ANCOR American Network of Community Options and Resources
Providers Offering Quality Supports to People with Disabilities

July 5, 2011

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS—229—P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: File Code CMS-2328-P
Methods for Assuring Access to Covered Medicaid Services
Submitted electronically via http://www.regulations.gov

To Whom It May Concern:

The American Network on Community Options and Resources (ANCOR) appreciates the opportunity to submit the following comments with respect to the above referenced Notice of Proposed Rulemaking, 76 Fed. Reg. 26342 (May 6, 2011) regarding *Methods for Assuring Access to Covered Medicaid Services*. ANCOR appreciates the opportunity to comment on a long-standing issue that deserves federal requirements and oversight.

ANCOR represents more than 800 private providers of community living and employment supports to more than 500,000 individuals with disabilities of all ages who employ more than 400,000 direct support professionals. Our members provide an array of supports and services to individuals with autism, intellectual and developmental disabilities, mental illness, sensory and physical impairments, individuals with multiple disabilities, as well as individuals who are elderly and have developed disabilities. Many of ANCOR's provider organizations were founded by family members of children and/or adults with significant disabilities, are currently administered by family members, directly employ individuals with disabilities and family members, and include family members and individuals with disabilities on their board of directors.

Central to our national non-profit organization's mission for 41 years is securing sufficient access to needed long-term supports and services and health care coverage for our nation's most vulnerable individuals—individuals with disabilities of all ages with very low-incomes who depend upon SSI and Medicaid. The regulations governing setting of provider reimbursement rates by states, and CMS's oversight of that process, are critical for assuring that individuals with disabilities receive quality health care and long-term supports and services. These regulations are critical to ensure the availability of sufficient qualified private providers of long-term supports and services.

The Case for Supporting CMS Regulation for State Requirement and CMS Oversight

We strongly concur with the following CMS statements: Payment rate changes made without consideration of the potential impact on access to care for Medicaid beneficiaries or without effective processes for assuring that the impact on access will be monitored, may lead to access problems. Payment rate changes are not in compliance with the Medicaid access requirements if they result in a denial of sufficient access to covered care and activities. " (preamble, page 26343).

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While states currently face significant budget challenges, states historically have faced budget challenges and, in particular, throughout the past decade. States are not alone in facing budget challenges or in wanting to have predictability in regards to their budgets.

Providers of Medicaid covered services, including providers of long-term services need predictability relative to their budgets in order to meet their mission and their contractual obligations with the state, regardless of provider rate reductions. Rather than terminating enrollees, reducing needed supports, or neglecting quality services, providers of supports and services frequently turn to outside contributions and fundraising efforts to meet their mission. It must be noted that state or other government operated providers are not forced to seek external funding to meet their state contractual obligations. In addition, regardless of increases in labor costs, medical inflation rate, housing costs, additional state regulatory burden, state changes in service definitions that add additional hours of service or required personnel for the same service, housing costs, and other cost factors, providers of long-term supports and services have faced multiple cuts in provider rates—both annually and throughout a given year. ANCOR members report that seldom do these "rate adjustments" occur in compliance with a formal and timely notice of public input.

Current Medicaid regulations require public notice for "significant" changes in methods and standards for setting payment rates. It is also long-standing CMS policy to require public notice for any change in payment methods and standards because there is no definable threshold for a "significant" change that applies across services, service providers, and beneficiaries. CMS notes in the preamble that there is confusion and uncertainty among states as to the analysis required to meet the Medicaid access requirements at 1902(a)(30)(A). ANCOR appreciates CMS's efforts to survey states regarding this requirement with states responding with a mix of answers that included some formal processes and some informal processes.

Comments made in the preamble to the proposed regulation make it clear that states are not currently following the mandates of Section (30)(A), which makes strong federal oversight critical. The preamble indicates that, when CMS has sought clarification on states' process for determining that access standards are met, it has become clear that states are not taking the determination seriously. The preamble states: "When asked for additional detail on the methodology that States used to determine compliance with the access requirement, only a few Sates indicated that they relied upon actual data to make a determination." (page 26348). Clearly, such determinations must be made on actual data, or they are meaningless. This confirms that a strongly enhanced regulatory framework is needed to ensure state compliance.

