NAMD
National Association of
Medicaid Directors

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: ***Request for Information: Data Metrics and Alternative Processes for Access to Care in the Medicaid Program*** **(CMS-2328-NC)**

Dear Ms. Wachino,

On behalf of the nation's Medicaid Directors, we appreciate the opportunity to inform CMS's thinking around monitoring access to care in the Medicaid program. The National Association of Medicaid Directors is a bipartisan organization which represents Medicaid Directors in the fifty states, the District of Colombia, and the territories.

Medicaid Directors take seriously their responsibilities to ensure Medicaid beneficiaries receive timely access to high-quality services to which they are entitled in a manner that is fiscally responsible. These responsibilities inform much of the innovation in delivery system and payment reform that is intended to achieve better care, better health, and lower costs in Medicaid across the country.

As a general matter, the line of questions posed within the RFI are troubling to NAMD and our members. In combination with the final rule, *Methods for Assuring Access to Covered Medicaid Services*, we are concerned that the federal agency is moving too far in the direction of tying access to reimbursement rates and limiting the ability of states to design appropriate payment methodologies. Further, the RFI questions are cause for concern because CMS seems to be signaling that it is moving towards a federal regulatory approach that is out of synch with the complexity of the program and realities under which state programs operate.

NAMD encourages CMS to consider these key principles as the agency continues its work on access monitoring:

First, authority to determine reimbursement rates and access thresholds should lie primarily with the state Medicaid agency. CMS correctly notes in the background to the RFI that Medicaid programs have diverse delivery system designs, covered populations, and provider networks. As such, states are best positioned to navigate the unique aspects and challenges posed by their health care landscapes, including setting appropriate access standards for beneficiaries and the associated rate-setting considerations that influence access. This is particularly true for states designing targeted benefits and systems for beneficiaries with complex service needs, such as individuals with serious mental illness, long term services and supports (LTSS) needs, and the Medicare-Medicaid dually eligible population. It is also true for certain subsets of the Medicaid population, such as Native Americans/Alaska Natives. States are also reorienting their delivery systems and purchasing strategies to reward value, both in fee-for-service (FFS) and managed care contexts. For states to realize their reform visions and drive value-based purchasing strategies, they must retain the authority to make access and rate-setting decisions that undergird this work.

Additionally, CMS should ensure that measure development and reporting initiatives are pursued with a specific, action-orientated purpose and balanced with the administrative burden posed by additional data collection, reporting, and analysis. Medicaid programs, as well as their health plan partners in states utilizing managed care, are already subject to significant reporting requirements on myriad aspects of their programs. These reporting requirements are likely to increase based on recent regulatory activity from the agency, including the final access rule for Medicaid fee-for-service (FFS) programs and provisions found in CMS's proposed regulation for Medicaid managed care programs. We encourage CMS to leverage existing data sources and state-reported information to inform its picture of access issues and minimize any additional reporting from the states.

If CMS or other federal agencies do move forward to develop access measures and implement new reporting requirements, the agency should work with states to ensure such measures are targeted, produce actionable information, and do not pose an undue burden on already-strained state administrative resources.

The RFI itself included an extensive number of complex questions, but a limited window for responding. Therefore, NAMD sought to address a core set of highly relevant and pressing questions from the state perspective. We continue to believe that this issue requires ongoing dialogue between the federal and state partners.

We offer more detailed comments on specific questions in the remainder of this letter.

