Georgetown University
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CENTER FOR CHILDREN
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VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: 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 Sir or Madam:

Thank you for the opportunity to comment on proposed rule 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."

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act.

Summary

Medicaid is the health insurer for 37 million children – some 40% of our Nation's children, who account for half of all Medicaid beneficiaries.[1] As a health insurer, Medicaid's job is to make sure that children enrolled in the program have access to the services they need that the program covers. Medicaid can't do its job if it doesn't know whether the children it covers are getting access to the services they need. For the millions of children in fee-for-service (FFS) Medicaid, the Access Rule issued by CMS in November 2015 is intended to give CMS and state Medicaid agencies the information they need to make evidence-based determinations about the

accessibility of covered services and the effect of proposed provider payment reductions on access. It is also intended to make the process of measuring and improving access transparent to stakeholders and the public.

Proposed rule CMS-2406-P would effectively gut the Access Rule, to the severe detriment of children and families and other Medicaid populations. It would exempt a third of all states from the Access Rule's transparency requirements altogether, leaving at least 3.9 million enrollees in FFS Medicaid, including 660,000 children, without the Rule's protections. And it would give the remaining states a safe harbor to cut payments to providers by 4% per year (6% over two years) without obtaining input from stakeholders or monitoring the effects on access, regardless of how low the rates being cut already are. Because of the way in which the proposed 4%/6% safe harbor would be calculated, states could literally cut payments to providers for EPSDT screening services by 100% without being required to consider or explain the potential effect on access.

The rationale for these proposals is to provide "burden relief" for states. 83 FR 12696 (March 23, 2018). This rationale is incoherent. The whole purpose of Medicaid is to pay for medically necessary services for eligible individuals. Without access to providers, by definition, no medically necessary services can be provided. Thus, if Medicaid is to achieve its purpose, children (and other populations) must have access to the providers of the services they need. The Access Rule is designed to enable states and CMS to determine whether there is access – i.e., whether Medicaid is achieving its purpose. That is an administrative responsibility for the states and CMS, not an administrative burden. The current Access Rule imposes some modest administrative responsibilities, such as preparation of an Access Monitoring Review Plan, and requires transparency. Gutting the Rule is not defensible on either a statutory or policy basis.

Children and families covered by Medicaid would be far better served by strengthening the Access Rule, not gutting it. There have been only two years of operational experience with the Access Rule, and while the quality of the first round of state Access Monitoring Review Plans (AMRPs) is variable, some show great promise in measuring access in a way that enables states to identify and correct gaps without undue administrative burden. We urge CMS to withdraw the proposed changes and instead require the next round of AMRPs to use a standardized set of data sources that would better inform CMS and state agency decision-making, as well as stakeholder and public understanding, regarding the access implications of cutting provider payment rates.

Our comments include numerous citations to supporting research, including links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text

of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

The Importance of Access to Children Enrolled in Medicaid

The preamble to the proposed rule focuses extensively on what CMS characterizes as the "administrative burden" for states associated with the Access Rule. The preamble gives far less attention to the central point of the statutory requirement that the Access Rule implements: promoting access to covered services by ensuring that payments to providers are "sufficient to enlist enough providers so that care and services are available under the [state Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area," section 1902(a)(30)(A) of the Social Security Act. In short, access to covered services is an important objective of the Medicaid program, which is why the Access Rule is so important to children and families and other beneficiary populations.

The research is clear that children covered by Medicaid have better access to needed care than do uninsured children. Compared to uninsured children, children with Medicaid or CHIP are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last two years.[2] Children with Medicaid or CHIP are also more likely to receive preventive care and have a personal physician or nurse than children who are uninsured.[3] The same study found that children who are uninsured are more likely to have unmet medical and dental needs than children with Medicaid/CHIP coverage.[4] Mothers covered by Medicaid are more likely than uninsured mothers to have a regular source of care, a doctor visit, and to receive preventive care.[5]

The research results are similar for parents. Parents and other adults covered by the Medicaid expansion under the Affordable Care Act (ACA) were more likely to have a personal doctor and have a dental visit than adults living in states that did not expand Medicaid.[6] Uninsured adults who gained coverage through Medicaid were almost twice as likely to have an annual checkup than individuals who remained uninsured.[7] Similarly, a study that focused on Medicaid eligibility expansions for parents between 1997 and 2009 found improved mental health outcomes for low-income parents.[8] Medicaid coverage may play a particularly important role improving access to mental health care; participants in the Oregon Experiment reported significantly better mental health with no significant changes in physical health one year after gaining coverage.[9]