Whether due to "confusion" or the deliberate failure by states to follow both regulation and CMS policy demonstrate the existing "corruption of the SPA process" and state obligations in complying with the statutory provision inherent in 1902(a)(30)(A). **The state responses and violations in meeting the statutory requirements, along with increasing litigation, also demonstrate the need for strong CMS oversight and enforcement.**

ANCOR providers report that, historically, little or no attention has been placed by states on the potential effects to access to care when states reduce provider rates for long-term services and supports. Seldom are the reductions accompanied by an analysis of the potential impact on access to care, including impact on providers and their ability to provide quality supports to enrollees. We will submit further comment on provider experiences below that demonstrate the necessity of a specific CMS regulation to address the confusion, uncertainty, and deliberate failure of states to adhere to 1902(a)(30(A), existing regulations, and CMS policy. Our comments, following our general comments in support of the CMS proposed regulation, also strengthen the case for greater CMS oversight and enforcement.

The necessity of strong CMS oversight of Medicaid rate-setting by the states is extremely important, now more than ever. Historically, lawsuits by private parties, both Medicaid enrollees and providers, have kept some pressure on the states to keep them from slashing provider rates to meet budgetary objectives without considering the impact on access to care. With private enforcement of 42 U.S.C.

§ 1396a(a)(30)(A) ("Section (30)(A)") at risk due to the pending *Douglas v. Independent Living Center* case at the Supreme Court, CMS's role in assuring that the mandates of this Medicaid Act provision are met by the states will be all the more critical. CMS will have to provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to assure that there is sufficient provider participation so that Medicaid enrollees can access necessary services.

ANCOR Supports CMS Direction of Proposed Regulation

Reductions in provider payments are likely to exacerbate the problem that Medicaid beneficiaries already face regarding access to many Medicaid covered services, including access to long-term services and supports. For many years, ANCOR providers have face what they perceive as a "corrupted SPA process" as states fail to adhere to current federal regulations and CMS policy and failure by CMS to enforce these requirements. This regulation is needed more than ever to stop these practices in its tracks and restore confidence in state and federal obligations.

The following serve as just a few examples of reports from ANCOR providers that demonstrate the failure by states to adhere to CMS regulations and policies and unilateral action by states without input and program assessment: written notice to providers by state of submission of SPA to CMS in the next month without any public input notice or opportunity to participate in state's decision; 18% reduction over 2 years with additional 2% across all services in 2011 placed in SPA with no opportunity for public input or analysis of impact on access to services or availability of providers to continue participating; rate cuts and rescissions made solely on budget projections and no upward rate adjustments made when legislature finds additional funding; states requiring providers to sign contracts that allow a percentage cut in rates without public notice and that such reductions will be made retroactively; provider cuts will be made "if the state does not have the money"; cuts will be made for any reason; providers told by state officials in a meeting that if they fight rate reductions, it will be made harder on them; contacting CMS regarding rate reductions will be harmful to providers regarding rate cuts; adding to contracts with no change in SPA that there will be increased requirements (that add additional 40% cost) to service requiring more nursing time, more training of direct support workers, and more face-to-face time with participants, and written notice that the state has retroactively cut their provider rates. Providers report that CMS approves changes in definition of services and utilization without reviewing provider rate. In addition providers report that some states .ANCOR has not specified the states in connection with these practices due to concerns of state retaliation. These practices have created an environment in which providers feel they are held "hostage" by states.

ANCOR supports CMS's efforts to make states more accountable for assuring that there is sufficient access to quality services for their Medicaid populations, both when proposing provider rate reductions and also on an ongoing basis to make sure that rates are not falling below levels necessary to assure adequate provider participation. We anticipate that there will be significant negative comments by states. Therefore it is important that ANCOR highlights our support of the provisions in the proposed regulation and the direction the agency has taken. We do so below and follow with further discussion, modifications and recommendations.

