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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

July 5, 2011

VIA ELECTRONIC SUBMISSION TO WWW.REGULATIONS.GOV

Ms. Cindy Mann
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2328-P
P.O. Box 8016
Baltimore, MD 21244-1850

ATTENTION: File Code CMS-2328-P

Dear Administrator Mann:

Thank you for the opportunity to review and comment on the proposed rules published at 76 Federal Register 26342 on May 6, 2011 (CMS-2328-P), proposing a standardized process for States to assure that “payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers” as required by §1902(a)(30)(A). The Arizona Health Care Cost Containment System (AHCCCS) is the State Agency that administers Arizona’s Medicaid Program, the Children’s Health Insurance Program (CHIP, known as KidsCare), and other health programs which are responsible for providing quality health care coverage to more than 1.3 million Arizonans. Arizona has operated its Medicaid program, including how it provides home and community based services, through an 1115 Demonstration Waiver since the inception of the program in 1982. AHCCCS has been required to renew or apply for a new waiver demonstration period every five years, and as necessary, amended its waiver throughout any given demonstration period.

As you are aware, Arizona like many other states, has been faced with unprecedented budget challenges for the last several years. Arizona has reduced its Medicaid costs by freezing eligibility in some of its expansion populations, eliminating or limiting optional services, imposing cost sharing requirements and accelerating anti-fraud activities. In total, Arizona’s Medicaid program has had over \$924 million in cumulative reductions when all items to date are fully annualized. Additionally, Arizona reduced costs through provider rate reductions. As part of these reductions, AHCCCS worked closely with CMS to review and report on the impact of access to care for its members. While Arizona appreciates the federal government’s efforts to establish a standardized framework to assist States to comply with 42 USC 1396a(a)(30)(A), the proposed access to care rules impose significant new, unnecessary burdens on States while minimally addressing the issues arising from recent access to care litigation. Moreover, the proposed rules provide an additional framework for litigation in this area, making all but certain continuing legal challenges faced by States. The Agency’s principle concerns are that reliance on the MACPAC framework to evaluate access to care is inappropriate and that the proposed rules

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are exceedingly burdensome, are unnecessarily prescriptive, and deviate from the statutory standards as discussed in more detail below.

Overarching MACPAC framework

The Medicaid and CHIP Payment and Access Commission (MACPAC) was first established in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and later expanded and funded through the Patient Protection and Affordable Care Act (P.L. 111-148). The MACPAC's first meeting was in September of 2010, and on March 15, 2011, the report was published. CMS is proposing to adopt this first draft in the form of the proposed rule for which States have to comply. The proposed rule acknowledges CMS has never provided clear and consistent guidance on how to measure access to health care and services. Thus, it is somewhat surprising that CMS is adopting a first draft framework established by an organization (MACPAC) in existence for less than a year.

Use of the MACPAC "framework" as identified in their March 2011 report is inappropriate. The preamble to the proposed rule states "MACPAC reviewed 30 years of research and consulted extensively with key stakeholders to develop a *recommendation* on how to measure access to care for Medicaid beneficiaries" (emphasis added) 76 FR 26342, 26343. It is inaccurate to describe the MACPAC framework as a recommendation for measuring access to care for Medicaid beneficiaries. In fact, the MACPAC report contains no recommendations regarding access to care or any other issue. Nor could the report include such a recommendation as the report does not include an examination of the budgetary consequence of such a recommendation as required by law at 42 USC 1396(b)(10).

To the contrary, the MACPAC report describes the March 2011 report as follows: "this first report to the Congress is foundational and lays the groundwork for recommendations in future reports" (MACPAC, March 2011, page 1). The report explicitly states "the development of a framework for examining access to care in Medicaid and CHIP is the Commission's *first step towards fulfilling its charge related to access*. Using this initial framework, adapted as needed, *we will first identify a set of measures that are feasible to collect and monitor over time*" (emphasis added, MACPAC, March 2011, page 140). Obviously, MACPAC did not intend the framework, in its present state, to be employed as the basis for measuring access to care. MACPAC has not even determined that the measures implicit in the framework are feasible to collect. Use of the framework as the basis for this rule is clearly premature.

