May 21, 2018

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

RE: CMS-2406-P Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold

Dear Secretary Azar:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, 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. 12696 (March 23, 2018).

MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of topics related to Medicaid and CHIP. The Commission also is charged with reviewing proposed regulations that affect access to care for Medicaid and CHIP beneficiaries.

The proposed rule referenced above would amend the process states must use to document whether payments in fee-for-service (FFS) Medicaid are sufficient to ensure access in a manner that is consistent with the equal access provision in the Social Security Act (§ 1902(a)(30)(A)). It is intended to address the concerns of states, particularly those with high levels of managed care enrollment, regarding the administrative burden associated with the existing requirements. While the Commission has long raised attention to the administrative capacity constraints of state Medicaid programs, it has concerns related to the proposed rule, as discussed below.

Ongoing need to monitor access

The proposed rule would establish exemptions for states with high managed care enrollment and states making nominal payment rate changes. It would also modify the requirements for the submission of state plan amendments for payment rate changes. States continue to be obligated under the statute to ensure

that payment rates are sufficient to meet the standard established by the equal access provision.

As noted in Chapter 4 of MACPAC's March 2017 *Report to Congress on Medicaid and CHIP*, on monitoring access in Medicaid, although managed care is now the dominant delivery system in Medicaid, monitoring access under FFS remains important for a number of reasons. First, more than half of Medicaid spending nationally is for services provided under FFS arrangements. Second, the populations that are most likely to remain in FFS Medicaid, such as individuals with disabilities, are among the most vulnerable, and ensuring their access to services is particularly important given their high health needs. Third, even in states with high managed care penetration, some services, such as long-term services and supports, dental services, and behavioral health services, are carved out of managed care contracts and provided through FFS arrangements. Furthermore, monitoring access can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guide program improvement efforts.

The Supreme Court ruling in *Armstrong v. Exceptional Child Center, Inc.* eliminated the private right of action to contest payment rate changes under FFS, concluding that CMS is better suited than the courts to make determinations related to the adequacy of payment rates.[1] The existing access monitoring rules stem from this obligation and were designed by CMS to strengthen the agency's review and enforcement capabilities. The Commission considers federal enforcement of the equal access provision the primary mechanism for ensuring that Medicaid beneficiaries have sufficient access to care when services are delivered under FFS arrangements. State activities to collect and report data are necessary for the federal government to carry out this role. These important responsibilities are corollaries to state obligations to ensure that managed care organizations monitor and demonstrate the adequacy of their provider networks.

State administrative capacity

A number of states with large managed care populations voiced concerns regarding the burden of monitoring the typically small and sometimes unique populations that continue to receive services in FFS. The proposed rule seeks to ease the administrative burden on these states, as well as those seeking nominal payment rate changes. The government estimates that this would result in modest savings to the states, given that they have already invested resources in developing their initial access monitoring plans.

The Commission does not find the argument for such a trade-off compelling, given the federal government's obligations to oversee state performance and assurances related to access. Moreover, exceptions to reporting may introduce gaps in oversight. In short, the need for states to maintain resources and tools to monitor access as an ongoing element of state program administration and decision making outweighs the limited savings states would achieve as a result of these changes.

MACPAC recognizes that agencies at both the state and federal level are expected to manage a large and diverse set of responsibilities but face ongoing staff shortages and limited resources. They are also constrained in their ability to collect, analyze, and report data, important functions for monitoring access in Medicaid. Limited state resources are a legitimate concern. Rather than eliminate obligations to monitor access, requirements should be targeted in a way that is efficient and effective. To that end, we encourage CMS to look

[1] *Armstrong v. Exceptional Child Center, Inc.*,135 S. Ct. 1378 (2015)

toward how access monitoring plans can be improved as states gain experience and how these tools can be best used to provide meaningful and actionable information.

Thresholds

The Commission also has concerns related to the proposed thresholds that would trigger reporting exceptions (i.e., 85 percent managed care enrollment and nominal payment rate changes of 4 and 6 percent). The proposed rule cited little evidence supporting these specific thresholds, or any data that could be used to assess alternatives. Should CMS proceed to implement thresholds such as those proposed or alternatives suggested by commenters, the Commission recommends that CMS examine the evidence and data supporting them and include such analysis in the final rule.

The Commission is concerned that the proposed threshold of 85 percent overall managed care enrollment obscures the role that FFS continues to play in Medicaid, especially for certain vulnerable populations and particular services. In addition, the proposed nominal payment reductions in a state with already low payment rates would have different implications for access than in a state with higher payment rates. The Commission suggests that any threshold should reflect both the role of managed care across different populations and services, and state baselines with regard to existing payment rates relative to other states and payers.

We appreciate the opportunity to provide comments on this proposed regulation.

Sincerely,

Penny Thompson
Chair

cc: The Honorable Orrin G. Hatch, Chairman, Committee on Finance, U.S. Senate
The Honorable Ron Wyden, Ranking Member, Committee on Finance, U.S. Senate
The Honorable Greg Walden, Chairman, Committee on Energy and Commerce, U.S. House of Representatives
The Honorable Frank Pallone Jr., Ranking Member, Committee on Energy and Commerce, U.S. House of Representatives
The Honorable Michael Burgess, Chairman, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives
The Honorable Gene Green, Ranking Member, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives