NAMD
National Association of Medicaid Directors

September 13, 2019

Seema Verma
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on CMS's proposed rescission of the Medicaid fee-for-service (FFS) access monitoring framework [CMS-2406-P2]. We are strongly supportive of CMS's proposal to remove the overly prescriptive and burdensome FFS access monitoring framework and look forward to convening states in partnership with CMS to develop more meaningful, actionable access assessment frameworks that reflect current state best practices. We encourage CMS to prioritize flexibility for state-developed processes to identify potential access challenges in their programs and take steps to study and rectify identified challenges, as appropriate.

The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, which provides a vital health care safety net for more than 72 million Americans. These services are delivered in both FFS and in managed care delivery systems across the states.

Medicaid Directors take seriously their responsibilities to ensure Medicaid beneficiaries receive timely access to high-quality services, while simultaneously ensuring such services are provided in a fiscally responsible manner. Medicaid statute requires Medicaid Directors to balance each of these aspects of the program, while being responsive to their state's unique population characteristics, provider landscape, and delivery system configuration.

***Challenges of Current Regulatory Framework***

As we articulated in previous comments on the current access rule and related Requests for Information, the December 2015 final rule implementing the access monitoring plan (AMP) requirement for FFS Medicaid programs created significant concerns for states. These concerns span operational issues and overall disagreement with the underlying assumptions of the rule. They include, but are not limited to:

- **Unreasonable Workloads for States to Implement Routine Rate Adjustments:** The access rule requires states to develop an AMP for any services subject to a rate reduction or a rate restructuring in order for a State Plan Amendment (SPA) to be approved. This requirement made no exceptions for rate reductions dictated by circumstances beyond the Medicaid agency's direct control, such as legislatively mandated rate reductions or a Medicare rate reduction which impacts state rate methodologies based on Medicare. The rule also did not provide exemptions for states making rate reductions or modifications under an approved rate methodology, nor did it provide relief for states with predominantly managed care delivery systems. CMS's November 2017 guidance provided some clarification on these operational issues, though state concerns persist.
- **Burdensome Rate Comparisons with Other Payers, Despite Difficulties in Conducting Meaningful Comparisons:** AMPs are required to compare a state's Medicaid rates to other payers, including neighboring state Medicaid programs, Medicare, and commercial payers. States have consistently encountered difficulties in gathering appropriate data for making these comparisons (particularly commercial payer data), as well as understanding the context of the rate information they are able to obtain. As noted above, the unique characteristics of each state's beneficiary population, provider landscape, and delivery system reform goals each impact rate setting, though none of this information is captured solely by reviewing the rate itself. While states can and do utilize rate comparisons in overall program evaluation, the rate comparisons required by the AMP are generally of limited value.
- **Overemphasizing the Role of Rates on Access:** On a more fundamental level, the access rule sets rates as a predominant factor impacting access to Medicaid services. While CMS acknowledges and expects states to use non-rate measures of access in their AMPs, the general framework of the rule – under which the rate modifications discussed above, by themselves, trigger an access review and monitoring requirement that must be included with a rate SPA – privileges rates over other factors that have just as much impact on access to care, such as overall provider availability for given service categories across payers. NAMD disagrees with the access rule's elevation of rates above these other factors on access.
- **Failing to Account for the Predominance of Managed Care:** The access rule applies only to FFS Medicaid programs. While several states have exclusively FFS delivery systems, the majority are predominantly using managed care plans to deliver Medicaid services, with only small FFS programs. As such, the access rule creates an inherent bifurcation across states based on their delivery system characteristics. Further, the rule does not contemplate exemptions from its requirements for predominantly managed care states, requiring them to dedicate limited staff resources to meet outsized federal regulatory requirements compared to the size of their FFS programs. While CMS's November 2017 guidance provided limited flexibility in this area, the ongoing bifurcation between FFS and managed care under the current approach remains operationally burdensome.

In practice, the FFS access rule has led to unnecessary and administratively burdensome work for states to satisfy an overly prescriptive federal requirement that does not reflect the true complexity of the Medicaid program.

***Current Successful Practices in Monitoring Access to Care***

States employ a variety of practices today to monitor beneficiary access to care. The majority of these practices are independent of rates or rate setting processes, though rates are a routinely considered factor. We believe these practices can represent a starting point for further discussion in the collaborative process described above. They include, but are not limited to:

- Comparing provider to Medicaid beneficiary ratios to similar ratios in the state's Medicare and/or private payer market;
- Monitoring the service utilization level in the Medicaid population compared to Medicare and/or the private market;
- Annual reports to state legislatures that study the impact of rate changes on provider retention, service utilization, and other relevant metrics;
- Monitoring routine channels of beneficiary and provider communication, such as the rate of grievances and appeals, phone or electronic communications, etc.
- Frequent reviews of managed care plan networks;
- Comparing managed care plans' networks to plan claims to verify contracted providers are seeing Medicaid patients;
- "Secret shopper" programs to assess managed care contracted providers' and/or providers in the state's FFS program's willingness to see both new and current Medicaid patients on a timely basis;
- Surveys of beneficiary experience in utilizing their Medicaid benefits; and
- Measuring drive-time distances for both potential and realized access to compare where beneficiaries are able to access care, where they ultimately receive services, and the potential differences between these locations.

***Principles for a New Access Framework***

NAMD appreciates CMS's intentions to work with us and our members to develop an alternative to the current access framework. Our hope is that a new framework will allow states the flexibility to design processes that reflect their unique program designs and characteristics, be oriented towards meaningful outcomes, and leverage existing regulatory structures, data sources, and reporting streams.

We recognize that this work will take dedicated time and resources, and may require sustained engagement with states over a period of months, in addition to engagement with other

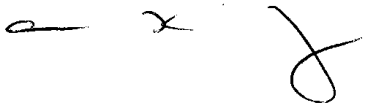
impacted stakeholders. In anticipation of such a process, we offer here two guiding principles for future work on access issues:

- **Documentation of State Processes to Identify Potential Access Issues:** CMS should require states to document the processes they currently utilize to identify when a beneficiary population or service category is likely to be experiencing challenges in accessing care. This documentation should not come with the expectation that states explicitly design new processes to satisfy this requirement; rather, it should be a unified source of existing state processes.
- **Attestation of Processes to Verify and Ameliorate Identified Access Issues:** CMS should require states to attest that, upon identifying a potential access issue via their documented identification processes, states have a process or processes to verify and address the identified challenge and to monitor the efficacy of the state's implemented solution. We do not believe that any one specific approach should be required for states to address identified access issues, as the contributing factors are likely unique and reflect specific characteristics of the state's health care landscape. States may opt to restructure a rate, as envisioned under the current regulatory framework, or they may redesign a benefit, create a new delivery model, or take some other action to address an access problem. The state may also identify factors beyond the Medicaid agency's control that lead to the access problem, such as a lack of a highly specialized provider type within the state.

A useful model for guiding this work is the successful collaboration between CMS, NAMD, and states to develop the Medicaid managed care network adequacy toolkit following the publication of the updated managed care regulatory framework in April 2016. That collaborative process entailed sustained and thoughtful discussion of multiple aspects of network adequacy, gave many states opportunities to discuss their practices with their peers, and produced a robust set of recommended practices for states and stakeholders to build upon.

Thank you for your responsiveness to state concerns around this rule. NAMD and our members look forward to continuing work with CMS to produce an effective, operationally feasible framework for assessing Medicaid beneficiaries' access to care.

Sincerely,



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