National Association of Public Hospitals and Health Systems

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Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-2328-P: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (May 6, 2011)

Dear Dr. Berwick:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned Proposed Rule. NAPH commends the Centers for Medicare & Medicaid Services (CMS) for taking action through this Proposed Rule to ensure Medicaid patients have access to care.

NAPH represents the nation's largest metropolitan area safety net hospitals and health systems that share the common mission of providing access to high quality health care to all patients regardless of ability to pay. These hospitals and health systems are critical sources of care for low-income and vulnerable patients in their communities—about half of all the care provided by NAPH members is for Medicaid and uninsured patients. Medicaid continues to be the most important source of revenue for public hospitals, accounting for 35 percent of NAPH members' total net revenues.

NAPH members are a critical component of access to inpatient and outpatient services, particularly in urban and metropolitan areas. In an analysis of the ten largest U.S. cities, NAPH members represent only 12 percent of local acute care hospitals, but provide a disproportionate share of critical services.[1] Specifically, NAPH member hospitals provide 23 percent of the emergency department visits and 33 percent of non-emergency outpatient visits. As major providers of trauma care, public hospitals represent 40 percent of Level I trauma providers and 63 percent of the burn care beds available to treat the critically-injured in these cities. Moreover,

[1] NAPH, 2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times, February 2011.

NAPH members are responsible for 29 percent of Medicaid discharges in these major metropolitan areas.

The vital link between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries cannot be overstated, particularly as we approach the significant expansion of Medicaid coverage in 2014. When Medicaid rates drop too low, many providers either cannot afford to or choose not to treat Medicaid patients, and those that do are often forced to shift the unreimbursed Medicaid costs onto other payers. While safety net providers can continue to be relied on to serve the Medicaid population, their ability to do so when they are compensated well below cost becomes severely compromised, directly impacting the care available to Medicaid patients. In short, through a reduction in either the number or capacity of providers serving Medicaid patients, inadequate Medicaid rates restrict beneficiaries' access to care, particularly as compared with the access available to the general population.

Further reductions in Medicaid funding will also undermine the efforts of safety net providers in leading the development of accountable care organizations, patient-centered medical homes, and other delivery system reforms to provide high-quality, cost-effective care to low income patients, even at currently very low Medicaid reimbursement levels. NAPH members have worked with states on Medicaid waivers and other initiatives that have proven to be effective models for providing cost effective care to a population base of low-income, uninsured patients. Any further reduction in Medicaid funding would be difficult for these programs to continue to serve the high (and increasing) volume of uninsured patients and disrupt the progress toward effectively managing their care by the time Medicaid assumes their costs in 2014. Last year, the nation's hospitals provided more than $49 billion in uncompensated care accrued through losses on care for patients covered by Medicaid and care for uninsured patients.[2] NAPH shouldered a significant portion of this burden—NAPH members represent only 2 percent of the nation's acute care hospitals, but delivered 20 percent of the uncompensated care provided by U.S. hospitals. In the current state fiscal situation, provider payment rates are particularly vulnerable as quick solutions to a budget deficit. Indeed, the recent National Governors Association report on state fiscal status shows that 33 states are proposing to reduce provider payments rates, and sixteen to freeze provider payment rates, in 2012.

While states have broad latitude in setting Medicaid payment rates, when states cut Medicaid reimbursement, the decision should involve careful analysis of the implications of such changes on the ability of providers to provide quality care and access to Medicaid beneficiaries. CMS should require that states demonstrate that payments remain compliant with the standards of Section 1902(a)(30)(A) of the Social Security Act, which requires states to "assure that payments … are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." For years, states have not been required to demonstrate that their Medicaid programs provide beneficiaries with such equal access. The CMS proposed regulation is a critical first step to protecting Medicaid patients' access to care. We strongly support the requirement for access reviews prior to any payment reductions and on an ongoing basis to ensure continued compliance (rather than

[2] AHA Annual Update on Hospital Uncompensated Care and Unreimbursed Care.

years of outdated payment rates). NAPH urges CMS to build upon this initial proposal as further described in the attached comments so that the Final Rule will effectively ensure beneficiary access to the full range of Medicaid services.

NAPH appreciates CMS' consideration of our recommendations, and looks forward to working with you and our members to ensure appropriate access to quality and efficient care for Medicaid beneficiaries. If you have any questions, please contact Xiaoyi Huang at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President & Chief Executive Officer

SPECIFIC NAPH COMMENTS ON PROPOSED RULE CMS-2328-P

1. CMS should make the comparison of Medicaid payment rates to other payers and/or cost an explicit fourth prong of the access analysis.

