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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

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200 Independence Avenue, S.W.
Washington, D.C. 20201

SUBJECT: CMS-2328-P Medicaid Program: Methods for Assuring Access to Covered Medicaid Services

Dear Dr. Berwick:

The California Hospital Association (CHA) submits the following comments in response to the May 5, 2011 Notice of Proposed Rulemaking (the "Proposed Regulations") issued by the Centers for Medicare and Medicaid Services (CMS) entitled "Medicaid Program: Methods for Assuring Access to Covered Medicaid Services." CHA is a trade association representing the interests more than 400 hospitals and health systems throughout California. CHA submits these comments on behalf of itself and its members.

California hospitals have a very special interest in the Proposed Regulations. CHA and its members have been subjected to Medi-Cal rate reductions and limitations for the past three decades that have been solely budget driven with little or no supporting analysis. CHA has often found itself with no recourse other than to seek relief through the courts to ensure that rates are adequate to promote quality of care and to afford beneficiaries access to services.

CHA applauds CMS's recent activity in closely reviewing State Plan Amendments (SPAs) encompassing rate reductions to ensure compliance with federal law, including the quality and access requirement of 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)"). In particular, CHA notes CMS's disapprovals of the California SPAs submitted to implement a 10% rate reduction effective July 1, 2008 ("AB 5"), and other rate reductions effective October 1, 2008 and March 1, 2009 ("AB 1183"), because the state failed to provide CMS with requested data evaluating the impact of the rate reductions on access to services. **CHA views meaningful CMS oversight as a critical component of the rate-setting process, and finds it to be essential to the federal interest in assuring the availability of high quality services to Medicaid beneficiaries is maintained.**

CHA appreciates CMS's efforts to develop regulations which for the first time in the more the 40 years since it was enacted impose specific requirements on states with respect to the equal access requirement, and address transparency and the involvement of stakeholders in the development by states and review by CMS of SPAs affecting Medicaid rates. As discussed below, there are

several aspects of the Proposed Regulations with which CHA agrees and finds to be a significant step forward.

Having been informed by our many years of experience in confronting Medi-Cal rate reductions and limits, however, we think that the Proposed Regulations should be modified in a number of significant respects. In summary, these include:

- Quality of Care. The Proposed Regulations do not discuss the requirement that Medicaid rates be consistent with quality. We think this is a significant omission. To be consistent with quality, rates must be high enough to reimburse a provider what it costs the provider to furnish quality care efficiently and economically.

- Sufficiency of Rates to Assure Adequate Access . Hospitals often afford Medicaid recipients access to services in spite of low rates. Thus, the mere fact that there appears to be access to hospital services does not demonstrate that the *rates* are sufficient to assure access. To be sufficient, the rates must be reasonably related to provider costs.

- Prohibition on Implementation of SPAs Before Federal Approval. California has frequently implemented SPAs reducing rates prior to submission to or approval by CMS. CMS should include a clear prohibition on this practice in its regulations.

- CMS Enforcement. CMS should adopt clear provisions enforcing SPA disapprovals. States must understand that there are prompt consequences where they implement rate changes which have not been approved by CMS.

- Transparency of State Process. The Proposed Regulations' provisions regarding public notice and participation should be enhanced to ensure that interested parties may have timely and complete access to proposed SPAs and related material.

- Public Participation in CMS Review Process. The final regulations should include provisions allowing for the meaningful participation of Medicaid recipients, providers, and other stakeholders in the CMS SPA review process.

- Additional Important Comments. The final regulations should also make changes to other issues in the review process such as provider input on access reviews, not applying the MACPAC framework to hospital services, and ensuring that managed care plans have complete networks that afford access to the full range of hospital services.