The research is also clear that children and families covered by Medicaid have access to needed services comparable to that of children and families covered by private insurance. One study found that children with Medicaid or CHIP coverage are more likely than children with employer-sponsored insurance (ESI) to have a routine checkup.[10] Children with Medicaid or CHIP coverage are equally likely to

have a regular source of care, and they experienced similar levels of difficulty finding general doctors, specialists and dentists compared to children with ESI.[11] These and other studies demonstrate Medicaid's success as a health insurer at improving access to care for low-income children and families.[12] They also underscore the important role of the Access Rule going forward. One purpose of the Access Rule is to help states comply with the statutory "equal access" requirement by identifying access measures, collecting baseline data, and establishing thresholds and incorporating the resulting analysis into their decision-making on payment rates. Another is to enable CMS to make evidence-based determinations as to whether a state's proposed payment rate cuts or restructuring complies with the statutory requirement for equal access. Both purposes are integral to maintaining the access gains that the research shows Medicaid has achieved.

The Importance of Provider Payment Rates to Access for Children Enrolled in Medicaid

Provider payment rates are not the only determinant of access to care. But the research confirms what common sense tells us, and what the Medicaid statute requires: payment rates do matter, so much so that they must be "sufficient to enlist enough providers so that care and services are available under the [state Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area," section 1902(A)(30)(A).

There is evidence that reductions in Medicaid provider payment rates result in diminished access. One study found that provider payment reductions led to a significant increase in the likelihood that a Medicaid enrollee had no provider visits in the last year.[13] In addition, the study found that payment reductions led Medicaid enrollees to seek more care in hospital outpatient departments instead of physicians' offices.[14] Decreases in payment significantly increase the likelihood that Medicaid enrollees are diagnosed with pregnancy complications, asthma, hypertension, abdominal pain, and urinary tract infections in an emergency department instead of a physician's office.[15]

There is also evidence that increases in Medicaid provider payments result in improved access. The increase in Medicaid payment rates for primary care providers to Medicare levels in 2013 and 2014 improved some measures of access to care. A "secret shopper" study in 10 states found that the availability of Medicaid primary care appointments increased by 7.7 percentage points after the reimbursement increase.[16] The study also found that states with larger reimbursement increases tended to have larger increases in appointment availability.[17] Research also shows that this primary care "bump" was particularly important for children. After the payment increase, office-based primary care pediatricians increased their rates of Medicaid participation.[18] **Our review of the literature on the relationship between Medicaid payment reductions and access to care finds that there is no support for the assumption that "nominal"**

cuts will not matter. The literature finds the opposite: that payment reductions will negatively impact access to care.

The Importance of the Current Access Rule for Children Enrolled in Medicaid

The Access Rule implements the Medicaid statute by requiring all state Medicaid agencies to (1) analyze whether beneficiaries have access to care; (2) take corrective action if access deficiencies are identified; (3) demonstrate sufficient access if the agency proposes to reduce provider payment rates; and (4) if CMS approves a payment rate reduction or restructuring, monitor continued access to care for at least three years. Although the Medicaid statute makes no such distinction, CMS has chosen to apply these requirements to FFS Medicaid only.

The mechanism for analyzing whether FFS beneficiaries have access to care is the Access Monitoring Review Plan (AMRP). The Access Rule requires each state to develop an AMRP and update it once every three years. The first round of AMRPs were due to CMS by October 1, 2016. The AMRP must contain an analysis of access to services that are of critical importance to children as well as other populations: primary care services (including dental care); physician specialist services; and behavioral health services. 42 CFR 447.203(b)(5). All of these are key elements of the EPSDT benefit which, as CMS has explained, has as its goal that "individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting."[19] In addition, the AMRP must contain an analysis of access to pre- and post-natal obstetric services, including labor and delivery, which are of foundational importance not just to pregnant women but also to the children they bear.

Under the current Access Rule, if a state Medicaid agency seeks to reduce (or restructure) FFS payment rates, it must first consider the access analysis it performed in its AMRP, and it must receive input on access from beneficiaries, providers, and other affected stakeholders. 42 CFR 447.204(a). If, following this consideration and input, the agency decides to submit a State Plan Amendment (SPA) proposing the reduction or restructuring to CMS, it must accompany that submission with an access review. In accordance with the AMRP, the access review "must demonstrate sufficient access for any service for which the state agency proposes to reduce payment rates or restructure provider payments to demonstrate compliance with the access requirements at section 1902(a)(3)(A) of the Act." 42 CFR 447.203(b)(6).

