January 4, 2016

Ms. Vikki Wachino
Director
Center for Medicaid and CHIP Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: ***Methods for Assuring Access to Covered Medicaid Services*** **(CMS-2328-FC)**

Dear Ms. Wachino:

We appreciate the opportunity to provide additional comments on certain aspects of the final rule regarding methods for assuring access to covered Medicaid services. We agree that states must have sufficient systems in place to monitor and review access to services. We also agree that such processes necessarily include some level of engagement with consumers and providers.

However, we remain concerned that CMS has added to the complexity of states' work to balance the statutory requirements pertaining to access with equally important assurances of economy, efficiency and appropriate utilization. Consistent with our comments to the 2011 proposed regulation, the final rule places burdensome requirements on states that outweigh the value that can be expected from the required data reporting and outputs.

In addition to providing comments on the specific issues called out in the regulation we request that CMS delay the deadline for submission of the initial access monitoring plan to, at the earliest, January 2017. Ideally, CMS should delay states' initial submissions of their AMPs to six months after the close of a state's next legislative session. This would provide a more reasonable timeframe for CMS to issue additional guidance and work with states. Importantly it also would be a more practical timeframe for Medicaid agencies to work with their legislatures

around the rule's expectations and secure additional budget authority to meet the rule's requirements.

Simply put, it is not practical for states to complete the scope of work CMS has articulated by July 1, 2016, particularly given the outstanding issues in the final regulation and intensity of engagement that will be required between state and CMS staff. For point of reference, we refer CMS to the ongoing process underway with implementation of the home and community-based services (HCBS) settings regulation. States were required to submit statewide transition plans but did not have sufficient sub-regulatory guidance critical for informing this work. Further, limitations on CMS staffing have strained the workflow between states and their federal partner.

The specific challenges states face in meeting the initial Access Monitoring Plan (AMP) deadline include:

- It is unlikely that many if any states can acquire *additional* resources to devote to this work based on the limited window CMS has specified for completion of this work. Instead, state Medicaid agencies will likely redirect existing resources away from other critical work.
- States face significant challenges in developing the elements of their plan and conducting meaningful notice and engagement pieces in this abbreviated timeframe.
- States are challenged to identify acceptable sources for commercial proprietary data as state Medicaid agencies do not necessarily have a readily identifiable source. We anticipate that states will need more robust conversation with CMS around the parameters for rate comparisons.
- Many states cannot make progress towards compliance unless and until CMS is able to provide clarity around the pending aspects of this rule, including but not limited to the extent to which this rule will apply to states with significant managed care programs.

The remainder of our letter addresses the provisions from the final rule for which CMS is seeking additional input.

Exceptions Process for Managed Care States

We support CMS' policy to establish an exceptions process for states using a managed care delivery system in their Medicaid programs. Considering the substantial resource investment states will have to make to develop AMPs for any remaining FFS populations, states and the federal government would not see a significant return on this effort where there are small FFS populations.

We believe there are two aspects to establishing a threshold for exceptions: the methodology for determining the threshold and the threshold level itself. A reasonable starting point for addressing these components is the following:

1) For purposes of determining the applicable population in the state, CMS should consider only those populations that are eligible to be enrolled in a managed care delivery system for full Medicaid benefits under the state plan; and
2) CMS should exempt from the final rule's requirements those states that seek to enroll 75 percent of such population (contingent upon an appropriate methodology for determining eligible populations).

We understand that CMS may have reservations about the populations left in these FFS programs. However, many of these FFS programs tailor to a relatively small set of beneficiaries, may apply to individuals who are eligible only for a limited Medicaid benefit and may be limited in scope to providing payment for services already received. In these circumstances, CMS's framework for access monitoring plans does not meaningfully apply.

As such, we recommend CMS exclude at least the following populations or situations in determining the methodology for applying the 75 percent managed care threshold exemption:

- Medically needy populations, since these individuals are likely to be enrolled in a Medicaid managed care plan going forward;
- The size of certain populations in the state's Medicaid program that may be eligible for a more limited scope of benefits not captured by CMS's access monitoring framework, such as undocumented immigrant populations,
- Individuals eligible for other coverage or for Medicare Savings Programs (Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, etc.);
- Instances of retroactive coverage periods, since services have already been accessed; and
- Time-limited FFS programs for new beneficiaries that are intended to allow for plan selection and enrollment, as this population's service needs are primarily addressed in the managed care delivery system, not the narrowly-applied FFS system.