ANCOR strongly recommends that the final CMS regulation include the following NPRM elements for assuring access to covered Medicaid services:

- **Federal requirement for state published reviews of all covered services affecting access to services, such as provider payment rates, that consider at minimum: (1) the extent to which enrollee needs are met; (2) the availability of care and providers; and (3) changes in beneficiary utilization of covered services.**

- **Federal requirement for certain data measures and irreductible minimum standards, including measures and standards that address access to Medicaid long-term supports and services, as part of the state access reviews.**

- **Federal requirement that access reviews include provider payment rates across categories of providers that includes state-government owned or operated, non-state government or operated, privately owned or operate.**

- **Federal requirement that describes measure states use to analyze access to care, including access to long-term services and supports, that relate to the framework, any issues with access discovered as a result of the review, and state recommendations on the sufficiency of access to care based on the review.**

- **Federal requirement for a specific timeframe for state access review, regardless of whether there is a change in provider payment rates.**

- **Federal requirement for the results of the access reviews made public.**

- **Federal requirement that states comply with access review requirements when the state submits <u>any</u> state plan amendment (SPA) that would reduce provider payment rates or restructure provider payments.**

- **Federal requirement for ongoing state monitoring mechanism for public input by beneficiaries <u>and providers</u> that includes record of volume and nature of responses to input on access to care.**

- **Federal requirement for states to submit a corrective action plan of CMS within 90 days when the access review or monitoring procedures determine access issues.**

- **Federal requirement for provider participation and public process prior to the submission of <u>any</u> SPA that proposes to reduce or restructure Medicaid service payment rates that includes a record of the volume and nature of the response to the input.**

- **Federal requirement that when CMS determines that service rates are modified without the required analysis, CMS <u>will</u> disapprove the SPA.**

- **Federal requirement for public notice of <u>any</u> changes in state methods and standards for setting payment rates that include a dedicated web site.**

<u>Recommendation: Regulation Should Provide Clear Criteria for Measuring Access</u>

ANCOR believes that the regulations, as proposed, do not provide for sufficiently clear criteria for measuring access and should be strengthened. Otherwise, the regulations will not even begin to resemble a federal enforcement scheme. The proposed regulations should be modified to set clear standards against which the agency will measure access to care in state Medicaid programs and should set uniform measures of access for which states must collect data. ANCOR supports the inclusion of specific data measures listed in the preamble. However, we believe those data measures do not address long-term supports and services and recommend the inclusion of specific data measures as follows.

Recommendation: We strongly recommend the inclusion of the following areas for data measures in the regulation:

1. **Time from application to Medicaid eligibility and qualification determinations for long-term services. This is important to address issues of inappropriate time lags.**
2. **Time from qualification for enrollment to receiving needed supports and services, including but not limited to state waiting lists.**

3. **State progress in meeting Olmstead state plan and Department of Justice ADA/Olmstead/CRIPPA lawsuits and settlements.**
4. **Prompt payment and delays in provider payments/reimbursements and state efforts to address delays.**
5. **Turnover and vacancy rates of direct support professionals (workers).**
6. **Voluntary and involuntary departure of qualified providers as Medicaid participants of long-term supports and services; and closure of community living programs and downsizing of provider capacities.**
7. **Develop a state "DASHBOARD" web site for data measures and assessments.**
8. **Changes in definition of services that place additional requirements upon providers and state analysis of impact of additional requirements while reducing rates.**
9. **Connection between rate-setting process and regulatory process that establish service requirements.**

Recommendation: Regulation Should Be Applicable to Medicaid Managed Care

In the preamble, CMS asserts that Section (30)(A) discusses "access to care for all Medicaid services paid through a State plan under fee-fo-service and [does] not extend to services provided through managed care arrangements. " Thus, CMS has made the proposed regulations inapplicable to managed care rates. ANCOR disagrees with this decision and urges CMS to apply the regulations to managed care plans.