A state's AMRP, along with its access review, also inform CMS's review of a State Plan Amendment (SPA) that proposes a provider payment rate reduction or restructuring. If CMS, after reviewing the access data presented, approves the SPA, the Access Rule requires the state agency to monitor, at least annually, for at least three years, whether there is continued access to care. 42 CFR 447.203(b)(6)(ii). The state's monitoring procedures are established in its AMRP. Because the AMRP

is subject to public review and comment prior to submission to CMS, 42 CFR 447.203(b), advocates for children and the providers who serve them have an opportunity to provide input regarding the measures, baseline data, and thresholds the state uses to monitor access to care.

In sum, **the procedural protections contained in the Access Rule are essential to children and the providers that serve them. These requirements are designed to ensure that state agency decisions to reduce or restructure payments are transparent and informed by analysis and stakeholder input. This is particularly important in ensuring continued, sustained access to EPSDT services, including primary care, physician specialist care, and behavioral health care.**[20]

The Proposed Rule Will Undermine Access for Millions of Children Enrolled in Medicaid

Children do not choose the states in which they live, and they do not choose whether they are covered through FFS or managed care Medicaid. *The proposed rule would eliminate all of the Access Rule's protections for children in FFS Medicaid in 18 states with managed care enrollment of 85 percent or greater. At least 3.9 million beneficiaries, including 660,000 children, would be left unprotected.* In addition, the proposed rule would create a safe harbor for payment rate cuts to EPSDT providers such that rate reductions could far exceed 4% in one year or 6% over 2 consecutive years without any access review or monitoring protections for children in FFS Medicaid.

Upon detailed examination, these proposed changes lack a convincing statutory or policy rationale and will undercut the ability of CMS to monitor and enforce compliance with the statutory equal access requirement in section 1902(a)(30)(A). Taken as a whole, these changes will not increase access to care by Medicaid FFS populations. Instead, they will almost certainly result in reduced access to care in those states that use the proposed high managed care exemption or the proposed 4%/6% safe harbor to cut provider payment rates. Our specific comments follow:

1.) *There is no statutory rationale for excluding over 660,000 children in high managed care states from the Access Rule's protections.* Under the proposed rule, states with an overall, comprehensive, risk-based managed care enrollment rate of 85% or more would be exempt from the requirement to develop an AMRP, to provide CMS an access review when it proposes a SPA to cut provider payment rates by any amount, to undertake a public process to solicit input on the access impact of a proposed rate reduction or restructuring, or to monitor the access effects of any approved rate reduction or restructuring for at least three years.

According to the Kaiser Medicaid Managed Care Tracker,[21] 18 states (AZ, DC, FL, HI, IA, KS, KY, LA, MD, NE, NJ, NM, OH, OR, RI, TX, UT, and WA), including the District of Columbia, had an MCO penetration rate of 85% or more as of July 1, 2017. We

analyzed the enrollment data submitted in these states' AMRPs.[22] The results are presented in Table 1. Fifteen out of the 18 states reported fee-for-service (FFS) enrollment. Total FFS enrollment in the 15 reporting states is roughly 3.9 million. Only 8 out of the 18 states reported a FFS child enrollment figure. At least 17% of total FFS enrollment – 660,000 – are children.

As is obvious from the Table, the data relating to overall FFS enrollment, and FFS enrollment by children, are incomplete. The 3.9 million total, and the 660,000 count for children, are both undercounts of the number of enrollees in FFS Medicaid in the 18 exempted states.

Table 1. Total FFS enrollment and FFS enrollment of selected populations

State	Total FFS enrollment	FFS children
AZ	210,000	
DC	62,485	6,350
FL	791,985	
HI	61	
IA		
KS		
KY	130,000	
LA		
MD	100,107	3,504
NE	2,500	
NJ	105,690	30,151
NM	78,318	37,654
OH	652,339	2,196
OR	162,256	
RI	41,210	2,473
TX	1,111,778	580,454
UT	112,277	
WA	338,657	1,509
Total	**3,899,663**	**664,291**
Percent of the total	**100%**	**17%**

There are several states where children are a particularly large share of FFS enrollment. Children are 10% of FFS enrollment in the District of Columbia, 29% in New Jersey, 48% in New Mexico, and 52% in Texas. In New Mexico, the vast majority of children enrolled in FFS are American Indian.