We discuss these recommendations and other comments further in Sections II and III of the letter, below. In Section I, we provide further background on the experience of California hospitals with Medi-Cal rate-setting. We think that this experience is important to an understanding of our comments on the Proposed Regulations

I. California Hospitals and Medi-Cal Rate Setting

A. A Brief History of the Medi-Cal Rate Cuts and Limits Affecting Hospitals

The history of Medi-Cal rate setting for California hospitals is that rates are frequently set as part of the budget process to achieve budgetary savings, with little or no analysis of the impact of the rates on quality or access. Particularly in times of financial stress, the state reduces rates where it think it can without being sanctioned by CMS or a court for violating federal law. It has been through access to the courts, and, more recently, through the CMS approval process that California hospitals have been able to avoid some of the more arbitrary rate changes.

A starting point is an across-the-board limit imposed by the state on reimbursement for inpatient hospital services in 1975. Until this limit, the state had reimbursed hospitals their reasonable costs as determined under Medicare cost reporting principles. Federal Medicaid law required reasonable cost reimbursement, but permitted the state's some flexibility to deviate from Medicare principles upon CMS (then the Health Care Financing Administration or "HCFA") approval. HCFA approved the rate cut, and CHA filed suit in federal court challenging the cut and HCFA's approval of it. The Ninth Circuit Court of Appeal found that HCFA's review was inadequate because HCFA failed to carefully review the entirety of the state's proposal. *See*, *California Hospital Association v. Obledo*, 602 F.2d 1357 (9th Cir. 1979).

Just two years after *CHA v. Obledo*, in 1981, the California Legislature adopted another arbitrary across-the-board rate limit on Medi-Cal reimbursement for inpatient hospital services when faced with another budget problem. By this time, Congress had replaced the requirement that Medicaid rates for inpatient hospital services reimburse reasonable costs with the Boren Amendment, requiring that the state find and assure HCFA that the rates were reasonable and adequate to meet the costs of an efficiently and economically operated facility and to assure access to services. CHA and other California hospital groups challenged this limit in federal court under the Boren Amendment. The United States District Court of the Central District of California invalidated the limit after finding that the state's findings and assurances were arbitrary and capricious. *California Hospital v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982); *aff'd* 705 F.2d 466 (9th Cir. 1983).

The state then took a different approach to try and reduce Medi-Cal expenditures. In 1982, the California Legislature adopted the Selective Provider Contracting Program (the "SPCP"), under which the state negotiated confidential contract rates with California hospitals for inpatient services. The SPCP has allowed the state to reduce Medi-Cal rates significantly below hospital costs. The SPCP rates have over time fallen further and further behind the cost of providing services.[1] There has not been litigation challenging the SPCP program or the rates under it, largely CHA suspects because of the "divide and conquer" approach used under the SPCP, and the lack of CMS oversight over rate adequacy. The experience under the SPCP does not demonstrate that the state found a reasonable and rational way to restrain the growth in Medi-Cal

[1] In its 2010 Annual Report to the California Legislature, the California Medical Assistance Commission noted that since 1983 payments under SPCP contract had saved the state general fund $11.43 billion dollars, and in 2010 had save the state general fund $479.1 million, meaning that Medi-Cal payments to hospitals for inpatient services were less than the cost of providing services by more than twice these amounts taking federal matching funds into account.

program expenditures. To the contrary, it demonstrates that when there is no court review or rigorous CMS oversight, rates will be driven by fiscal pressure and not to assure that hospitals receive adequate reimbursement to allow for the furnishing of quality patient care.

In 1982, again in response to budgetary concerns, the state reduced Medi-Cal rates for hospital outpatient services. The state paid for outpatient services on a per service basis using a rate schedule. The state reduced these rates by 10% for most services and by 25% for clinical laboratory services. The rate reductions were generally restored in 1985, but the rates largely remained frozen for the next 16 years. In 1990, CHA challenged the inadequacy of the hospital outpatient rates in federal court under Section 30(A). By 1992, the rates reimbursed on average about 41% of hospital costs. The case ultimately made its way to the Ninth Circuit, where in 1997 the court found that the rates were not valid under Section 30(A) because the state had failed to consider costs when adopting the rates, the rates were not reasonably related to hospital costs, and the state did not supply a good reason for the rates being lower than costs. *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997). The matter was remanded to the state agency to adopt valid rates. Finally, in 2001 the state and the hospitals entered into a settlement increasing the rates prospectively over several years and providing additional reimbursement for the past. Significantly, the state has not increased the base hospital outpatient rates under Medi-Cal since 2004.