CMS has proposed to ensure that states meet the standards of Section 1902(a)(30)(A) by implementing procedural requirements for states to perform reviews of access to Medicaid services both 1) before proposing State Plan Amendments to reduce provider payment rates and 2) on an ongoing basis, such that a subset of Medicaid covered services would be reviewed each year and access to all covered services would be reviewed every five years. CMS intended to provide flexibility to states in determining how they will demonstrate sufficient access, and thus generally has not indentified a universal set of measures or data that the states must use. Instead, the proposed regulations lay out a general framework for the issues that must be addressed in the required access reviews, adopting the Medicaid and CHIP Payment and Access Commission's (MACPAC's) access structure from its March 2011 report.[3] Specifically, CMS has proposed to incorporate the following three prongs identified by MACPAC into the regulations implementing 1902(a)(30)(A):

> States must document in their access review, using data trends and factors, an analysis that demonstrates sufficient access to care, considering, at a minimum:
>
> (i) The extent to which enrollee needs are met;
>
> (ii) The availability of care and providers; and
>
> (iii) Changes in beneficiary utilization of covered services.

Proposed Section 447.203(b)(1). While not incorporated as an explicit prong of this access framework, CMS has proposed that the reviews also include beneficiary input and state responses to that input, as well as a review of Medicaid payment data:

> (1) An estimate of the percentile, which Medicaid payment represents of the estimated average customary provider charges.
>
> (2) An estimate of the percentile, which Medicaid payment represents of one, or more, of the following: Medicare payment rates, the average commercial payment rates, or the applicable Medicaid allowable cost of the services.
>
> (3) An estimate of the composite average percentage increase or decrease resulting from any proposed revision in payment rates.

Proposed Section 447.203(b)(1)(iii)(B). The Medicaid payment data must "include all base and supplemental payments" and be stratified by upper payment limit category (i.e., state government-owned or operated, non-state government owned or operated, and privately owned or operated).

CMS' rule does not attempt to provide further guidance on the substantive standards outlined in Section 1902(a)(30)(A). For example, there is no indication of threshold percentiles that states

[3] MACPAC March 2011 Report to the Congress on Medicaid and CHIP, Chapter 4, available at http://www.macpac.gov/reports.

must meet for rates to be adequate, or particular demonstrations on other access measures. Rather, CMS will continue to exercise discretion in determining whether the results on the state's access reviews are sufficient to satisfy Section 1902(a)(30)(A). Given this approach, NAPH recommends that CMS strengthen the procedural framework in the Final Rule to ensure that there are mechanisms for access issues to at least be identified and addressed.
NAPH understands CMS' preference for a review framework that does not focus on one particular data element, but instead acknowledges that access to covered services is affected by multiple factors. NAPH members know well the complexity of ensuring Medicaid access, and have been working for years to improve accessibility through transportation, after-hours access, community-based clinics, cultural competence and translation and interpretation services, among many other efforts. That said, we believe that payment rates are directly correlated to access—as Congress itself acknowledged in enacting Section 1902(a)(30)(A)—and should be a critical part of the access review.

Several studies have demonstrated that inadequate physician payment rates under Medicaid lead to access problems. While there is less literature on the impact of inadequate reimbursement rates on access to hospital services, such impact has been documented as well. For example, studies have found that inadequate Medicaid payment affects program decisions for hospitals, and as a result, for Medicaid beneficiaries.

- "When financial performance declines, hospitals perform service-by-service analysis and reduce or eliminate money-losing programs. Services with large numbers of Medicaid patients are more likely to generate losses when payments are substantially below cost.
- Hospitals also are careful when planning new programs. Projects that are not financially feasible due to low Medicaid payment levels and high numbers of Medicaid patients frequently are not implemented.
- Low Medicaid payments also can contribute to financial distress. Low or negative margins affect hospitals in numerous ways. Distressed hospitals are at risk for closure, creating potential access problems for local communities. These facilities also are more likely to experience a change of ownership, such as mergers or acquisitions. Distressed hospitals are characterized by staff layoffs, closure of unprofitable but often needed services, and management turnover. Hospital management is not able to focus on growing or developing new programs, is at a disadvantage when attempting to recruit new staff, and may need to delay investments in facilities or needed equipment.
- When operating margins are negative for years at a time, hospitals must tap endowment and other cash reserves (if available) to fund operating expenses. Over time, negative operating margins increase the risk of financial distress and of potential bankruptcy and closure."[4]