CMS has not explained how excluding at least 660,000 children in FFS Medicaid in these 18 states from the Access Rule's protections will ensure

access to needed services for these children. Nor has it explained how the exclusion will enable CMS to determine whether these 18 states are complying with section 1902(a)(30)(A) with respect to payment rates for services needed by these children. We request an explanation on both points.

2.) *There is no policy rationale for excluding at least 660,000 children in high managed care states from the Access Rule's protections*. Even assuming there is a statutory rationale for excluding children in FFS Medicaid in the 18 exempted states from the Access Rule protections, what is the policy rationale? CMS has not explained how it is "administratively burdensome" for a health insurer for children to assess whether the children it covers through FFS have access to EPSDT and other needed services. Nor has CMS explained how it is "administratively burdensome" for state Medicaid agencies to consider the implications for access of children to EPSDT and other needed services before proposing reductions in payments to providers? We request an explanation on both points.

3.) *Under the proposed rule, CMS would likely have insufficient data on which to review FFS payment rate cuts proposed by high managed care states for compliance with Medicaid law.* Under the current Access Rule, all states must submit access reviews based on their AMRPs when they propose SPAs to reduce FFS provider rates. Under the proposed rule, states with 85% or greater managed care penetration (currently 18 states) will be required only to submit an "alternative analysis and certification" that demonstrates compliance with the equal access requirement of section 1902(a)(30)(A). The proposed rule does not specify any content to this "alternative analysis," but it is clear that this analysis would not be grounded in the access measures or baseline data contained in the state's AMRP, since these states would be exempt from the requirement of developing and updating an AMRP.

If the proposed rule is adopted, how will CMS carry out its responsibility to review any rate reduction or restructuring SPAs submitted by exempt states for compliance with the requirement of the Medicaid statute that payments be "sufficient" to ensure access to services for children and other populations? On what data will CMS base its decision to approve or disapprove a proposed rate reduction SPA? If CMS decides to approve a proposed SPA, how will CMS know what the effect of its approval is on beneficiary access to services, since the state would be exempt from the three-year monitoring requirement? CMS has not explained how it would resolve any of these critical operational issues. We request an explanation on all three points.

4.) *There is no statutory rationale for exempting FFS provider payment cuts of less than 4% in one year or 6% over two years from analysis of access effects by either the state Medicaid agency or CMS.* Section 1902(a)(30)(A) requires that payment rates be "sufficient to enlist enough providers so that care and services are available under [the state Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area." This is a

requirement for state Medicaid programs and compliance with the requirement is the responsibility of CMS. There is no exception for payment rates that are cut less than 4% in one year or 6% over two. Nor is there any authority for the Secretary to create such an exception. All payment rates must be "sufficient" to achieve equal access, regardless of how much they are cut.

Under the proposed rule, states that do not meet the 85% or greater threshold for managed care enrollment would nonetheless be exempt from the requirements for an access review and post-cut monitoring if the proposed reduction or restructuring of provider payment would be below 4% for a Medicaid service category in total within a single State Fiscal Year and 6% over two consecutive SFYs. CMS has articulated the statutory basis for this safe harbor. We request an explanation.

5.) *The proposed safe harbor for payment cuts of 4% in one year or 6% over two will be extraordinarily difficult for states and CMS to operationalize.* Under the proposed rule, the 4%/6% safe harbor threshold is not tied to payment rates specific to procedure codes. Instead, it is tied to "overall service category *spending*". Medicaid spending is a function not only of the payment rate for a procedure code but also the number of times that code is billed and paid for on behalf of a beneficiary, which in turn reflects the utilization of the service being targeted for cuts. If utilization of a specific procedure code was relatively infrequent, a cut in a rate for that procedure code could be well above 4%/6% before *spending* in that procedure code's service category was reduced by 4% or 6%.