The state tried to save money in 1996 by changing the meaning of the term "median" in connection with Medi-Cal reimbursement for skilled nursing services furnished by hospital distinct part nursing facilities ("DP/NFs"). The state reimburses hospitals for DP/NF services based on the lower of the facility's reasonable costs or a median cost per day of DP/NFs. Beginning in 1996, the state exclude DP/NFs from the median calculations which had lower than a 20% Medi-Cal utilization. These facilities tended to have higher costs, so their exclusion reduced Medi-Cal payments. CHA challenged this change in methodology in state court. The state court held that the change violated the Boren Amendment because the state failed to demonstrate a reasonable basis for excluding the low utilization facilities other than to reduce payments. When the state continued to apply the same method the next year, CHA sued again, and the court held that the state was barred by the doctrine of "collateral estoppel" from applying the method.

The state, however, continued to apply the exclusion methodology in setting DP/NF rates although it had been invalidated twice by the California courts. CHA was forced to sue again. The California Court of Appeal again held that the methodology was invalid, this time under Section 30(A) as the Boren Amendment had been repealed. The Court of Appeal again noted that the state had not demonstrated a reasonable basis for excluding the low utilization facilities from the computation of the median. *California Hospital Association v. Maxwell-Jolly*, 188 Cal. App. 4th 599 (2010), *petition for certiorari pending* ("*CHA v. Maxwell-Jolly*").

The state was again facing budgetary problems for the state's 2004-05 fiscal year. This time, the Legislature froze DP/NF rates and rates for inpatient hospital services furnished by hospitals without SPCP contracts. Both of these rate freezes were challenged in court and both were found to be invalid. The DP/NF rate freeze was invalidated under Section 30(A) in *CHA v.*

Maxwell-Jolly because the Legislature had enacted it without doing any analysis of the reasonableness of the freeze. The inpatient rate freeze was invalidated under 42 U.S.C. § 1396a(a)(13)(A) because the state had failed to adopt the freeze through a public process which affords interested parties the ability to comment on the rate change.

Since 2008, the state has been confronted by a severe fiscal crisis. The California Legislature has enacted multiple Medi-Cal rate cuts and limits since then in an effort to save money, including rate cuts affecting hospitals. This has unfortunately led to more litigation. Each time the limits have been litigated they have been invalidated, either because the state failed to develop support for the rate cut or limit before enacting it, or the state tried to implement the cut or limit before it was approved by CMS. Additionally, CMS has now disapproved several SPAs relating to these new rate cuts. The 2008 through 2010 rate cuts include:

1. The AB 5 10% rate cut litigation. The California Legislature cut many Medi-Cal rates by 10% effective July 1, 2008, including non-contract inpatient hospital, DP/NF, and hospital outpatient rates. The 10% rate cut was replaced by a lower reduction for most services effective March 1, 2009, but continued to apply to non-contract inpatient hospital services until April 13, 2011, when it was repealed. The 10% rate cut was preliminarily enjoined as to non-contract inpatient hospital services in *Santa Rosa Memorial Hospital v. Maxwell-Jolly*, and was also determined to be likely invalid by the federal courts in *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 660 (9th Cir. 2009) because neither the state Legislature nor the state Medicaid agency analyzed the reduction for compliance with Section 30(A) before enacting and implementing it.

2. The AB 1183 rate litigation. The California Legislature replace the 10% rate cut with a 5% rate cut for DP/NF and subacute services, and a 1% rate cut for hospital outpatient services, effective March 1, 2009. The Legislature also limited Medi-Cal rates for non-contract inpatient hospital services to 95% of the regional average SPCP contract rates effective October 1, 2008, and repealed it effective April 13, 2011. These rate cuts were preliminarily enjoined in *California Pharmacists Association* because the state once again failed to analyze the impact of the reduced rates on quality and access as required by Section 30(A) prior to enacting or implementing them.

