. As discussed above, *Armstrong* leaves little recourse to enforce their right to equal access in federal court. It is therefore particularly important that states establish strong processes for monitoring access in their Medicaid programs, AND that CMS oversee those state processes to ensure that they are effective. Since CMS has established processes for monitoring and overseeing network adequacy in Medicaid managed care programs through separate rulemaking, rescinding the current equal access regulations will particularly impact beneficiaries in fee-for-service Medicaid programs. As of 2017, over 24 million Medicaid beneficiaries receive care from fee-for-service Medicaid.[37] Many of those beneficiaries have specialized health care needs and are most likely to be negatively impacted by access problems in Medicaid fee-for-service, including seniors and people with disabilities eligible for both Medicaid and Medicare, people with cancer, children with complex medical conditions, Native Americans and Alaskan Natives, people with behavioral health conditions including opioid use disorders, and people who live in rural areas.

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[35] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67,579.
[36] *Id.* at 33,731.
[37] Ctrs. Medicare & Medicaid Servs., *Medicaid Managed Care Enrollment and Program Characteristics, 2017* at 17 (2019), https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf.

For example, as of 2017, over seven million individuals eligible for Medicare and Medicaid (approximately three-quarters of all of those dually eligible for Medicare and Medicaid) continue to receive services through fee-for-service Medicaid.[38] 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. Similarly, in many states, women with breast and cervical cancer enrolled in Medicaid through the Breast and Cervical Cancer Treatment program receive their care fee-for-service.[39] People with cancer are another high-need population.

In addition, as of 2017, 14 states deliver services to all children in Medicaid on a fee-for-service basis.[40] A total of 26 states deliver services to all or some children with special health care needs on a fee-for-service basis.[41] Thirty-one states deliver services to all or some children in foster care or receiving adoption assistance on a fee-for-service basis.[42] 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, and those who have experienced family separations.[43] Rescinding the current regulations will result in less oversight of the services delivered to these children.

Rescinding the rule will also disproportionately impact Indigenous Medicaid beneficiaries. Because of particular statutory provisions established to recognize the sovereign status of indigenous tribes in the U.S., as of 2017, in 43 states Native Americans and Alaskan Natives receive Medicaid on a fee-for-service basis.[44] In New Mexico, nearly all of the fee-for-service population is composed of Native American enrollees.[45] In Arizona and Washington, more than

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[38] *See id.* at 13.
[39] *See, e.g.,* State of Florida, *Medicaid Access Monitoring Review Plan* 7 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/fl-amrp-16.pdf; Maryland Dep't Health & Mental Hygiene, *Access Monitoring Review Plan for the State of Maryland* 2 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/md-amrp-16.pdf; State of West Virginia, *Access Monitoring Review Plan* 24 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/wv-amrp-16.pdf.
[40] Ctrs. Medicare & Medicaid Servs.,*supra* note 37, at 182.
[41] *Id.*
[42] *Id.*
[43] *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).
[44] Ctrs. Medicare & Medicaid Servs.,*supra* note 37, at 182.
[45] New Mexico Medicaid, *Access Monitoring Review Plan for Fee-For-Service Recipients* 11 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/nm-amrp-16.pdf.

half of full service Medicaid fee-for-service enrollees are Native American.[46] Access is particularly important for Native American and Alaska Native 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."[47]

In addition, a recent analysis suggests that 19 states offer behavioral health services such as mental health and substance use disorder services, through fee-for-service Medicaid.[48] 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 behavioral health services seems particularly counter-intuitive, especially since, again, access to behavioral health services is an area of focus in the current regulations.

In several states, people in rural and frontier regions receive Medicaid services on a fee-for-service basis.[49] CMS has announced that it is undertaking a specific focus on "[e]nsuring access to high-quality health care to all Americans in rural settings."[50] Allowing state Medicaid Programs to forgo rigorous monitoring of access to health care in rural regions is odds with this goal.

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.[51] Thus, CMS's role in monitoring and overseeing access is particularly important. 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. Without any requirement that states regularly rigorously review access and report findings to

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[46] Arizona Health Care Cost Contain. Sys., *2016 Access Monitoring Review Plan* 3 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/az-amrp-16.pdf; Washington State Health Care Auth., *Fee for Service Access Monitoring Review Plan* 7 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/wa-amrp-16.pdf.