Furthermore, it is inappropriate to establish the framework as the basis for assessing access to care with respect to all covered services listed in section 1905 of the Medicaid Act ("...the State agency must complete the access review on a State-determined timeframe, provided that: ... (ii) All covered services undergo a full review at least once every 5 years ..." (Proposed § 447.203(b)(2), 76 FR 26361). The MACPAC report, at page 126, clearly states "the 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."

Finally, use of the MACPAC framework is inappropriate because it is clear from the March 2011 report that the MACPAC viewed its charge as different from establishing a method of determining compliance with section 1902(a)(30)(A). While the relevant provision of the

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Medicaid Act requires a comparison of Medicaid enrollee access to “the extent that such care and services are available to the general population in the geographic area,” the MACPAC report does not provide recommendations, suggested recommendations or even suggested measures for access to care in the general population. At best, the MACPAC report suggests potential (but untested) means for the initial design of measures that would measure just one side of the equation set forth as the Medicaid standard. It is simply illogical and fruitless to suggest that collecting data regarding just one aspect of a comparative standard provides any insight or guidance with respect to compliance with such a standard.

A final concern with the MACPAC framework is the third component of changes in beneficiary utilization of covered services. The ability to react to changes in the delivery system requires real time monitoring capacity. Utilization analysis presents a natural lag and requires that an analyst constantly look for a specific change in a specific service. Another option would be to closely monitor grievance and appeals activity, thus providing Medicaid managers with a real time data point when examining issues that may be occurring in a network.

Recommendation: CMS has provided oversight of the Medicaid program for over 45 years and has partnered with States to implement a number of significant changes throughout this time. States and CMS should be more directly involved in developing the framework, especially since the states will assume primary responsibility to meet the requirements. Arizona urges CMS to delay implementation of the final rule until it has worked directly with States to obtain feedback and recommendations on alternatives to accurately measure access to care.

Specific Proposed Regulatory Changes

Mechanisms for Ongoing Input

Arizona does not agree that surveys of beneficiaries’ experiences and satisfaction as required under the proposed rule at 447.203(b)(4) provide relevant information regarding compliance with the access standard in section 1902(a)(30)(A). The NPRM, at page 26345 states CMS’ position that “in general, we are confident that the Medicaid data will implicitly address general access standards in the geographic area. For example, data on beneficiary experience and satisfaction will take into account expectations based on community standards, and the percentage of community providers enrolled and accepting Medicaid patients will necessarily indicate the availability of such providers in the community.” Few individuals in the general population participate in more than one health care delivery system simultaneously. Only a fraction of Medicaid beneficiaries are simultaneously covered by another delivery system (e.g., comprehensive private health insurance). As such, it is unlikely that anyone has personal knowledge of access standards outside of the delivery system in which they participate. This is even less likely for Medicaid beneficiaries. Any opinions regarding community standards for access to healthcare are likely to be, at best, highly subjective, based on second- or third-hand information regarding impressions formed from past experiences of uncertain age.

Recommendation: While Arizona values the opinions of its beneficiaries, in this particular context, the marginal value of such opinions is immaterial to any meaningful, objective evaluation of compliance with the statutory standard. States should have flexibility to determine the best tools to obtain beneficiary feedback for complying with statutory standards.

Enrollee Needs

The Preamble acknowledges that there is no broadly accepted methodology to definitively measure access to care and services. Furthermore, the Preamble states that if beneficiaries are able to gain access to care, then the standard is satisfied regardless of other factors, including payment levels. In keeping with this approach, it is critical that States be provided discretion to determine what measures to use to evaluate access to care notwithstanding the 3 part framework articulated by CMS: enrollee needs, availability of care and utilization. The proposed rule at 447.203(b)(1)(i) requires an analysis to demonstrate sufficient access to care with consideration to the extent to which enrollee needs are met. This is a broad standard that would be difficult to assess. It also conflicts with the corresponding regulation at 447.204 which requires that “services under the plan are available to recipients at least to the extent that those services are available to the general population.” The framework established by MACPAC and adopted by CMS is much broader and is ill-defined in comparison to the actual statutory requirements.