3. The 2009 DP/NF and subacute rate freeze. The California Legislature froze Medi-Cal DP/NF and subactue rates effective August 1, 2009. The federal district court preliminarily enjoined this freeze on February 24, 2010, as neither the Legislature nor the state Medicaid agency had analyzed the impact of the rate freeze on quality and access prior to enacting and implementing the freeze.

4. The 2010 Inpatient Rate Freeze and Rollback. Effective July 1, 2010, the California Legislature enacted legislation which provided that Medi-Cal rates for inpatient hospital services, both contract and non-contract, could not exceed the rates in effect on January 1, 2010. The United States District Court for the Eastern District of California preliminarily enjoined this rate freeze and rollback because the state had implemented it without first obtaining CMS approval, and it violated the Contracts Clauses of the United States and California

Constitutions because it was being applied retroactively and voided rate adjustments previously agreed to. The California Legislature has since repealed this provision.

Very significantly, on November 18, 2010 CMS disapproved SPAs submitted by the California Medicaid agency to implement the AB 5 and AB 1183 reductions. In December 2008 and March 2009, CMS had requested additional information from the state because national data indicated that the rate reductions might cause a problem with beneficiary access to services. Since the state Medicaid agency never responded to CMS's requests for additional information notwithstanding a 90 day deadline for such responses, CMS disapproved the SPAs.

Finally, the California legislature has again enacted new Medi-Cal rate cuts to be effective as of June 1, 2011. We believe (although have not yet confirmed) that just a few days ago, on June 30, 2011, the California Department of Health Care Services submitted new proposed SPAs to implement these new cuts.. CHA has not yet received a copy of the proposed SPAs. However, based on the action taken by the California Legislature, we anticipate that these proposed SPAs may include (1) a 10% reduction to hospital outpatient rates, (2) a roll-back of rates for DP/NF and subacute services to 2008-09 levels less ten percent, which CHA estimates will amount to a rate cut of about 23% to 25%, (3) new co-payments chargeable to Medi-Cal beneficiaries, including a $50 copayment on hospital emergency room services and a $100 copayment on inpatient days up to a total of $200, and (4) significant reductions to non-hospital rates and limitations on the coverage of physician and other services. These cuts, which were done solely for budgetary purposes, will have a devastating impact on the availability of services to Medi-Cal beneficiaries.

B. <u>The Importance of this History to the Development of Access and CMS Approval Regulations</u>

The long history of Medi-Cal rate cuts and court intervention demonstrates that it is critical to the federal government's interest in the Medicaid program that the standards for rate setting be clear and rigorous, and that CMS review of changes in rate methodologies must be thorough.

Left completely to their own devices, states under budgetary pressures will cut provider payment rates under Medicaid as a first option. Such cuts are relatively easy to accomplish, have immediate fiscal impact, and are often politically more palatable than other actions states may take to solve their fiscal problems.

Rate cuts, however, have significant short and long-term consequences. The chronic underfunding of providers by state Medicaid programs will necessarily have an adverse impact on quality or access, or both. Even where the impact is not immediate, there will clearly be a deterioration in the availability or services over time.

We are seeing the impacts of Medicaid underfunding in California. Over the past 15 years, more than 50 California hospitals have closed. The state has lost more than 60 emergency rooms, and many hospitals have dropped out of regional trauma networks. Hospitals frequently cite poor Medi-Cal payment rates as a major reason for closure.

California's DP/NFs have been particularly hard hit by rate cuts over the past few years, with the state proposing to implement a new rate reduction that CHA estimates will reduce reimbursement by about 25%. The Medi-Cal program has lost 15% of our DP/NF beds since 2006, and a good number of facilities have indicated that they will eliminate or reduce their Medi-Cal DP/NF services if the new reductions are implemented. As a result, patients will have to travel well outside of their communities and away from their families to obtain skilled nursing services, if these services are available at all. Services for patients requiring a higher level of skilled nursing care are becoming increasingly difficult to find, as the DP/NFs often are able to care for higher acuity patients than are free-standing skilled nursing facilities. This leads to longer stays in acute care beds, which is not consistent with the efficient and economical delivery of patient care.