Nearly 70 percent of Medicaid enrollees in the country are now enrolled in some form of managed care, with well over half of these enrollees in managed care organizations (as opposed to primary care case management programs). Despite legal requirements that capitation payments made by states to plans be "actuarially sound," ANCOR hears reports of the failure of managed care organizations to maintain adequate networks of providers, particularly specialty care providers. Many managed care organizations, while receiving capitation payments from the state, pay their providers on a fee-for-service basis. The payments to these providers can be low. The inadequate provider networks are, at least in part, the results of these low provider rates paid by the MCOs. The capitation paid to the MCO should not operate as a barrier to shield the MCOs fee-for-service payments to participating providers from the protections of Section (30)(A). However successfully the proposed regulations are enforced, they will not assure adequate access to the majority of Medicaid enrollees if benchmarks for access and CMS oversight are not applied to managed care plans.

ANCOR recognizes that another provision of the Medicaid Act, 42 U.S.C. § 1396b(m)(2)(A), and Part 438 of the Regulations set a standard of actuarial soundness for capitation payments under managed care risk arrangements. However, there is nothing in Section (30)(A) that would exempt its requirement that rates be adequate to assure access to services from applying to the rates that managed care plans pay to providers. Both requirements are applicable and, together, should act to assure that managed care plans receive adequate capitation payments from states and that managed care plans that are acting as the states' agents in providing care to enrollees should pay adequate rates to the providers in their networks to assure adequate access.

Applying the Section (30)(A) requirement to states in relation to their managed care plans is particularly important in light of the insufficient job that CMS apparently has been doing in reviewing the actuarial soundness of states' managed care rates. *See* GAO Report, *MEDICAID MANAGED CARE: CMS's Oversight of States' Rate Setting Needs Improvement,* August 2010. The GAO stated in its report:

> CMS's regulations do not include standards for the type, amount, or age of the data used to set rates, and states are not required to report to CMS on

the quality of the data. When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability.

Thus, in addition to including managed care within the purview of the Section (30)(A), CMS should also revise its part 438 regulations to set forth clearer standards for managed care rate review. Finally, we are alarmed that excluding managed care organizations from meeting the requirements of Section (30)(A) would establish a dangerous precedent for allowing them to ignore other Medicaid consumer protections in the future.

ANCOR advocated for many years that section 1115 waivers must include specific state requirements for public notice and input. We were successful with the inclusion of provisions in the ACA to address state and federal requirements regarding public notice, input, and transparency. ANCOR commented on CMS proposed section 1115 regulations. However, CMS has not issued final regulations.

States are pursuing1115 waivers to implement managed care arrangements. ANCOR providers are reporting state efforts (through state announcements and concept papers) to enfold long-term services and supports. in state concept papers. Providers also report that there are no clear state discussions regarding provider or beneficiary public notice and input processes. **Given ANCOR provider past experiences with states ignoring SPA and rate-setting requirements and CMS failure to enforce these requirements, it is all the more critical that the final CMS Medicaid access to covered services apply to managed care.**

Recommendation: Regulation Should Clarify That No SPA Can Be Implemented Prior to CMS Approval

Historically, CMS has been reluctant to undertake any strong enforcement actions if a state has set rates too low in violation of Section (30)(A). In the context of a proposed rate reduction, CMS does have a clear enforcement option, which is to deny a SPA request. However, states have, in the past, chosen to implement rate reductions without waiting for CMS action on their SPA requests, essentially ignoring federal regulation and policy with no concern for CMS consequences.

ANCOR joins with others in the belief that the law is clear, as determined by the United States Court of Appeals for the Ninth Circuit, that State Plan Amendments, including those proposing rate-setting adjustments, cannot be implemented until approved by CMS, although the regulations, at Section 447.256(c) permit implementation retroactive to the beginning of the quarter during which the SPA is submitted. Furthermore, CMS issued guidance to the states confirming that implementation is not permitted prior to SPA approvals. *See* State Medicaid Directors Letter #01-020, January 2, 2001. However, this has not been sufficient to prevent states from implementing rate reductions prior to CMS review, as evidenced by California's actions in recent years. Thus, to assure that CMS's authority to review and deny SPA requests has meaning, CMS should amend the regulations to absolutely clarify that SPAs that include rate reductions cannot be implemented until CMS has an opportunity to review the SPA.