In our analysis below of why the 4%/6% safe harbor is fundamentally irrational, we focus on rates by procedure code. However, we are not responsible for administering the Access Rule or the proposed 4%/6% safe harbor; CMS is. CMS has not explained how it will determine whether the 4%/6% threshold is met. What specific documentation (procedure codes affected, code-specific utilization, overall spending in the service category, etc.) will CMS require states to submit when claiming the 4%/6% safe harbor? Is it feasible for CMS to determine, based on the documentation submitted, whether a state's rate-cutting SPA qualifies for the 4%/6% safe harbor? What is the estimated administrative cost of the state production and CMS review of this documentation in terms of FTE hours? We request CMS's explanation on all three points.

6.) *The proposed safe harbor for payment cuts of 4% in one year or 6% over two is fundamentally irrational.* In preparing these comments, we reviewed the October, 2016 AMRPs of 20 states: 18 with high managed care enrollment, plus California and Nevada. (CA and NV were included because CCF works with organizations in those states to improve access to care by children and families). Ten of these AMRPs included a comparison of provider reimbursement rates. States most commonly compared their FFS Medicaid reimbursement rates by procedure code to those in Medicare or Medicaid in a neighboring state. We selected a sample of reimbursement rates reported by states in their AMRPs and modeled a four and six

percent payment reduction. The results appear at Tables 2 and 3.

Table 2 presents rates paid by California for pediatric dental services and Iowa for pediatric evaluation and management. A 4% reduction in the California payment rate for pediatric dental services would reduce it from 52% to 50% of the rate for those same services in Texas; neither rate is likely to address the low access to dental care for Medicaid children.[23] A 4% reduction in the E&M rate in Iowa would reduce it from 63% to 60% of the Medicare rate for that service. Again, this rate cut is not likely to enhance access.

Table 2. Projections of allowable payment rate cuts to pediatric providers under the NPRM

State	Procedure code	Description	Medicaid rate	Comparison group and rate	Percent of comparison's rate	Percent of comparison's rate after 4% cut	Percent of comparison's rate after 6% cut
CA	D0120	Pediatric oral evaluation	$15.00	Medicaid in Texas ($28.85)	52%	50% (rate reduced to $14.40)	49% (rate reduced to $14.10)
IA	99213	Evaluation and management (can be used by pediatricians, for behavioral health services, and more)[24]	$43.23	Medicare ($68.37)	63%	61% (rate reduced to $41.50)	59% (rate reduced to $40.64)

Table 3 shows how a 4% (or 6% over two years) rate reduction is likely to have very different implications for access depending on the payment rate against which the reduction is taken. California reported a payment rate of $15 for primary care services, or 52% of the rate in Texas; a 4% cut in California's payment rate would reduce it to 50% of the Texas rate. In contrast, Nevada reported paying $25.01 for a chest x-ray, or 107 % of the Medicare rate. If Nevada were to reduce its payment rate by 4%, it would still pay more than the Medicare rate.

Table 3. Projections of allowable payment rate cuts to pediatric providers under the NPRM

State	Procedure code	Description	Medicaid rate	Comparison group and rate	Percent of comparison's rate	Percent of comparison's rate after 4% cut	Percent of comparison's rate after 6% cut
CA	None included	Primary care services	$15.00	Medicaid in Texas ($28.85)	52%	50% (rate reduced to $14.40)	49% (rate reduced to $14.10)
NV	71010	Chest x-ray 1	$25.01	Medicare ($23.35)	107%	103% (rate reduced to $24.01)	101% (rate reduced to $23.51)

The potential access implications of the same 4% cut in these two different circumstances are very different. The California payment rate for primary care services seems highly problematic even before a 4% cut; at a minimum, the state should be analyzing the effect of its current low payment rates on access to primary care services for children and other populations; any reduction from those already low levels should require a higher level of scrutiny, not a safe harbor exemption. The Nevada rate, in contrast, is already more generous than the rate Medicare pays; it is reasonable to presume that the Medicare rate, while likely not as generous as the commercial rate, is not a barrier to access, so that a rate higher than the Medicare rate would likely not raise red flags.
CMS has not explained the statutory or policy rationale for exempting from access review provider rate cuts of less than 4% in one year or 6% over two regardless of the rate against which the reduction would be taken. What is the statutory rationale? The policy rationale?

7.) *As proposed, the basis for calculating the 4%/6% safe harbor threshold would enable cuts to EPSDT service providers well above 4% or 6%.* Under the proposed rule, the 4%/6% threshold would apply to "overall service category spending," proposed 447.203(b)(6)(ii). The preamble explains: "For purposes of this proposed rule, service categories are those generally defined under sections 1905(a)(1) through (29) of the Act (that is, inpatient hospital services, outpatient hospital services, other laboratory and X-ray service, etc.) and other applicable sections that specify categories of services eligible for medical assistance under the State plan." (83 FR 12699).