In addition, the standards at 447.204 are also problematic if the term “general population” is meant to be a fully insured population with 100% access to care. The Equal Access statute makes clear that beneficiary access is satisfied when access to care and services are available under the plan *at least to the extent* care and services are available to the general population in the geographic area.

Recommendation: The State should not have to measure the extent to which enrollee needs are met, as this is an arbitrary requirement based on a vague statement. Rather than specify the collection and analysis of mandatory payment data elements in 447.203(b), States must be provided flexibility to determine which factors best reflect their expertise and local considerations. Although beneficiary input is helpful in providing context to access to care issues, reliance on data from hotlines and surveys is not always meaningful.

Finally, the term “general population” should be interpreted to include Medicaid members as well. The rules should clearly specify the standard, that is: that availability of Medicaid care and services may not be *less than* care and services available to the *general population* in the geographic area. States should be provided flexibility in establishing the criteria to measure whether or not Medicaid beneficiaries receive care and services equivalent to the care and services received by the general population in the geographic area.

Payment Level Comparisons

Requiring States to conduct reviews using the mandatory payment data specified in 447.203(b)(1)(B) and (C), go beyond the 1396a(a)(30)(A) standard. The proposed rule requires states to review and compare an estimate of the percentage of Medicaid payments that reflect: 1) provider billed charges; 2) either Medicare or average commercial payer rates; and 3) an estimate of the average percentage increase or decrease proposed. The Preamble states this list was developed based on how States set rates and the availability of data; however, such comparisons do not reflect a state Medicaid program’s experience with market forces in their areas for their specific populations. As an example, using Medicare rates does not account for the different levels of acuity that exist between individuals who are elderly or with disabilities to those who

are healthy young adults. They also do not account for the differences between Medicaid members and the general population with access to private commercial insurance.

Arizona opposes the proposed requirement that the access review must include an “estimate of the percentile, which Medicaid payment represents of the estimated average customary provider charges.” First, as CMS notes in section V. *Provisions of the Proposed Regulations*, “most States set Medicaid rates based on *one of the three* above noted structures to which we are requiring a comparison and the comparable data should be easily obtained” (emphasis added). It is also unclear whether “charges” refers to average billed charges or the payment that is customarily accepted by the provider as payment in full. If the former, the data is meaningless; if the later, the data is not readily available. Since the statutory standard applies to Medicaid payments, logically, the comparison should be to the payments providers generally accept from other payors. It is widely recognized that providers routinely accept less than total billed charges as payment in full from first and third party payors. As such, while information regarding billed charges appears on claims the State receives, a comparison to billed charges provides no information regarding customary payments from other payors. Unfortunately, information regarding customary payments from other payors is not publicly available for comparison. Second, while the Preamble to the NPRM (at 26353) states that CMS selected this comparison because “in [CMS’] experience, most States set Medicaid rates based on *one* of the three above-noted structures [referring to subparagraphs (1), (2), and (3) of (B)],” the proposed regulation mandates the use of all three. Furthermore, billed charges do not necessarily reflect the actual costs of services or anything meaningful to a payer. Also, this data is not readily available or accessible, thus, increasing the administrative burden for states.

Recommendation: The AHCCCS Administration urges CMS to provide States with flexibility to determine the elements most appropriate for review of access to care that are meaningful for their specific populations and programs. The Preamble recognizes that Courts are divided regarding the necessity of conducting prior cost studies before implementing provider rate cuts. Therefore, the rules should provide States with discretion to determine whether cost studies are necessary. It is also critical that the rules explicitly state that cost studies are *not required* to satisfy the access to care standards nor are they a *prerequisite* to instituting payment reductions or restructuring.

Review of all Covered Services

The proposed rules at 447.203(b)(2)(i) and (ii) require states to conduct a review of all covered services at least once every five years with a subset occurring by January 1st of each year. This poses an undue administrative burden for states that are already faced with scarce resources for everyday operations.

Recommendation: States should have the flexibility to determine whether access issues exist, the process for monitoring such issues, and how to address them.