Recommendation: Regulation Should Clarify That Reductions Done Through Legislative Enactments Do Not Satisfy Requirements of Section 30(A)

Much of the litigation under the repealed Boren Amendment applied to rate reductions or rate freezes adopted by state Medicaid agencies. There are only a few reported decisions that deal clearly with rate reductions or freezes enacted by State legislatures. However, such reductions are increasingly common, as in the rate reductions at issue in *Independent Living Center* and related cases.

Although there is case authority for applying notice and comment requirements to legislatively-enacted rate reductions, the lack of extensive authority has allowed states to ignore the Supremacy Clause of the Constitution and take the position that legislatively-enacted rate-setting is somehow subject to more relaxed federal requirements than rate-setting done by the state agency. The revised regulations should assure that states cannot avoid any of the requirements of Section 30(A) and its implementing regulations by having rate-setting done directly by the legislature. Further, all public notice and comment requirements, including those for institutional rate setting as set forth in the current version of 42 U.S.C. § 1396a(a)(13)(A), which replaced the Boren Amendment, must apply equally to rate-setting done by the legislature. There should be no assumption that legislative rate-setting *per se* satisfies public comment requirements, since rate-setting may be done by state legislatures, sometimes in behind close door sessions, without full opportunities for public comment.

Role of State Medicaid Advisory Panel

What role does CMS contemplate for the individual state Medicaid advisory panels? ANCOR believes that CMS should include a role for these panels in the participation in the review and public input as a requirement prior to state submission of SPAs which include rate reductions.

Proposed Revisions to Section 447.203 – Documentation of access to care and service payment rates.

ANCOR applauds CMS for requiring that states complete periodic access review of their payment structures regardless of whether they are in the process of revising their rates. In many cases states have gone for years and years without adjusting rates and have evaded CMS review because no SPA requests came before CMS. It is absolutely critical that this concept remain in the final regulations.

Section 447.203(b)(1) Access *review data requirements*.

CMS has not set specific standards or guidelines for achievement of the access requirement or specific data that must be collected, analyzed and disclosed by the states, but instead has adopted the framework set forth in the March 2011 report by the Medicaid and CHIP Payment and Access Commission (MACPAC) as guiding principles for states' analysis of the Section (30)(A) requirements. ANCOR does not believe that this somewhat vague framework gives sufficient guidance to states for doing the required analysis or that it gives sufficient guidance to CMS regional offices for their review of state Medicaid rates.

The MACPAC report is only a preliminary discussion of what should go into an effective review and analysis of adequate enrollee access. MACPAC has indicated that it plans to develop a set of measures that can be used to determine current access levels and to track access levels moving forward, but it has not yet developed such measures. Moreover, **MACPAC has specifically indicated that the general framework it has set forth applies only to primary and specialty care providers (i.e., physicians), but not to hospital, ancillary, long-term care or other services**. Thus, it is not even clear that the general framework put forth by MACPAC will ultimately be considered by MACPAC to be appropriate, let alone appropriate for all the varied types of Medicaid rates that are covered by the Section (30)(A) requirements. It is clear that whatever regulations it issues, CMS will want to follow up and review them when MACPAC completes its work. However, CMS should not hold up finalizing the regulations until then, but should issue more specific guidance for now, which can always be revisited at a later date.