Access to Care Data Collection and Methodology

- **Concerns with National Core Measure Set:** <u>NAMD does not support CMS setting a national core measure set for access to care. We have strong reservations about whether or what actionable information federal analysis of a core set of measures will have for states or our federal partners.</u> The high degree of variation among states in the Medicaid program requires a more state-specific, tailored approach than that afforded by mandatory reporting on a national core set; at worst such a core set could impede ongoing state delivery system and payment innovations. States should have the flexibility to tailor measures to match their program designs and population characteristics – indeed, many have already done so.
    - Should CMS opt to pursue a national core measure set, we encourage the agency to work closely with state Medicaid agencies to carry out this work. Ultimately such efforts should result in a focused, high-value measure set which features a limited menu of measures for states to select and apply to appropriate service types.
    - CMS must consult with states around the projected cost of new resources associated with data collection and the anticipated value of information that will be produced, on a state-specific basis. For example, CMS will need to consider the costs of conducting surveys, whether there is sufficient sample size within a state and the resources states would need to carry out this work.
    - CMS should be clear about any mechanisms it might expect states to utilize for data collection under any federally prescribed core measure set. CMS should articulate any expectation well in advance of its intended reporting period for such data to give states sufficient time to build the systems and staff expertise necessary for this data collection, and to prevent states from investing in tools that CMS does not intend to use at a later point in the reporting framework.
    - Consistent with our recommendations on measures in other areas of the Medicaid program, there must be a process to ensure the core set remains focused on priority aspects of access, even as new measures are developed in the future. Further, modifications to the core set should occur no more frequently than every three years.
- **Primary Indicators of Access to Care:** We believe that the indicators identified in the RFI (such as appointment times, wait times, and call center times) provide a reasonable framework for assessing certain access conditions, and many states currently utilize such indicators in their programs. However, states must have the latitude to determine the

specific targets for these indicators in the context of their health care market. For example, it would be unreasonable to expect that CMS could prescribe federal indicators appropriate for states as diverse from each other as Alaska and New York, or for that matter, even within these states.

- **Factors to Consider in Data Collection:** We encourage CMS to give significant consideration to program design characteristics and covered populations in its data collection efforts. Medicaid fee-for-service (FFS) programs differ from managed care programs in fundamental ways, and these programs take on different characteristics depending on the beneficiary populations they target. For instance, a FFS program for the medically frail is vastly different from a managed behavioral health benefit, and CMS should take those differences into account. Program authorities, program and benefit design, population characteristics, and the types and amounts of necessary providers are all factors that should be considered.
- **LTSS and HCBS:** CMS should consider the evolving landscape of long-term services and supports (LTSS) benefits, in particular ongoing state efforts to reorient LTSS towards the community. CMS's own home and community-based settings (HCBS) final rule, which requires states to comprehensively assess their programs, policies, providers, and HCBS settings, is intended to transform access for HCBS. Other federal policy developments, such as the Department of Labor's application of the Fair Labor Standards Act's minimum wage and overtime protections to home health workers, will also alter the LTSS provider workforce picture across the states. On a more fundamental level, the guiding principle in states around LTSS service delivery is transitioning into a person-centered approach, in which individuals increasingly plan the types of services they wish and the settings and providers they want to receive services from. Measuring LTSS access must be done within this person-centered context. This is a difficult task, and NAMD encourages CMS to continue working with states, plans, and other stakeholders to identify successful person-centered LTSS measurement strategies.

  Additionally, CMS must bear in mind that a key facet of HCBS 1915(c) waiver authorities is the state's ability to designate program budget and enrollment caps. This aspect of HCBS service delivery is fundamental to how these programs operate, and should be a key consideration in any access measure development work.

Access to Care Thresholds/Goals

NAMD believes it would be inappropriate for CMS to set national thresholds for access to care.

National thresholds are unlikely to generate meaningful comparisons of access to services – and thus improved outcomes -- across the diverse state programs and populations. Instead, such a top-down approach is likely to impede state flexibility to design and administer effective, efficient programs. Further, we have strong reservations about the possible uses CMS identified for federally determined thresholds (issuing compliance actions to states, use in beneficiary appeals process, cross-state benchmarking, etc).

States remain the appropriate entity for setting access thresholds, as they understand the nuances of the dynamics specific to their health care landscape. Depending on the service type and the provider workforce, a state's Medicaid access thresholds may also function as access thresholds for other payers in the state – all the more reason to leave such decisions at the state level.