Special provisions for proposed rate reductions

The proposed rules at 447.203(b)(3) limit State discretion in determining the elements and timing of the reviews. Mandating States to conduct a comprehensive review of all covered services once every 5 years as well as prior to submittal of a SPA in which payment levels are reduced or

restructured, without providing States the authority to establish threshold criteria or standards to trigger such reviews, is onerous, costly, and an imprudent use of the Medicaid Agency's resources. The proposed rule is not the standard required by the law and creates a number of undue administrative burdens for States. This also conflicts with States' legislative and budgetary cycles and would prevent States from making timely adjustments to rates.

Recommendation: States must be afforded the flexibility to establish criteria suitable to their programs. At a minimum, States must be provided discretion to develop criteria to determine whether an access issue even exists, regardless of payment levels and specific timeframes. If and only if access issues are identified, then the requirement for an in-depth review would be appropriate. Moreover, the rules should explicitly permit States to classify (and group) services as described in Part 440 Subpart A, e.g. outpatient services, inpatient services, physician services, services by other licensed practitioners, etc. In developing criteria regarding access, the most important measures are those which are available in real time, such as appeals, complaints, and quality management data, as opposed to information which is more remote in time and subject to lag.

Addressing access questions and remediation of access issues.

Arizona opposes the proposed requirement at § 447.203(b)(5) that mandates the creation and implementation of corrective action plans for "access issues, regardless of whether the issue would indicate non-compliance with the statutory standard." 76 FR 26361. In the absence of non-compliance, it is unclear what the State is expected to correct. The proposed regulation does not purport to establish any access standard other than the statutory standard. Compliance with this proposed regulation will be impossible to achieve because the proposed regulation provides no guidance on what type of "corrective action" is necessary to correct a "deficiency" that is not based on "non-compliance" with either the statutory standard or an unstated regulatory standard. While the preamble to the NPRM (at 26347) states that CMS is proposing to "allow" States to identify access issues, the text of the proposed rule mandates the identification of access issues.

Recommendation: At best, this requirement will likely result in extended disagreements between the State and CMS regarding the need for "corrective action plans" to address undefined "access issues." At worst, it presents an endless opportunity for providers and eligibility individuals to bring enforcement actions against the State. Given the structure of this proposed regulation, the outcome of any such litigation will inevitably be determined by ad hoc judicial determinations creating great uncertainty and burden in the administration of the program.

Provider Participation and Public Process

The proposed rule at 447.204 requires states to have ongoing mechanisms for beneficiary feedback, even if the proposed rate change doesn't have an impact on continued service access. It also requires states to have a process for tracking and responding to such input. Requiring this level of monitoring is disconcerting given States' lack of resources and staffing shortages, especially in light of all of the upcoming changes that will occur with health care reform.

Recommendation: The Agency supports the proposed regulation recognizing electronic publication as a means of complying with public notice requirements. However, the AHCCCS

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Administration strongly opposes removal of the term "significant" in 447.205 for purposes of providing public notice. It is urged that the rules be revised to allow States to define what constitutes "significant." In addition, potential access issues should not impact or delay the SPA review and approval process. Furthermore, States already have and use other timely and quantifiable tools for obtaining member feedback and identifying potential access issues including the grievance and appeals process, quality monitoring and performance measures. Should CMS require a public input process, the proposed rule should be revised to include a threshold for states to use in determining when such input is needed.

I respectfully request CMS to consider delaying the effective date of the proposed rules, allowing time to work with States to develop a framework that correlates with addressing access to services issues. This includes how to identify whether access issues exist and the means to address them. CMS should also reconsider the estimated impact of the proposed rules. Arizona believes that the cost estimates significantly understate the true cost of implementing the proposed regulations. I share the goal of ensuring our members have sufficient access to services and am confident with the mechanisms AHCCCS currently has in place for monitoring and addressing access to care when issues of concern surface.

I appreciate this opportunity to comment on the proposed rules and to provide Arizona's perspective regarding these provisions. Please contact my office if you have any questions or concerns.

Sincerely,



Monica Coury
Assistant Director

cc: Steve Rubio
Jessica Schubel
Cheryl Young