Exceptions for Populations Not Under State Authority

We do not believe it is appropriate for states to be required to conduct access monitoring for populations not fully under the state Medicaid agency's authority. For instance, states do not completely control reimbursement rates, benefit design, or provider contracting for the Medicare-Medicaid dually eligible population, and thus should not be expected to ensure access to a full array of services for this population.

This also holds true for other populations with alternative coverage sources, such as Native Americans/Alaska Natives who utilize the Indian Health Service (IHS) or Tribal facilities. For several states, a substantial percentage of the Medicaid population receives services through these facilities, which have their policies and rates set by the federal government. The state does not have control over this rate setting, and as such should not be expected to include these populations in AMPs aimed at monitoring access for services for which states possess rate-setting authority. This concern is particularly pressing in light of the new tribal claiming guidance CMS is developing for services received through an Indian Health Service (IHS) or Tribal facility.

Comments on Access Review Requirements

- **Rate Changes:** States are very concerned about the requirements around AMPs in response to rate reductions and restructuring of reimbursement methodologies. We urge CMS to revisit the provisions for applying AMPs in the context of such changes. If CMS moves forward in applying the rule as written, the federal agency should provide clear guidance around its expectations for how states should proceed in at least the instances discussed below. Additionally, we request the agency also modify the requirement to mitigate the burden for states that are implementing minor changes in reimbursement rates or methodology or where a change is tied to another payer.

  Rate Methodology. There is significant ambiguity around what will constitute a rate reduction in the context of changing the state's underlying rate methodologies, which may be an important driver of other critical state reform goals. This ambiguity adds a new layer of uncertainty around timelines for CMS approvals of new payment methodologies and complicates the relationship between states and CMS in the pursuit of delivery system and payment reforms. Further, the requirement that states include analysis of the impact of proposed rate reductions or restructuring alongside their state plan amendments requesting such changes will introduce additional delays in the state plan amendment (SPA) approval process.

  The proposed rule also appears to establish a burdensome approach to access monitoring after a minor restructuring of the underlying rate methodology, which may in turn have unintended consequences. First, a state's rate restructuring may be developed in a budget-neutral manner in terms of the impact on overall program spending, but may be intended to redirect payments to incentivize delivery system reforms and alter provider utilization patterns – for example, rebalancing long-term services and supports delivery towards the community, a goal driven in part by CMS's

HCBS settings rule. Imposing access reviews on service types that the state is strategically shifting away from undercuts a key policy lever for driving delivery system reform, and may well run counter to CMS's own goals for innovative service delivery. CMS should consider how to apply access monitoring requirements in a manner that supports, rather than impedes, important state-driven innovations.

Linkages with Other Payers. Another factor CMS must account for are those situations where certain states opt to base rates for specific services on another, non-state payer (for example, as a percentage of Medicare's rates). Occasionally, the other payer reduces rates or modifies its payment methodology for reasons beyond the state's control, but this has no impact on access. States should not be expected to maintain higher rates for services or be held to a higher access standard than their benchmark payer. These situations should not trigger a requirement for the state to submit an AMP.

Broad-based Rate Modifications. Rate changes may also be imposed for some or all services by a state's legislature in a given state fiscal year. It is our understanding that such an occurrence would trigger mandatory inclusion of all impacted services (potentially all covered Medicaid services) into a state's AMP under such a scenario. This is an unreasonable requirement which would severely tax already scarce state administrative resources.

Further, if CMS's requirement for access monitoring delays SPA approvals or otherwise lengthens the timelines for states to implement policy changes, state Medicaid agencies may be forced to make undesirable adjustments to one or more of eligibility policy, optional services or administrative resources. We believe this result would be contrary to both states' and CMS's desires for the Medicaid program.

- **Complaint Volume:** Another area of concern is the revisions found at Section 447.203(b)(5)(ii)(G), which requires states to incorporate into their AMPs to review access for services based on receipt of "significantly higher than usual" beneficiary, provider, or stakeholder access complaints. While states can and do utilize beneficiary and provider grievances to monitor access in their Medicaid programs, we believe that this "significantly higher" standard is ambiguous. It is possible this regulation will leave states' rate setting processes, rate proposals, and other reform work highly susceptible to litigation or other delays by a high volume of organized provider complaints, especially in the age of digital communication.

