JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

September 13, 2019

Submitted electronically to https://www.regulations.gov

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2406-P2
P.O. Box 8016
Baltimore, Maryland 21244

RE: RIN 0938-AT41 – Methods for Assuring Access to Covered Medicaid Services--Rescission

Justice in Aging appreciates the opportunity to provide a response to the above-referenced proposed rescission of the rule implementing the Medicaid Equal Access provision known as the Medicaid Access Rule.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We strongly oppose the proposal to rescind the Medicaid Access Rule without a replacement that is developed with stakeholders, including Medicaid beneficiaries. The Equal Access Provision of the Medicaid statute requires state Medicaid programs to set payment rates to ensure provider participation such that Medicaid services are available at least as readily as they are for people who are not in Medicaid.[1] The current regulation implementing this provision sets forth the required process for states to document whether fee-for-service (FFS) Medicaid payments are sufficient to assure such beneficiary access. More specifically, the rule requires that state Medicaid agencies consider the access implications of changes in provider payment rates and take beneficiary and provider input into account in deciding payment policies.

The proposed rescission, without a replacement, would make it impossible for the Centers for Medicare & Medicaid Services (CMS) to monitor and enforce access to covered services in state

[1] 42 U.S.C. § 1396a(a)(30)(A).

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Medicaid programs. As we have commented before[2] and reiterate below, weakening enforcement of access protections would disproportionately harm individuals dually eligible for Medicare and Medicaid, people of color, and other populations with high health care needs. Moreover, strong federal oversight is even more critical following the Supreme Court decision in *Armstrong v. Exceptional Child Center, Inc*.,[3] because individuals cannot seek redress for insufficient access to services through the courts and therefore rely on CMS for oversight and enforcement of these critical protections.

We hereby incorporate our previous comments on RIN 0938-AT41 dated May 22, 2018, and our response to the November 2, 2015, Request for Information on "Data Metrics and Alternative Processes for Access to Care in the Medicaid Program"[4] (both attached to this submission), as well as comments submitted by the National Health Law Program in response to this proposed rescission.

Payment Rates

Ensuring adequate payment is central to access, especially for individuals dually eligible for Medicare and Medicaid. For low-income Medicare beneficiaries who are Qualified Medicare Beneficiaries (QMBs), state Medicaid programs have an obligation to reimburse Medicare providers for deductibles and co-insurance after the Medicare program pays its share. States are permitted, however, to limit those payments to the lesser of the Medicaid rate for the service or the Medicare co-insurance amount. Forty-seven states have adopted this "lesser-of" policy and are therefore only responsible for reimbursing Medicare providers up to the Medicaid rate. The result is that low Medicaid reimbursement rates mean that Medicare providers do not receive any reimbursement from the state for the 20% Medicare coinsurance and therefore opt not to serve dually eligible beneficiaries.[5] Not rigorously monitoring changes in state Medicaid reimbursement rates will exacerbate this problem, leaving dually eligible individuals in already underserved areas without any providers.

Fee-for-Service Population

Nationwide, over 30% of Medicaid enrollees receive some or all of their services through fee-for-service (FFS).[6] Moreover, over half of states have less than half of their aged/blind/disabled

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[2] Justice in Aging, Response to CMS-2328-NC – Medicaid Program; Request for Information (RFI)-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (Jan. 4, 2016, www.justiceinaging.org/wp-content/uploads/2016/01/Justice-in-Aging-comments-Access-to-Care-RFI.pdf.

[3] 135 S.Ct. 1378 (2015)

[4] 80 Fed. Reg. 67,377 (Nov. 2, 2015)

[5] Ctrs. for Medicare & Medicaid Services, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," (July 2015), www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

[6] Ctrs. for Medicare & Medicaid Services, 2017 Share of Medicaid Enrollees in Managed Care, https://data.medicaid.gov/Enrollment/2017-Share-of-Medicaid-Enrollees-in-Managed-Care/ikdz-jh6q; Kaiser Family Found., Medicaid Managed Care Market Tracker: Total Medicaid MCO Enrollment 2017,

Medicaid population enrolled in comprehensive managed care.[7] In addition, as of 2017, 12 states did not have any comprehensive Medicaid managed care plans—meaning that Medicaid enrollees in these states are receiving most of their services through FFS.[8]

In states that do have comprehensive Medicaid managed care plans, the primary populations who remain in FFS are complex populations that are carved out of managed care enrollment on the basis that managed care cannot adequately serve them. Specifically, section 1932(a) of the Social Security Act provides for the exclusion of specific populations including Medicare beneficiaries and certain children with special health care needs from mandatory enrollment in managed care. Individuals who are in areas where they only have one managed care plan to choose from (usually in rural areas) are also excluded from mandatory enrollment.[9] Beyond these exclusions, states also have the flexibility to allow for exclusions to managed care enrollment for populations who will not be well served by managed care. For example, in California, individuals who have complex medical conditions are not required to enroll in a managed care plan if their doctor is not contracted with the health plan and the doctor cannot be changed without risking their health.[10]

Even in states with a high percentage of Medicaid enrollees in managed care, beneficiaries who are in fee-for-service have high health care needs and are most likely to be negatively impacted by access problems. For example, in Maryland, Ohio, and Oregon, all states with overall managed care enrollment above 85%, the populations that continue to receive services through FFS Medicaid include all or some individuals dually enrolled in Medicare and Medicaid.[11] Dually eligible individuals who receive Medicaid are a high-need and high-cost population who on

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www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] Kaiser Family Found., Medicaid Managed Care Market Tracker: Medicaid Managed Care Penetration Rates by Eligibility Group as of July 1, 2018, www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[8] Kaiser Family Found., Medicaid Managed Care Market Tracker: Total Medicaid MCOs 2017, www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Medicaid%20MCOs%22,%22sort%22:%22desc%22%7D.