CMS could consider working with states to develop consistent elements of access thresholds to align the overall functioning of such thresholds across Medicaid programs. However, any elements must allow sufficient flexibility for states to account for variation in their program structures, served populations, geographic and cultural characteristics, the penetration of technology, workforce capacity, use of out-of-state providers and covered services.

Alternative Processes for Access Concerns

States currently utilize a wide variety of mechanisms for monitoring and responding to beneficiary access concerns, both in FFS and managed care contexts. These current practices are sufficient for ameliorating access issues, and often provide multiple levels of appeal to beneficiaries to ensure their concerns are fully considered. We refer CMS to our October 2014 letter on access standards in Medicaid managed care, which informs our comments here.

In managed care environments, states set network adequacy standards which may include travel time and distance from beneficiaries to various provider types, provider to enrollee ratios, and appointment wait times. States also regularly consult with their plan partners to monitor key service utilization trends and stay informed about plans' own processes and tools to monitor access concerns within their networks.

Both managed care and FFS states rely on monitoring their beneficiary grievances and appeals processes to detect access issues. Consumer satisfaction surveys provide another key mechanism for all states to assess the state of access within their programs, though we wish to stress that such surveys can be costly for smaller states and should not be a de facto expectation. Some state Medicaid programs work with their state licensing boards to compare Medicaid provider enrollment with licensed practitioners in the state's geographic regions to ensure sufficient provider capacity in the program, while others have legislatively-required monitoring plans that produce annual reports assessing the relationship between rates, quality, and access.

Taken together, states have ample reason to be confident that they have the tools in place to detect beneficiary-identified access problems. While we do not believe additional, federally-developed access concern resolution processes are necessary, we encourage CMS to serve as a convener and collaborator with states to identify promising and innovative practices in this area.

Access to Care Measures

We reiterate the need for CMS to partner with states in developing any new access to care measures that may be necessary to fill in gaps in existing data sources. State participation in this process is critical to ensure new measures are high-value, appropriately targeted, and aligned across multiple programs, as the costs and administrative resources required to conduct additional data collection and reporting further strains states' already-taxed administrative capacity. Additionally, developed measures must be sufficiently flexible to account for variations in provider capacity both between states and among the different geographic areas within a state. Measures should also allow states to incorporate telehealth initiatives, particularly for highly specialized provider types, behavioral health providers, and other state-identified provider types. Further, measures should be nimble enough so as to keep pace with evolving technology and innovations that states and providers may leverage to facilitate access, particularly for specialty services.

We are particularly concerned with CMS's intentions in considering comparisons of state Medicaid payment rates with other payers, including Medicare and commercial payers. States face substantial difficulties in obtaining accurate payment rates from other payers, particularly commercial payers who may negotiate varying rates for different provider sites (and may consider this information proprietary). Further, these other payers are not subject to the same coverage provisions as the Medicaid program and cover substantially different populations. For instance, the Medicare program's structure and payment methodologies reflect the demographic needs of the Medicare population – a population that, while overlapping at times with Medicaid, is substantially different from Medicaid covered populations and their service needs. While we understand that Medicare payment rates are an easily accessible data source, we caution against using comparisons of Medicare and Medicaid payment rates as anything more than a general reference point.

On a more fundamental level, Medicaid programs have a responsibility to be effective stewards of public taxpayer dollars. This is mandated by the Medicaid statute, which requires a balance of efficiency, economy, and quality of care, as well as minimizing unnecessary service utilization while ensuring comparable service access to the general population. Further, Medicaid programs are often the largest portion of a state's budget, and all states save one require balanced budgets. No other payer faces a similar set of requirements, and thus comparisons to other payers must necessarily be highly contextualized to generate any significant comparison. Without this nuance, straight rate comparisons may give an inaccurate picture of a state's Medicaid program in comparison to these other payers, which could in turn lead to unintended policy consequences, such as the elimination of optional Medicaid services to correct a perceived budgetary imbalance.

NAMD and our members look forward to additional opportunities to work with CMS around effective access measurement. Please direct any questions regarding our comments here to Andrea Maresca [andrea.maresca@medicaiddirectors.org].

Sincerely,

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