While MACPAC will undoubtedly eventually come up with access measures that will be worth considering, CMS has enough experience with these issues to provide clear measures now. As CMS and its predecessor HCFA have recognized over the years, no single factor will consistently and reliably measure access. Therefore, the federal policies have recognized that it is preferable to look to a variety of factors relating to the health care delivery system itself—such as the number of participating physicians, geographic location, travel time and waiting time—as well as factors indicating whether potential access has become realized access, such as utilization rates, reported health care needs, and satisfaction with care. For example, in 2001, CMS required states to provide Plans of Action regarding dental rates, which had been identified as being extremely inadequate. *See* State Medicaid Directors Letter #01-010, January 18, 2001. In that SMDL, CMS suggested a number of access/rate measures that states could use, e.g. that Medicaid rates for dentists should be set at least at the 75th percentile of fees charged by dentists in the state to assure adequate access. CMS could use this measure, or similar measures for which it may have data, in the interim until MACPAC comes up with more updated measures. (Almost all of the states submitted an action plan, thus evidencing the ability of state program to respond to CMS's leadership.) In its approvals of numerous section 1115 demonstration projects in the 1990s, the federal agency consistently required each approved state to meet specific appointment scheduling and travel distance times as measures of adequate access and provider participation. Between 1990 and 1993, then-HCFA distributed State Medicaid Manual provisions that included standards for implementing the section 6402 of the OBRA 1989. And while the OBRA provision was later repealed, the access standards framed by HCFA are still relevant (e.g. at least 50% of pediatric practitioners, 100% if there is only one such practitioner in a county or geographic area—participate fully in Medicaid). Clearly, the agency has a history of requiring states to meet access guidelines, and it should build upon, rather than walk away from, those standards now.

With respect to specific data on Medicaid payments , CMS has proposed that states be required to collect data comparing Medicaid payments to average customary provider charges, but has given states an option to collect data on comparison of Medicaid rates to Medicare payment rates, commercial payment rates or Medicaid allowable costs. ANCOR believes that the other measures are significant also and urges CMS to require that data on <u>all three</u> of the other measures be collected and analyzed by states. Medicaid rates are often much lower than rates paid by other payers, so comparisons to both Medicare and commercial rates are important. If Medicaid rates are far below these other payers, that is an important indication that the rates are too low and endanger access. Use of all three measures of comparison is also critical because of the significant gaps in these payers' rate structures, for example Medicare's gaps with respect to services for children and dental services.

Recommendation: ANCOR believes that a comparison to costs is a critical part of any analysis of rate sufficiency. We believe that the regulation should stipulate "that, where states require cost reports and/or cost studies (the latter also required at times by legislative bodies), the state must include those reports and studies it is analysis.

Recommendation: The proposed regulations at § 447.203(b)(1)(B) regarding "Access review Medicaid payment data" should be revised to make clear that data should be obtained and provided for each item or service separately, not for Medicaid payments in the aggregate. Thus, it would not be sufficient for a state to provide data, for example, showing that its Medicaid payments total in the aggregate 95% of Medicare payments for the same aggregate services. It is quite possible that rates are reasonable for some services, but far too low for other services. It is important, therefore, that data be provided for each individual type of Medicaid service.

<u>Section 447.203(b)(2) Access Review Timeframe.</u>

ANCOR endorses CMS's decision to require rate reviews on an ongoing basis and not just when a state decides to implement rate reductions. History has shown that many years can go by without rate adjustments by states, so that Medicaid rates can fall extremely far behind the rates paid by other payers. This is a feature of the proposed regulations that absolutely must be retained in the final regulations.

As drafted, the regulations require that each Medicaid service undergo a full access review every 5 years, beginning January 1 of the year beginning no sooner than 12 months after the effective date of the regulations. This is too long a period for compliance. Assuming, for example, the regulations became effective in February 2012, then the 5 year review period would not begin until January 2014 and rates for some services would not be reviewed until the end of 2019, almost 9 years from now. In light of the fact that states should already have been assuring that their rate structures complied with Section (30)(A), and that CMS has discovered that states have not been taking that obligation seriously and have not been basing rates on any actual evidence, states should be required to do their rate reviews on a much more expedited basis.