[47] Indian Health Servs., Disparities, https://www.ihs.gov/newsroom/factsheets/disparities (last visited May 7, 2018).

[48] Inst. Medicaid Innovation, *Behavioral Health Coverage in Medicaid Managed Care* 8-9 (2019), https://www.medicaidinnovation.org/_images/content/2019-IMI-Behavioral_Health_in_Medicaid-Report.pdf.

[49] *See, e.g.,* Nevada Dep't Health & Hum. Servs*., A Plan to Monitor Healthcare Access for Nevada Medicaid Beneficiaries* 5 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/nv-amrp-16.pdf; Utah Dep't Health, *Access Monitoring Review Plan* 9 (2016), https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/ut-amrp-16.pdf.

[50] Ctrs. Medicare & Medicaid Servs., *Rural Health Strategy* 2 (2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.

[51] *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).

CMS, it will be difficult for CMS to understand where there are access problems and address them. Medicaid beneficiaries with a high need for services who continue to receive services on a fee-for-service basis could face diminished access without any meaningful oversight or opportunity for redress. If the access problems are concentrated among high-need beneficiaries, including seniors, people with disabilities, people with cancer, children, Native Americans and Alaska Natives, people with behavioral health conditions, and people in rural areas, that should draw more scrutiny from CMS, not less. If access problems are concentrated among beneficiaries who have historically been discriminated against, that should draw more scrutiny from CMS, not less.

II. CMS can improve on the existing regulatory scheme.

a. CMS should develop a robust process for collecting stakeholder input on how to best monitor access

In the Regulatory Impact Statement accompanying the proposed rule, CMS states "we believe removing the regulatory requirements [*i.e.*, repealing the equal access rule] is the best course of action as we move forward in the development and implementation of a comprehensive approach to monitoring access across Medicaid delivery systems."[52] CMS does not explain what this "comprehensive approach to monitoring access" will be, how it will be an improvement over the Access Rule, or when it will be implemented. The only certainty is that the current regulatory scheme will be eliminated, and with its elimination, CMS, the states, and the public will lose valuable data and analysis regarding access to care for Medicaid beneficiaries – data that might inform the development of a comprehensive approach.

While NHeLP opposes CMS's current proposal to rescind the equal access regulations in their entirety, there is room to improve the current regulations. We recommend that CMS establish a transparent, stakeholder process to determine how it can best monitor access to Medicaid services that is accessible to beneficiaries and advocates and develop recommendations through that process that could ultimately be put forth as proposed revisions to the current regulatory scheme. The stakeholder process should include a diverse group of stakeholders including beneficiaries, legal services providers, and other beneficiary advocates in addition to research experts, states, Medicaid managed care plans, and providers. We recommend that CMS hold in-person hearings around the country on this topic and set-up an online portal to collect new feedback on how it can best measure and monitor access to Medicaid services. CMS should compile and post the information it collects on a public website and use it to

[52] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. at 33,732.

inform a new rulemaking process with notice and comment to vet improvements on the current regulatory scheme. Given the importance of monitoring equal access in Medicaid, the requirements must be set forth in regulation, rather than, as CMS suggests in the preamble to this proposal, sub-regulatory guidance such as a Dear State Medicaid Director letter.[53]

As a part of this process, CMS should work with stakeholders to identify existing information and data on which it can draw to create updated recommendations to revise the regulations. CMS already has a wealth of information on which to draw to improve the current regulatory scheme. After October of this year, it will have two cycle's worth of state Access Monitoring Review Plans that it can analyze to determine what methods states have successfully implemented to monitor and ensure access to Medicaid services. In addition, it has gathered extensive input from working with states to implement network adequacy standards and certify networks for Medicaid managed care programs. CMS also collected over 1,000 comments on its 2015 RFI, which asked for:

> information on core access to care measures and metrics that could be used to measure access to care for beneficiaries in the Medicaid program (including in fee-for-service and managed care delivery systems) and used to develop local, state and national thresholds and goals to inform and improve access in the program. . . . [and] feedback on approaches to using the metrics, which could include setting access goals and thresholds and formal processes for beneficiaries to raise access concerns.[54]

CMS also can draw on its experience measuring and monitoring network adequacy for Medicare Advantage plans, and QHPs in the federal Exchange. These sources of information can help CMS determine effective methods and metrics of assessing access to inform its regulation of state Medicaid programs going forward.

b. Any comprehensive approach to regulating equal access must cover all Medicaid services.