We therefore recommend that CMS explicitly incorporate a comparison of Medicaid payments to payments from other payers in the same market, such as the data analysis at proposed section 447.203(b)(1)(iii)(B)(2), as a fourth prong of the access review under (b)(1). This analysis

[4] Lewin Group, Analysis of Medicaid Reimbursement in Oregon, February 26, 2003.

should be stratified by UPL grouping, as in the Proposed Rule.[5] The comparison should include the following elements:

> States must document in their access review, using data trends and factors, an analysis that demonstrates sufficient access to care, considering, at a minimum:
>
> (i) The extent to which enrollee needs are met;
> (ii) The availability of care and providers;
> (iii) Changes in beneficiary utilization of covered services; and
> (iv) The extent to which provider payment rates are equivalent to rates for services that are available to the general population in the geographic area, as demonstrated through a comparison to Medicare payment rates, prevailing commercial rates, or cost.

In addition, NAPH recommends that the Final Rule include the following clarifications about this fourth prong of the analysis:

a) CMS should deem a State to meet this fourth prong if Medicaid payments equal specified benchmark rates or cost.

A concern perhaps shared by both providers and states is that the Proposed Rule outlines processes, but does not provide clarity with regard to the substantive standards that CMS will apply to determine if the results of the proposed reviews satisfy 1902(a)(30)(A). To provide some clarity and predictability, while still preserving state flexibility, CMS should deem a state to meet the requirements of the fourth prong for purposes of the proposed SPA review or ongoing access review if the state can document that the proposed Medicaid reimbursement rates either (i) cover average costs incurred by providers, (ii) are equivalent to what Medicare would have paid, or (iii) equal the prevailing commercial rates in the geographic area. If the state's payment comparison does not demonstrate that it meets one of these criteria, the state would have the burden of demonstrating to CMS that such below-benchmark payment levels will not negatively affect access, through a more robust showing on the other three prongs of the access analysis. Furthermore, consistent with CMS' statement in the preamble, the Proposed Rule itself should explicitly provide that the lower the rates are in comparison to the selected comparison data (cost, Medicare rate, or prevailing commercial rates), the higher the burden on the state to make such a showing and the stricter the CMS review.[6]

[5] In assessing whether rates meet the specified benchmarks, we agree that CMS should require that states perform separate analyses to ensure that Medicaid reimbursement rates will be sufficient not only for providers overall, but also for grouping of providers that will reflect payment levels to the safety net providers often treating the most complex patients and providing critical, and underfunded, services.

[6] 76 Fed. Reg. at 26349 ("We note that Federal oversight of State reviews will likely be more stringent when the State proposes changes in provider payment of significant magnitude, or when we have other evidence, either through data or other sources, of an access problem.")

b) CMS should explicitly define "cost" applicable for purposes of this payment comparison.

If states choose to document a comparison of Medicaid rates to cost under the fourth prong of the access review analysis, CMS should clarify that cost should be calculated as the agency has defined it—i.e., through a Medicare cost reporting methodology according to the same standards as under other parts of the Medicaid program. This will help to ensure that the definition of cost is not manipulated to indicate sufficient payment rates, and will also allow CMS to compare Medicaid payment levels as compared to costs across different state Medicaid programs.

c) CMS should include in this forth prong a mechanism to ensure that the payment analysis does not mask underpayment for certain specific services that could lead to access issues.

Proposed section 447.203 describes the services for which states must perform access reviews as "each covered benefit" and "all covered services." CMS should clarify what this language means. Is this a reference to broad categories of covered services, such as all inpatient hospitals services, all outpatient hospital services, physician services regardless of specialty, etc.? We believe that it is important that the analyses not mask inadequate payment rates for particular services within these categories. For example, NAPH members provide many vital inpatient services that are not available anywhere else in their communities, but are significantly underpaid and each year result in losses to the hospitals (trauma care, burn care, neonatal intensive care, psychiatric inpatient care, etc.). Furthermore, a review of payment for physician services may not reveal issues of access to particular specialties. CMS could require states to perform the payment analysis at a more granular service level. Alternatively, given the administrative burden of completing the analysis at the service level, CMS could provide a clear mechanism for providers to identify specific access concerns to their state and directly to CMS, as described in Section 5 below.

d) CMS should exclude certain supplemental payments, such as DSH, from the access payment analysis.