Recommendation: Timing of Reviews

1. For the first cycle, all rates should be reviewed by the end of the second full calendar year following the effective date of the regulations.
2. In subsequent cycles, rates should be reviewed at least every 3 years, rather than every 5 years as proposed.
3. Priority should be given to any services regarding which CMS has knowledge of particular access problems. Rate reviews for these services should be required to be completed by the end of the first full calendar year following the effective date of the regulations.
4. The regulations as proposed currently vaguely allow the states to review a subset of services each calendar year during the 5 year review period (which we are requesting be reduced to 3 years). This would allow the state to review a minimal number of services during the first review period and save the majority of rate reviews until the last year of the period. The regulations should require that 1/3 of services be reviewed each year.
5. The regulations should explicitly include that all Medicaid long-term services and supports options must be included in these reviews.

Recommendation: Require Results Posted on Website

The proposed regulations require that the results of the rate reviews be made public, but do not require that the reviews be posted on the internet. Putting the reviews on a web site is given only as an option. All state Medicaid agencies maintain websites, and there is no reason why the regulations should not require that the rate reviews be posted on the websites. Otherwise, this would place the burden on the public to seek the reviews through public record requests and potentially be requested to incur the cost of copying before the records could be seen. There should be as much transparency as possible.

Section 447.203(b)(3) Special Provisions for Proposed Provider Rate Reductions or Restructuring

ANCOR supports CMS's proposal that any SPA proposing a rate reduction should be accompanied by an access review performed within 12 months of the rate reduction. CMS should clarify the language in the proposed regulation which states that a State must submit such an access review with any SPA "that would reduce provider payment rates or restructure provider payments in

unclear as to what the clause “in circumstances when the changes could result in access issues” modifies. ANCOR does not think there should be an exception for “restructuring” of provider payments, which is an unclear concept.

Recommendation: Require Access Review for Any Rate Reduction
The regulation should clarify that any SPA which reduces provider payment rates must be accompanied by an access review. All SPAs that reduce provider rates (whether done by simply reducing a fee schedule or by changing a methodology) should require an access review.

Section 447.203(b)(3)(C) Stratification Requirement

ANCOR strongly supports this CMS providing states to include data across categories of providers that include state government-owned and operated, non-state government owned or operated, and privately owned or operated. It has been ANCOR provider experiences in multiple states that private provider rates for long-term supports and services are lower that state or other government rates. In some cases, the rates are 25% or more low. This disparity affects private providers’ abilities to attract and retain direct support staff as well as other operating factors.

Section 447.203(b)(4) Ongoing Monitoring and Mechanisms for Ongoing Input.

ANCOR strongly supports the proposed provision that would require a state to develop procedures to monitor the impact on access when a rate reduction is approved by CMS and implemented by the state. However, ANCOR believes that the requirements in this regard should be more specific. Presumably, the state will have submitted an access review with a methodology showing sufficient access that can withstand a rate reduction, and CMS will have reviewed and approved the methodology used for the access review prior to approving the SPA.

Recommendation: The state should be required to use the same methodology to measure access once the rate reduction is put into place, or else there would not be a fair comparison of the impact of the rate reduction.

Recommendation:, CMS should set specific timeframes for the required monitoring procedures. At a minimum, the State should be required to monitor the impact on access at 6 months, 1 year and 2 years after the rate reduction, to make sure there is no short term or longer term impact on access that may result.

ANCOR supports the requirement in the proposed rule that the states must adopt mechanisms for beneficiary input on access to care and maintain records of the input. However, ANCOR believes the requirement must include input by other stakeholders.

Recommendation: This section should be revised to explicitly include provider input. We also suggest that the mechanism include all affected stakeholders. Further, the regulation should require that the input obtained shall be made available to the public.

Section 447.203(b)(5) Addressing access questions and remediation of access issues.

The proposed regulations provide that a state must submit a corrective action plan if it determines, through its review or monitoring procedures, that there is an access problem. ANCOR supports this concept and is comfortable with the proposal that such corrective action plan must be submitted within 90 days of discovery of the access problem and shall provide for correction to the access

problem within 12 months. However, ANCOR believes that this provision lacks requirements regarding the significant oversight role that CMS should play in assuring access.

Recommendation: It should be made clear that CMS will review the state's submitted access rate reviews within a specified time frame (preferably 90 days) and is empowered to determine that the data demonstrates an access problem that warrants corrective action. This should not be left solely to the state's discretion.