EPSDT is the pediatric Medicaid benefit.[25] It is especially important for children with special needs, who often need access to specialist or long-term care services.[26] As a statutory matter, EPSDT is located within the overall service category 1905(a)(4), along with nursing facility services, family planning services and supplies, and tobacco cessation services for pregnant women.

Using national FY 2016 expenditure reports from MBES/CBES, we modeled a 4 percent payment reduction to the 1905(a)(4) service category. [27] As shown in Table 4, below, the total national expenditure for medical assistance in this service category was roughly $41.85 billion, with nursing facility services accounting for $41 billion of the total.[28] A 4% reduction in payments in this service category would equal about $1.67 billion, which is almost double the total spending on EPSDT screening services. **Thus, under the proposed rule, states on average could cut payments for EPSDT screening services by as much as 100% without breaching the 4% threshold.**

Table 4. Medical Assistance Program Expenditures, FY 2016

Service Category	Total Expenditures
EPSDT screening	$846,860,331
Family planning	$1,617,186
Nursing facility services	$41,001,035,349
Tobacco cessation for pregnant women	$254,999
Total	$41,849,767,865

CMS has not explained the statutory rationale for designing a safe harbor for provider payment reductions or restructurings based on statutory service categories. Nor has CMS explained the policy rationale for exposing EPSDT providers and the children they serve to deep rate cuts with no access review. What are the statutory and policy rationales?

8.) *Even if EPSDT is its own "overall service category," the 4%/6% rate cut threshold remains arbitrary and allows capricious policy results.* Despite the unambiguous language in the preamble, we will assume for purposes of these comments that nursing facility services, EPSDT, family planning services and supplies, and tobacco cessation services for pregnant women are each their own "Medicaid service category," so that the 4%/6% are measured against spending on EPSDT services only. CMS has not explained how it intends to apply the 4%/6% threshold to EPSDT, or what the implications of the 4%/6% threshold (however applied) are for access to EPSDT services. This is critical because the children remaining in FFS (whether in exempt or non-exempt states) are likely to be high-cost, high-need children for whom access to EPSDT services is particularly important.

Would the 4%/6% threshold apply equally to each component of EPSDT – i.e., screening services, diagnostic services, and treatment services? If it applied equally to each component, how would that affect payment rate cuts in the treatment services component, which includes physician specialist care, hospitalizations for complex conditions, behavioral health services, developmental interventions, etc. Or would CMS aggregate all components, so that states could cut payment rates for the less expensive screening and practitioner services by more than 4%/ 6% while still staying under the safe harbor threshold because of the higher cost of, say, institutional treatment services?

We respectfully request that CMS provide a public explanation and analysis of the impact of 4%/6% FFS rate cuts on EPSDT services, including the amounts spent for each component of EPSDT services for the most recent FY for which data are available. We also request the CMS make public the evidence it has that access to the entire range of EPSDT services by children in FFS Medicaid is currently adequate in each state that is not a high managed care state so that provider payment rates can be cut by 4%/6% with no likely reduction in that access.

9.) *A rate cut of 4% in one year or 6% in two can affect not just payment rates in FFS Medicaid but also those in managed care Medicaid.* The preamble to the proposed rule asserts that a reduction of 4% or 6% is "nominal." (83 FR 12699). We disagree with this assertion – such a cut is not insignificant—especially when the cut is taken against an already low FFS payment rate. More importantly, in characterizing a 4%/6% payment reduction as "nominal," CMS ignores the potential impact of FFS rate reductions on state capitation payments to managed care organizations (MCOs) and on MCO payments to network providers. These potential effects magnify the consequences of permitting so-called "nominal" rate reductions on children and families, as the large majority of children enrolled in Medicaid are enrolled in Medicaid MCOs.