Proposed Section 447.203(b)(1)(iii)(B)(3) states that "Medicaid payment rates must include both base and supplemental payments." CMS should clarify that the supplemental payments to be included in this review should not include Medicaid disproportionate share hospital (DSH) payments, as these payments include support for the uncompensated costs of services provided to the uninsured. For similar reasons, CMS should exclude payments received from uncompensated care pools, such as Safety Net Care Pools or Low Income Pools, established through Medicaid waivers.

CMS should further clarify that Medicaid HIT payments should not be included in this review, as these payments are not payments for Medicaid services and are meant to support the costs of becoming meaningful users of HIT.

e) CMS review of the fourth prong should account for the increasing role of providers in funding Medicaid payments.

CMS' review of the payment analysis under the fourth prong should factor in the reality that states are increasingly requiring providers to shoulder a greater percentage of non-federal share of Medicaid payments. To the extent that providers are funding a portion of the payments themselves (through intergovernmental transfers, certified public expenditures or provider taxes), the gross payment amounts are not fully available to pay for the cost of care provided to Medicaid patients, which will therefore have an impact on access. Particularly where payments are below the specified benchmarks described above, CMS should exclude self-funded dollars when evaluating the adequacy of payment rates as part of the access review.

2. CMS should provide guidance in the Final Rule on appropriate measures for access to hospital services and other services not addressed in the MACPAC framework, and to the extent possible, some standardized measures that can be reported across all states.

CMS' Proposed Rule aims to provide flexibility to the states in selecting appropriate measures for determining and tracking access levels. In doing so, CMS did not include any specific measures in the regulatory language, but has proposed to leave it to the states to analyze access using "data trends and factors" that consider at a minimum "(i) the extent to which enrollee needs are met; (ii) the availability of care and providers; and (iii) changes in beneficiary utilization of covered services." Proposed 447.203(b)(1). CMS provided examples of measures that states could consider in the preamble to the Proposed Rule.[7]

NAPH is concerned that the preamble guidance provided to states does not reflect issues of access to hospital services. CMS' access analysis is based on MACPAC's report, in which MACPAC explicitly states that "[t]he initial framework presented here focuses on primary and specialty care providers and services and does not specifically address hospital, ancillary, long-term care or other services and supports. Access to care for these critical services will be addressed in future work."[8] It does not appear that CMS went beyond MACPAC's preliminary framework to consider how problems of access to hospital services, and particularly access to safety net hospitals, differ from access to an appointment in a physician's office. For example, provider participation is one of the measures discussed in the MACPAC report and in the preamble to the Proposed Rule. This is a relevant measure for access to physicians, who may choose not to accept Medicaid patients. However, any hospital that participates in the Medicare program and operates an emergency department cannot opt out of providing at least emergency care for Medicaid patients, regardless of the reimbursement rates, under EMTALA. Moreover, many safety net hospitals have obligations to their local government or as part of their mission generally to provide care regardless of patients' ability to pay. Measuring the number of participating providers thus will not help to identify barriers to access to hospital services or assess whether a rate reduction will threaten the viability of a particular hospital service.

[7] 76 Fed. Reg. at 26345-46.

[8] MACPAC March 2011 Report to the Congress on Medicaid and CHIP, page 126.

At a minimum, CMS should propose measures that are relevant for all services, including hospital services and other services not addressed in MACPAC's framework. Measures should also focus on issues of particular relevance to the Medicaid population, for example, the number of providers with after-hours access, language services availability and other indicators of culturally competent care, etc. They should also demonstrate appropriate ranges of preventative, primary care, and specialty services offered to Medicaid patients and providers sufficient in number, mix, and geographic distribution to meet the needs of the number of Medicaid patients in the service area. When MACPAC completes its process of identifying a set of measures to determine and track access levels, CMS can incorporate measures as appropriate through future rulemaking or guidance. For purposes of this Final Rule, however, CMS should identify existing data and measures based on its experience and existing resources. NAPH offers to serve as a resource to CMS in helping to identify such measures.