Recommendation: If CMS determines that the state's access review demonstrates an access problem, regardless of whether the state on its own acknowledges such a problem, then CMS should require the state to develop a corrective action plan. A deadline should be provided for the state to develop such a plan in this circumstance, preferably 90 days after CMS's discovery.

Recommendation: The regulation should state that the corrective action plan must be approved by CMS. If CMS disapproves the corrective action plan, then the state should be given 60 days to provide a revised plan in accordance with direction that CMS shall give to the state.

Section 447.204 *Medicaid* provider participation and public process to inform access to care.

ANCOR strongly supports the proposal requiring that states confer with beneficiaries and stakeholders prior to submission of a SPA that reduces or restructures payment rates. (We note that there is no qualification in this section that would require public input only when a "restructuring" of payment rates is likely to lead to an access problem, unlike the language used when describing when an access review must be submitted to CMS with a SPA. ANCOR assumes this is intentional and fully agrees that public input should be required when any restructuring is contemplated, regardless of whether or not the state believes it will lead to an access problem.

However, the proposed language should include specific timetables that will allow enough time for real and valuable public input. In the past, California, for example, when following public notice procedures regarding rate-setting, has allowed as little as five days to receive public comments. If states are not given specific minimum time frames to follow, then the public notice and comment requirement may become meaningless.

Recommendation: States should be required to give beneficiaries, providers, and other stakeholders at least 60 days to comment on proposals to reduce or restructure provider payment rates. While public hearings may be part of the process, the opportunity to submit written comments, which must be considered and addressed by the state agency, is paramount.

Recommendation: The regulation provides that CMS "may" disapprove a SPA if it determines that the state is proposing modified rates without the required public input. Since public input is an integral and required part of the new regulatory scheme, the proposed language should be amended to state that CMS "must "disapprove the SPA if the state has not allowed for public input as contemplated by the regulations.

Section 447.205 Public notice of changes in statewide methods and standards for setting payment rates.

CMS has proposed one change to § 447.205 to allow for public notice to be provided on an agency website, rather than published in a newspaper or state register. ANCOR agrees that electronic publication is an appropriate alternative for providing public notice, and, in fact, suggests that electronic publication be mandated, in light of current media use. However, ANCOR believes there should be additional requirements.

Recommendation: The regulation should continue to require public notice in newspaper and other state registers and require a dedicated web site for public notice. The web site should allow beneficiaries, providers, and other stakeholders the opportunity to subscribe to email notice of public notice and opportunities for input.

CMS has questioned in the preamble whether the correct standard for requiring public notice is any "significant" proposed change in a states methods and standards, as currently required, whether a specific threshold for significance should be set, or whether the adjective "significant" should be removed altogether. **We believe, since, as CMS acknowledges, there is currently no clear threshold for significance, that this term is too vague and should be removed**. Because Medicaid rates have historically been so low, we believe that any reduction in rates could endanger access and quality of care, and, therefore, any reduction in rates should trigger the public notice requirements.

Recommendation: The regulation should stipulate **that any reduction in rates require an access review and public notice requirements.**

Recommendation: Section 447.205 should be amended to tie in with the public process requirement in the proposed revision to § 447.204. The revised § 447.204 would then require a public process before a SPA is submitted, and tie in with the requirements set forth in § 447.205 as to how notice should be given. Procedures for the timing of public notice and comment could also be placed into § 447.205 and then cross-referenced in § 447.204. Thus, public notice and comment would be required pursuant to § 447.204 whenever a SPA reducing rates is being submitted, and § 447.205 would set forth the parameters of the public notice and comment requirement. Section 447.205 would also apply in situations where rates were being reduced by states, but, because of the wording of the current State Plan, a SPA may not be required.

We appreciate your consideration of these comments... If you have questions or would like to discuss them with ANCOR, please do not hesitate to contact me by email at sgalbraith@ancor.org or at 703-535-7850.

Sincerely,
Suellen R. Galbraith
ANCOR Senior Policy Advisor