States that elect to enroll children in MCOs must pay those MCOs capitation rates that are actuarially sound. In determining those rates, states and their actuaries may rely on fee-for-service claims data. See, for example, the *2017-2018 Medicaid Managed Care Rate Development Guide* (April 2017), section 2.B.ii.(a) at pp. 8-9.[1] **Thus, reductions in payment rates to FFS providers for EPSDT and other services to children could affect not only access by children in FFS Medicaid, but could also result in downward adjustments to capitation rates for rate cells affecting children enrolled in MCOs. And in MCOs that base their payment rates to network providers on the state's Medicaid FFS rates, rate reduction could flow through to MCO network providers as well.**

We are unaware of any publicly available data regarding which states rely on FFS payment rates in setting MCO capitation rates. Because CMS reviews all state actuarial rate certifications, CMS is in a position to determine how many states rely on FFS payment rate data in certifying rate cells for children, and how many children are affected by those rates.

We respectfully request that CMS explain which states base their MCO capitation rates on FFS provider rates so that it is possible to assess whether an FFS rate reduction is truly "nominal". If a state's proposed 4% (or 6% over two years) reduction of payments to FFS providers will also result in a corresponding reduction in that state's capitation payments to MCOs for children or other enrolled populations, how does CMS believe that such a reduction could rationally be considered "nominal"?

There is some information available on state policies regarding MCO payment rates to network providers. According to the Kaiser Family Foundation, 18 states require MCO rates to follow FFS rate changes for some provider types and 2 states (LA and

[1] Centers for Medicare and Medicaid Services, "2017-2018 Medicaid Managed Care Rate Development Guide" (Washington: Centers for Medicare and Medicaid Services, April 2017), available at https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2018-medicaid-rate-guide.pdf.

MS) require MCO payment rates to be the same as FFS payment rates for all provider types.[29] In these 20 states, cuts in payment rates to FFS providers may translate directly in cuts to MCO network providers.

CMS has given no indication that it has considered the implications of reductions (or restructurings) of FFS payment rates on payment rates for MCO network providers and the consequences for access to care by children enrolled in MCOs. Given the potential ripple effect of FFS payment cuts, how can even those below the 4%/6% threshold be considered insignificant? We request an explanation.

10.) *The proposed requirement for an "alternative analysis and supporting documentation" would not ensure compliance with Medicaid's access requirement.* Under the proposed rule, states proposing rate reductions or restructurings below the 4%/6% threshold would not be required to consider access data in their AMRP, to solicit input from providers and beneficiaries, or to submit an access review to CMS for purposes of its review of the state's SPA. Instead, they would be required to submit to CMS "an alternative analysis, along with supporting data, to demonstrate compliance with section 1902(a)(30)(A) of the Act…." (proposed 447.204(d)). The proposed rule does not specify what information this "alternative analysis, along with supporting data," should contain. The preamble at 83 FR 12700 requests comments "to inform future sub-regulatory guidance to states."

This provision does not make sense. CMS is the agency with responsibility for enforcing compliance with section 1902(a)(30)(A). It exercised that responsibility by publishing, after notice and comment rulemaking, the current Access Rule. That Rule requires that states, in their AMRPs, set forth specific measures the state uses to analyze access to care as well as baseline data associated with the measures, 447.203(b)(4). To the extent that states are in compliance with this requirement, the AMRPs they submitted and that were posted on the CMS website, already set forth the access measures and baseline data that would be the basis for any access review.

As indicated above, we do not believe there is any statutory or policy basis for creating a safe harbor for rate reductions or restructures below 4%/6%. Even if CMS has the authority to create such a safe harbor, there is no reason to substitute an "alternative analysis with supporting data" for the current access review. *The complying states have already submitted access measures and baseline data in their October 2016 AMRPs; all they would need to do is apply these measures and baseline data (updated as appropriate) in their access review submission to CMS*. Noncomplying states should be required to resubmit AMRPs with specific measures and baseline data that can then be incorporated in their access reviews.

CMS has not explained how, in reviewing SPAs that reduce or restructure FFS provider payment rates, it will be able to make an informed determination as to whether the state is in compliance with section 1902(a)(30)(A) without these

measures and baseline (and updated) data. On what other measures or data would CMS rely? We request an explanation.

The proposed changes in the Access Rule would undermine access by Medicaid populations other than children.

In these comments we have focused on the harms of the proposed changes in the Access Rule for children and the providers who serve them. We emphasize, however, that the proposed exemption for high managed care states and the safe harbor for 4%/6% payment cuts would also undermine access for other vulnerable Medicaid populations for whom access is crucial, including pregnant women, individuals with disabilities, and dual eligibles. Each of the concerns identified above, except those specific to EPSDT services for children, would apply to the other populations. Before proceeding with any changes to the current Access Rule, CMS should conduct a thorough analysis of the potential implications of the proposed changes for each of the vulnerable subpopulations in Medicaid.