CMS should further consider identifying a set of uniform measures for which states must collect data, or that CMS will weigh more heavily in its analysis, based on CMS experience and existing studies. This will enable CMS to compare data across states and develop a better understanding of measures that particularly impact access. CMS could still provide flexibility to states to satisfy the four prongs of the analysis using other measures, but the burden would be on the state to demonstrate the strength of its alterative measures.

Finally, CMS requested comment on its proposal to create an access review template for states and what elements should be included in such a template.[9] We agree with CMS that the template should, at a minimum, included the Medicaid payment rate comparison (as modified and made an explicit fourth prong above). This template should also include stakeholder feedback, explicitly including provider feedback, as described in Section 4 below.

3. CMS should require access review for every State Plan Amendment that reduces provider rates and approve the review before any rate reductions may be implemented, and an explicit role for CMS in post-implementation monitoring.

a) CMS should delete language suggesting that access review is triggered by a State Plan Amendment reducing provider rates only "when changes could result in access issues."

NAPH strongly supports the need for access review, including the Medicaid payment data review, whenever a state submits any state plan amendment (SPA) to reduce provider payment rates. CMS should delete language in 447.203(b)(3) requiring that states submit an access review with a SPA that would reduce provider payment rates or restructure provider payments only "in circumstance[s] when the changes could result in access issue." States should be required to demonstrate sufficient access before any proposal that would reduce provider payments. As CMS acknowledges in the preamble "it may be difficult to predict the impact that a provider rate reduction or restructuring of provider payments will have on access."[10] Therefore, the access review requirement should apply to all such SPAs.

[9] 76 Fed. Reg. at 26346.

[10] 76 Fed. Reg. at 26345.

b) CMS should only permit states to apply rate reductions prospectively.

Given the significant potential for rate reductions to affect the ability of providers to provide access to services, CMS regulations should only permit states to implement such cuts prospectively and after CMS approval. When a state submits a SPA that reduces Medicaid reimbursement rates, CMS should not approve an effective date before the approval date. Although 42 USC § 447.256(c) permits CMS-approved SPAs to become effective as early as the first day of the quarter in which the state submitted the SPA, retroactive application of rate reductions can cause hardship to Medicaid providers and, consequently, to the care provided to beneficiaries.

Similarly, it should not be permissible for a state to withhold payments to providers based on pending SPAs that would reduce rates, since that would allow a state to make a reduction even before the impact of that reduction (and the attendant compliance with the Section (a)(30)(A) standards) has been assessed.

c) CMS should require states to project the impact of a rate reduction on access.

Section 447.203(b)(3) requires states to submit, in conjunction with a SPA that reduces payment rates, an access review that was conducted within the prior 12 months demonstrating sufficient access for any service for which rates are proposed to be reduced. It is insufficient to measure access solely in the year *prior to* the rate reduction. The state should be required to project the impact of the rate reduction on access as well. (This would include, as part of the payment rate analysis under NAPH's recommended fourth prong, an estimate of the percentage decrease in Medicaid payments resulting from the proposed rate change, as CMS seems to have contemplated under proposed 447.203(b)(1)(iii)(B)(3)).

d) CMS should define in the regulations its role in post-implementation monitoring.

Section 447.203(b)(3)(ii) requires the state to develop procedures to monitor continued access to care after implementation of a SPA that reduces payment rates. CMS should at least require that states track the measures they used in conjunction with the submission of the SPA to demonstrate that the rates would not affect access prior to the SPA, should add a deadline for such a review to be performed, should require the submission of the results to CMS for review. If the review demonstrates that access has been impaired subsequent to the implementation of the rate reduction, then the rate reduction should be immediately suspended. The State should not be permitted to reestablish the rate reduction unless it submits and receives approval for a corrective action plan that includes demonstrable steps to enhance access and that is consistent with the proposal at 447.203(b)(5), as strengthened based on our comments in Section 5 below.

4. CMS should include in the regulations explicit mechanisms for providers to share concerns about access directly with CMS.

CMS has proposed certain limited mechanisms for beneficiary and other stakeholder feedback to the states as part of the access review process. In addition to broadening these feedback mechanisms to include affected providers, as described in more detail below, it is critical that CMS create a mechanism for affected providers to communicate directly to CMS both during the federal SPA review process, during the monitoring period after implementation of the SPA, and as a means of raising access concerns during the ongoing reviews, rather than requiring that their concerns to be filtered through the state. If CMS is serious about enforcing the equal access requirement, it must be able to undertake an independent assessment of the adequacy of the access, including close review of the information submitted by the state and direct information from providers, beneficiaries and others directly impacted. This right to a direct appeal to CMS will be particularly important if providers and beneficiaries lose the right to enforce these requirements in court; direct access to the agency decision makers would become their sole opportunity to have their concerns heard. While providers should and will continue to make efforts to work with their states, there are instances in which this is not possible and access may not be ensured without a means to voice access concerns to CMS directly. Furthermore, when providers raise such concerns with CMS, the agency should undertake the more stringent review described in the preamble[11] when there are potential access concerns.