[9] 42 USC § 1396u-2(a)(1)(A)(i)(I); 42 USC § 1396u-2(a)(3)(A)

[10] 22 CCR § 53887.

[11] *See*, Maryland Dep't Health & Mental Hygiene, Access Monitoring Review Plan for the State of Maryland (2016); Ohio Dep't Medicaid, "Ohio Access Monitoring Review Plan," (2016); Oregon Health Auth., "Oregon Access Monitoring Review Plan," (2016); *see also* Mathematica Policy Res. Ctrs., "Medicare & Medicaid Servs, Medicaid Managed Care Enrollment and Program Characteristics 2015," at 22 (2016), www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2015-medicaid-managed-care-enrollment-report.pdf.

average have three or more chronic conditions; 60% require assistance with daily activities of living; and 60% have a cognitive or mental impairment.[12]

Ensuring access to care for the FFS population is also critical to addressing health disparities. For example, people of color are more likely to live in communities with a shortage of health professionals.[13] Additionally, Native American Medicaid beneficiaries are excluded from managed care requirements under section 1932(a) of the Social Security Act and indeed make up a high share of the FFS population. For example, in New Mexico, nearly all of the FFS population is composed of Native American enrollees.[14] In Arizona and Washington, more than half of full benefit Medicaid FFS enrollees are Native American.[15] Access is particularly important for Native American Medicaid beneficiaries since Native Americans have "long experienced lower health status when compared with other Americans. . . [including] lower life expectancy and the disproportionate disease burden."[16]

When access problems are concentrated among individuals with high-needs and facing health disparities, including seniors, people with disabilities, children, and people of color, CMS should be providing increased oversight to enforce access rules, not less.

Fee-for-Service Benefits

In addition to populations being carved out from managed care, certain benefits are also carved out. In many states, critical services like behavioral health, substance abuse, and dental are only provided through FFS to all Medicaid recipients regardless of their enrollment in managed care or FFS. As of 2015, twenty-two states carved out all or some of their dental services from their Medicaid managed care program and delivered them on a FFS basis.[17] Access to primary care dental services is one of the areas that states are required to monitor under the regulations. Failing to require states to report on access to carved-out dental services that are delivered FFS will obscure serious access problems.

In California, the state's failure to monitor dental in the FFS system has resulted in significant access issues. As of 2015, only 20% of adult Medicaid beneficiaries received even one dental

[12] Kaiser Family Found., "Medicaid's Role for Medicare Beneficiaries," (Feb. 16, 2017), www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/.
[13] Families USA, Dental Therapists Can Improve Access to Dental Care for Underserved Communities (2016), https://familiesusa.org/product/dental-therapists-can-improve-access-dental-care-underserved-communities.
[14] New Mexico Medicaid, "Access Monitoring Review Plan for Fee-For-Service/Recipients," (2016).
[15] Arizona Health Care Cost Contain. Sys., "2016 Access Monitoring Review Plan," (2016); Washington State Health Care Auth., "Fee For Service Access Monitoring Review Plan, (2016)."
[16] Indian Health Servs., Disparities, www.ihs.gov/newsroom/factsheets/disparities (last visited May 7, 2018).
[17] Mathematica Policy Res, *supra,* note 11 at 90-323.

service.[18] There are no dental providers serving Medicaid enrollees in five California counties.[19] CMS' role in monitoring and enforcing equal access in the delivery of benefits through state Medicaid programs is demonstrably critical. California's dental care access problems demonstrate that current CMS monitoring has been insufficient and should be strengthened, not reduced.

In addition, given CMS' attention to Medicaid's role in the ongoing opioid crisis, allowing states to forgo reporting on access to opioid treatment and other substance use treatment services seems particularly counter-intuitive, especially since access to behavioral health services is an area of focus in the current regulations. Similarly, allowing state Medicaid Programs to forgo rigorous monitoring of access to health care in rural regions is at odds with CMS's goal of "[e]nsuring access to high-quality health care to all Americans in rural settings."[20]

Conclusion

Medicaid FFS benefits act as a lifeline allowing dual-eligible and high-needs populations to access critical health, behavioral health, and long-term care. CMS has a central role in ensuring access to these services. We have serious concerns that the rescinding the 2015 rule will result in less access for the very populations who depend most on these services. CMS should take more time and engage in more robust monitoring of beneficiary access under the existing regulatory framework before making changes. At the very least, CMS should wait until states have submitted the second round of Access Monitoring and Review Plans and create a viable alternative with input from all stakeholders before proceeding with rescinding the current requirements.

Thank you for the opportunity to submit comments. If you have any questions or would like to discuss our comments in more detail, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[18] CHHS Open Data, Multi Year Medi-Cal Dental Measures Data by Age Groups Calendar Year 2013 to 2015, available at https://data.chhs.ca.gov/.
[19] Little Hoover Commission, "Fixing Denti-Cal," (April 2016), available at www.lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf
[20] Centers for Medicare & Medicaid Services, "Rural Health Strategy," (2018), available at, www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.