The Access Rule should be Strengthened to Make Medicaid Work Better for Children

In the preamble to the proposed rule at 83 FR 12698, CMS states "… in the future, and informed by stakeholder feedback, we may look to adopt a more standardized form and content for the states' AMRP submissions." We urge CMS to withdraw its proposed changes to the current Access Rule and instead focus on improving the content of AMRPs, especially as they relate to access to EPSDT by children. We believe that better AMRPs would enhance the ability of state Medicaid agencies, CMS, and other stakeholders to assess access in FFS Medicaid and compare access between FFS Medicaid and managed care Medicaid.

In preparing these comments, we reviewed each of the AMRPs submitted by the 18 states that would be exempt from the Access Rule under the proposed rule, as well as that of California and Nevada. As shown in Table 5, four data sources were in common, although not universal, use: (1) FFS enrollment, (2) provider enrollment; (3) reimbursement rates compared to other payors, and (4) CAHPS or call center data regarding enrollee experiences and complaints. This strongly suggests that these data sources are both important to states and administratively feasible to collect and analyze.

There is a logic to these data sources: it is impossible to measure access to services in FFS Medicaid, and the effect of payment on that access, unless you know how many enrollees are in FFS, how many providers are enrolled to serve them, what those providers are being paid by Medicaid in relation to other payors, and whether beneficiaries are satisfied with their access to needed services. We believe CMS should require state Medicaid agencies to use all of these data sources in developing their next AMRPs. And, in each case, CMS should require that the data sources identify: children under 18 from other FFS enrollees; EPSDT providers from other

providers; payment rates for EPSDT services from other payment rates for other services; and beneficiary satisfaction/complaint results for children specifically.

Table 5. Data Sources in October 1, 2016 AMRPs for 20 Selected States

State	FFS enrollment	Provider enrollment	Reimbursement rates compared to other payers	CAHPS/ survey data/ call center data
Arizona	x			
California	x	x	X	x
District of Columbia	x	x	X	x
Florida	x	x		
Hawaii	x			
Iowa			x	x
Kansas				
Kentucky	x			
Louisiana				
Maryland	x	x		x
Nebraska	x	x	x	
Nevada	x	x	x	
New Jersey	x			
New Mexico	x	x	x	x
Ohio	x	x	x	x
Oregon	x		x	x
Rhode Island	x		x	
Texas	x	x		
Utah	x		x	x
Washington	x	x	x	

We note that some states developed far more sophisticated measures and data sources. For example, the District of Columbia AMRP https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/dc-amrp-2016.pdf includes: (1) a comparison of FFS payments to payments by MCOs to network providers; (2) the percentage of licensed providers (by type) that are enrolled in Medicaid and the percentage that billed for at least one service during the year; (3) utilization (example: primary care utilization) and (4) separate data on FFS utilization by children.

The FFS utilization data for children present the percentage of children and youth under 21 years old who received at least one service from a primary care provider every year between FY 2011 and FY 2016. We believe that such data are available to all states with children in FFS Medicaid, that they can help inform a state's access

analysis for children in FFS, and that they would enable states, CMS, and stakeholders to compare children's access in FFS to children's access in managed care to make the Medicaid program work better for all children regardless of delivery system or state of residence.

We urge CMS to withdraw its proposal to exempt high-penetration managed care states from the requirement to develop an AMRP and instead require all AMRPs submitted by October 1, 2019, to include child-specific utilization data that will illuminate access.

Thank you for the opportunity to submit these comments. Please contact Karina Wagnerman at Georgetown's Center for Children and Families (email: khw24@georgetown.edu) if you have questions.

Respectfully submitted,
Georgetown University Center for Children and Families

[1] The number of children enrolled in Medicaid was retrieved from Medicaid and CHIP Number of Children Ever Enrolled, 2016, available at https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf; the percent of children covered through Medicaid (and other public health insurance) was retrieved from American Community Survey Fact Finder, "Public Health Insurance Coverage By Type" (Washington: United States Census Bureau, 2016), available at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2704&prodType=table; and the share of Medicaid enrollees that is children was retrieved from Medicaid CHIP Enrollment Data, February 2018, available at https://www.medicaid.gov/medicaid/program-information/downloads/february-2018-enrollment-data.zip.

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