With regard to the opportunities for beneficiary and stakeholder input to the state in the Proposed Rule, NAPH recommends that CMS broaden the requirements to explicitly include affected providers.

- CMS has proposed to include an ongoing mechanism for beneficiary feedback on access to care at 447.203(b)(4), and would require states to include the information collected through this process in the access reviews performed on an ongoing basis and prior to SPAs that would reduce rates. CMS should broaden this feedback mechanism to include feedback from providers, especially safety net providers such as high DSH hospitals and federally-qualified health centers. Providers will be best able to identify the impact of rate changes on more specific services potentially masked in the higher level access reviews. Furthermore, given the complexity of access issues related to hospital services and particularly critical safety net services, providers will be in the best position to identify access issues before they have significant impacts on beneficiaries.
- CMS has proposed a requirement at 447.204(a)(2) that states "consider" stakeholder feedback as part of the SPA process. Section 447.204 is entitled "Medicaid *provider participation* and public process to inform access to care," yet the language of the regulation does not actually mention providers. Section 447.204(a)(2) should be revised to refer explicitly to providers of the services subject to the rate change, especially safety net providers such as high DSH hospitals and federally-qualified health centers, as among the stakeholders whose input must be sought.

[11] 76 Fed. Reg. at 26349 ("We note that Federal oversight of State reviews will likely be more stringent when the State proposes changes in provider payment of significant magnitude, or when we have other evidence, either through data or other sources, of an access problem.")

- CMS should also require states to include provider, especially safety net provider, and beneficiary input as part of the monitoring procedures after implementation of the SPA under 447.203(b)(3)(ii).

Finally, we note that out of state providers serving the state's Medicaid beneficiaries should have a role in the access reviews. Their input should be a part of the cross-state collaboration that CMS states in the preamble that it intends to facilitate.[12]

5. CMS should clarify and strengthen the enforcement of the proposed regulations in order to ensure that this process offers meaningful protection to Medicaid beneficiaries and the providers that serve them.

a) CMS should clarify its role in developing Corrective Action Plans and their scope and enforcement.

Proposed section 447.203(b)(5) provides that:

> If a State's access review or monitoring procedures determine access issues, regardless of whether the issue would indicate noncompliance with the statutory standard, the State agency is responsible for submitting a corrective action plan to CMS with specific steps and timelines to address the issue within 90 days of discovery. While the corrective action plan may include longer-term measures, the goal for remediation of the access deficiency should be no longer than 12 months.

CMS should clarify that the state is not the sole arbiter of whether there are access issues that need to be addressed. Rather, CMS may also determine, based on the access review performed during the SPA approval process or based on the results of the ongoing reviews or feedback from beneficiaries and providers, that there is an access problem requiring corrective action, and should be involved in approving resulting plans. In developing the corrective action plan, CMS and the state should consult with providers of the relevant service(s) where access problems have been identified.

Furthermore, CMS should revise its proposed regulation so that the target deadline for compliance depends on the type of remediation activity included in the corrective action plan. For example, if the corrective action plan involves raising provider rates, it should be done immediately, not within a year. Changes to other access review indices, however, may require up to a year. The regulatory language should make clear that the corrective action plan will include a specific deadline for compliance appropriate for the particular compliance action—but in any case, not to exceed a year.

In the preamble, CMS suggested that a state could come into compliance through activities like "telemedicine or integrated models of care (such as health homes or primary care case management) policies that service to make care available in efficient and effective ways."[13]

[12] 76 Fed. Reg. at 26346.

[13] 76 Fed. Reg. at 26347.