  We request that CMS work with states and other stakeholders to articulate a clear expectation of what constitutes "significantly higher" complaints, and allow states to

develop the baseline amount of such complaints in order to make this comparison. One potential solution would be to consider complaint volume "significantly higher" if such volume is three standard deviations higher than an average volume, calculated on a rolling basis every quarter.

Furthermore, CMS should grant states the flexibility to determine the nature of received complaints to determine whether such complaints are indeed related to access issues, or if they may be driven by program management features such as utilization controls. The complaint process should not become a vehicle for exerting pressure on state Medicaid programs to raise rates for a given service if the service does, in fact, have sufficient providers enrolled to ensure appropriate beneficiary access to that service.

- **Concerns around Sources of Other Public and Commercial Payer Data and Overall Utility of Rate Comparisons:** As discussed above, states do not have an easily accessible source of commercial payer data to meet CMS's requirement of comparing Medicaid payment rates to commercial payer rates on a percentage basis (Section 447.203(b)(3)). States will require CMS's engagement in identifying such data sources, particularly if the scope of services included in a state's AMP expand beyond the five mandatory service types identified in the rule.

  Additionally, not all states utilize Medicare reimbursement as a benchmark. Therefore, accessing Medicare rates without sufficient guidance from CMS regarding how these rates are applied can result in inaccurate analyses. For example, Medicare's fee schedule for physician-administered drugs is not always consistently applied by that program, and states must be made aware of such nuances in order to accurately make these comparisons. CMS should work with states to provide the appropriate context around how Medicare rates are applied to inform states' analytical work.

  On a more fundamental level, we question the utility of requiring states to compare their Medicaid program rates with other payers, whether they be commercial payers, Medicare, or other Medicaid programs. Payments do not necessarily equate to access, as CMS acknowledges in the introduction of its access RFI. There are myriad factors impacting rate setting, ranging from a covered population's underlying characteristics and service needs to program structure, benefit design, program licensing requirements, observation requirements for lower-level provider types, and the shifting reform landscape within states and across the nation. Deriving a meaningful comparison among these programs requires an intimate understanding of these factors, one which states cannot reasonably be expected to possess.

A cursory comparison of payment rates across programs does not do this complexity justice, and may give the inaccurate perception that states are underpaying or overpaying compared to other programs. This impression could in turn give the appearance that a state's Medicaid program is somehow flawed or improperly setting its rates, when the opposite may well be the case. In fact, some states that have performed their own analyses to benchmark their rates against Medicare and their neighboring states found it challenging both to obtain accurate data for the analysis and to derive value from the findings. We do not anticipate these facts changing for the comparisons CMS requires in state AMPs.

- **Specialty Services:** States also request more guidance and clarity around CMS's inclusion of specialty services as a mandatory component of state AMPs at Section 447.203(b)(5)(ii)(B). Specialty services is a vast category of service providers which can encompass both more common specialists and relatively rare, highly specialized providers. In some instances, states may have only a handful of certain specialists in a state – or the nearest specialist may be in an adjacent state metropolitan area and only see Medicaid patients on an ad hoc basis. States need further clarity around CMS's expectations for reasonable access to these types of extremely limited, specialized provider types.

- **Timelines for Updating AMP Analyses:** We do not believe the requirement for states to review and update their AMPs every three years is a reasonable requirement. Instead, states should only be required to conduct mandatory updates to their monitoring plans every five years, unless access problems are identified under the existing plan which warrant changes.

NAMD shares CMS's goals in ensuring Medicaid beneficiaries receive access to services to which they are entitled. However, we stress that plans for monitoring, identifying, and ameliorating beneficiary access issues must be designed in a manner that is sensitive to state Medicaid programs' underlying system designs, policy considerations, covered populations, ongoing delivery system innovations, and administrative resources.

We appreciate your consideration of our request to extend the deadline for initial monitoring plans and look forward to your response. As we have done on other issues, NAMD and our members welcome the opportunity to work with CMS in further developing effective access monitoring initiatives. If your staff has questions regarding our comments here, please direct them to Andrea Maresca, NAMD's Director of Federal Policy and Strategy.

Sincerely,

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Arizona Health Care Cost
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