We appreciate that CMS has signaled its intent to approach its enforcement of the equal access requirement comprehensively. NHeLP has long opposed CMS's limiting the scope of its equal access regulations to non-waiver Medicaid services delivered on a fee-for-service basis.[55] As we have previously stated, the § 1902(a)(30)(A) requirement is a broad Medicaid

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[53] *See id.* at 33,723-24.

[54] Medicaid Program: Request for Information: Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (CMS-2328-NC), REGULATIONS.GOV, https://www.regulations.gov/document?D=CMS-2011-0062-0187 (last visited Aug. 28, 2019).

[55] *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-

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 access across Medicaid, including waiver services and services delivered through managed care programs. Indeed, CMS has already begun to work with states to develop robust network adequacy standards in their Medicaid managed care programs, and, as discussed above, should evaluate how it can apply the lessons it has learned about measuring access across Medicaid as appropriate.

It is also clear that the equal access provision extends to services provided in HCBS waiver programs. CMS has recognized this fact in its own technical guidance. For example, CMS guidance on 1915(c) services states that "1902(a)(30)(A) of the Act requires that payments for Medicaid services be consistent with efficiency, economy, and quality of care."[56] This language is repeated in the updated guide released this January.[57] Technical assistance presentations from CMS to states on HCBS rate setting also reiterate this requirement.[58]

c. The final regulations should aim to increase standardization and draw upon tested measures and methods.

As it approaches the process of improving the current equal access regulations, 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. For one, we urge CMS to require that all states create a standard complaint process to capture the number and nature of access problems that beneficiaries experience. This complaint process should include: a centralized contact point for access-related complaints, regular beneficiary surveys, an ombuds program, and a

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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/.

[56] Ctrs. Medicare & Medicaid Servs., *Instructions, Technical Guide and Review Criteria for 1915(c) Applications* 252 (2015), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf.

[57] Ctrs. Medicare & Medicaid Servs., *Instructions, Technical Guide and Review Criteria for 1915(c) Applications* 260 (2019), https://www.nasddds.org/uploads/documents/Version3.6InstructionsJan2019.pdf.

[58] Ctrs. Medicare & Medicaid Servs., *Documentation of Rate Setting Methodology* 8 (2016), https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1b-transparent-documentation.pdf.

mechanism for collecting access concerns from the state Medicaid Care Advisory Committee. We also urge CMS to require that the complaint process data not only be made available to CMS upon request, but also be made publicly available on a state website. CMS should conduct regular audits of the complaint data for each state to ensure that the state processes are adequately capturing the access problems facing beneficiaries.

CMS has previously considered adopting a more standardized method of measuring and monitoring equal access in Medicaid.[59] Such an approach would be consistent with the agency's obligations under federal law, which charges CMS with the responsibility of enforcing the Medicaid Act. Establishing core access measures will allow it adhere to its enforcement responsibilities 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 measures will ensure that standards do not vary too widely from one state to another and that oversight by CMS is not arbitrary or fragmented.[60] 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.[61] We have updated those suggestions and attached an updated version to this letter. In addition, we have enclosed our comments on prior proposals to implement the equal access provision and we incorporate

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[59] Medicaid Program: Methods for Assuring Access to Covered Medicaid Services-Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold, 83 Fed. Reg. 12,696, 12,698 (Mar. 23, 2018); *see also* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. at 33,724 (noting that CMS has "been working extensively with states, through a vendor, to identify best practices and develop standardized templates that can be used to analyze access").

[60] *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."), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

[61] 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.

those comments herein. We commend CMS to review our suggestions and reach out to us to discuss them further.

Conclusion

We appreciate the opportunity to provide comments on this proposal. We oppose the proposed rescission and instead urge CMS to leave the current regulations in place while it develops a process for improving its methods of monitoring access to services in Medicaid for the future. If you have any questions, please contact me (coursolle@healthlaw.org; 310-736-1652).

Thank you,

Abbi Coursolle
Senior Attorney

Cc: Jane Perkins, Legal Director, National Health Law Program

Encl: Updated Access Metrics
NHeLP Equal Access Regulation Comments, May 22, 2018
NHeLP Equal Access Regulation Comments, January 4, 2016
NHeLP Equal Access RFI Comments, January 4, 2016
NHeLP Equal Access Regulation Comments, June 17, 2011