NAPH supports such innovation and is working with its members and with federal government to share and expand innovative models. However, if the state is required to come into compliance using such methods, there should be specific targets or improvements in access measures in a short time frame—i.e., within the year. Some of these activities may not make a difference in access until a longer period of time has passed. While the state should not be discouraged from pursuing such approaches, there should be bridge measures (potentially including rate increases) during the period until those delivery system changes show results. Finally, CMS should revise the regulatory language to include explicit consequences for failure to comply with a corrective action plan. As proposed, Section 447.203(b)(5) does not provide for any consequence if the state does not comply within the specified time period. CMS should explicitly cite its ability to withhold federal financial participation, but should consider other, more targeted enforcement options that will ensure that access problems can be corrected as swiftly as possible.

b) CMS should strengthen the consequences of failing to undertake access review and public process prior to SPA approval.

Currently, Section 447.204(b) states that CMS "may" disapprove a SPA if CMS determines that service rates are modified without undergoing the rate review process defined in 447.203 and the review of public input described in 447.204(a)(2). CMS should revise this language to say that it "shall" disapprove such a SPA. Otherwise, the entire proposed access review and public process structure for SPAs will be meaningless.

6. CMS should confirm the effective date of the SPA and ongoing access review provisions of the rule.

It appears that the provisions related to state plan amendments for proposed provider rate reductions or restructuring would become effective when the Final Rule becomes effective. We would ask CMS to clarify this point. Given the number of states considering and implementing provider payment reductions, CMS should implement this requirement as soon as the Final Rule becomes effective to ensure that payment changes are not being implemented based only on budget considerations and without consideration of the 1902(a)(30)(A) standards.

CMS has further proposed that the state does not have to begin the annual reviews until January 1 of the year beginning no sooner than 12 months after the effective date of the final rule. We understand this to mean that states will have to submit their first annual review January 1, 2013 at the earliest. Given the importance of preserving access and quality, particularly before the expansion in 2014, CMS should require states to begin the access reviews as soon as possible. Acknowledging that the Final Rule may not become effective by January 1, 2012, CMS could require states to begin the reviews on the sooner of the first day of the *state* fiscal year or the first day of the calendar year after the Final Rule becomes effective.

Finally, CMS proposes that the ongoing access reviews should be completed for all services every five years. We believe this time period is too long, particularly given the upcoming Medicaid expansion. CMS should shorten this time period to three years, at least for the first set of reviews.

7. Public Notice

a. CMS should require public notice of all changes in payment methods and standards.

CMS requests comments on how to handle past confusion as to when public notice is required when a state proposes to change payment methods and standards, due to the current language of 447.205(a) that calls for notice of "significant" changes.[14] We agree with CMS' existing interpretation of this regulatory provision, which requires notice of all such changes because their impact can be quite complicated and may affect different providers differently. NAPH supports the proposed revision to 447.205(a) to remove the term "significant" in order to best reflect CMS' current interpretation. This change should not result in any additional burden to the states. First, this change would only codify CMS' existing requirement, and second, CMS has proposed to permit states to accomplish this notice through posting on the state website. Beneficiaries, providers and other stakeholders cannot identify issues that could impact access and quality of care if they are not notified prior to the implementation of changes in payment methods and standards.

b. CMS should require States to post the results of the access reviews on their website within a specified time from completion each year.

Proposed Section 447.203(b)(2)(iii) requires states to make the results of the access review available to the public, and suggests that posting to the website may be one possible option). CMS should instead require states to post the results of the review on their website by a specified deadline (possibly January 15 given that the review of some portion of services is supposed to be finished by January 1 each year). This should be a less burdensome process for the states, particularly given that states asked CMS to allow them to publish notices of rate changes through posting on their websites, and will be more transparent.

8. CMS should ensure that Medicaid managed care payment methods and procedures are also sufficient to ensure access and consistent with efficiency, economy, and quality of care.

CMS states in the preamble that it is currently undertaking a review of state managed care access standards and is considering future proposals to address access issues under managed care delivery systems. This review is critically important, as over 70 percent of Medicaid enrollees are not in some form of managed care,[15] and states are increasingly looking to Medicaid managed care as a way to limit costs. CMS should ensure that Medicaid managed care payments to providers are also sufficient to ensure access and consistent with quality of care, efficiency and economy, and that Medicaid plans and/or states undertake such a review on an ongoing basis as described in this Proposed Rule. Access and quality of care should not vary for Medicaid beneficiaries merely because they are covered under managed care versus a fee-for-service model.

[14] 76 Fed. Reg. at 26352.

[15] Kaiser Family Foundation, Medicaid and Managed Care: Key Data, Trends, and Issues, February 2010.