The new cuts in the proposed SPAs we think were submitted by California on June 30, 2011 highlight the need for comprehensive CMS scrutiny of proposed SPAs which would reduce rates or otherwise alter payment methods, as well as a transparent review process with the opportunity for stakeholder input. CHA strongly believes that these cuts go well beyond a reasonable response to California's fiscal issues, and will lead to a severe deprivation of beneficiary access to quality care. CHA and other provider and beneficiary organizations have been making their concerns known to CMS. Yet, CHA and others have been hamstrung in our ability to provide CMS with information that will be helpful to CMS in its review, as we have not yet seen the specific proposed SPAs submitted to CMS and have not been given access to any information submitted to CMS in support of the proposed SPAs. Additionally, while CHA greatly appreciates CMS's willingness to meet with and receive comments from stakeholders concerning these SPAs, there is no formal process available to CHA and other stakeholders to communicate our concerns. CHA does not know of the deadline within which it must submit material to CMS about these new SPAs to ensure it will be fully considered by CMS, is not aware of a formal process by which it can promptly obtain the proposed SPAs and other material submitted by the state, and is concerned that the law and regulations do not specifically require an opportunity for public comment to CMS prior to a CMS decision on whether to approve the SPAs.

The specific comments we make below are heavily influenced by our experience in California. Specifically, clear rate standards are required so that states and other interested parties know what is expected. States must be required to perform analyses of the impact of rates on efficiency and economy before new rates are enacted or implemented, as the states have the best access to the available data. The rates must bear a reasonable relationship to provider costs in order to ensure the availability of high quality care to Medicaid beneficiaries. Providers and other interested parties must be timely furnished with the relevant information when states propose rate modifications, and must be afforded an opportunity to submit meaningful comments in connection with state proposals. CMS must scrutinize state rate proposals with care to ensure that they are not being made solely to reduce state expenditures, but will result in rates that are consistent with high quality care and are sufficient to ensure that beneficiaries will have access to services both in the short and long term. States must not be allowed to implement rate changes prior to CMS approval. CMS must get serious about enforcement. These steps are all essential to ensure that rates are adequate and that Medicaid beneficiaries will have access to quality care.

II. Major Conceptual Comments

A. Quality of Care

Section 30(A) requires that Medicaid rates be consistent with efficiency, economy, and quality of care, in addition to being sufficient to ensure adequate provider participation so that beneficiaries have equal access to services. The Proposed Regulations ignore the statutory mandate that rates be consistent with quality care.

The legislative history of Section 30(A) makes it clear that the requirement that rates be consistent with efficiency, economy, an quality of care is distinct from the equal access requirement. Since its enactment in 1968, Section 30(A) has required that Medicaid payments be consistent with efficiency, economy, and quality of care. The equal access provision was not added to Section 30(A) until 1989. It would have been unnecessary to add the equal access clause if the efficiency, economy, and quality of care provision required nothing more than equal access. Accordingly, it must be concluded that the rates must meet two separate requirement. First, they must be consistent with quality of care. Second, the must be sufficient to enlist enough providers to assure equal access to services.

The Ninth Circuit in *Orthopaedic Hospital* correctly concluded that for rates to be consistent with quality care, rates must in general be high enough to cover the costs of providing quality care. The court noted that "consistent" means "in agreement with, compatible, or conforming to the same principles or course of action." It seems apparent that for a rate to be in agreement with or compatible with quality of care the rate must be high enough to pay what it costs to provide quality care.

The problem with any other view is that it imposes virtually no lower limit on rates. The state in *Orthopaedic Hospital* argued that its rates could be as low the state desired so long as quality care was in fact provided. The state asserted that its rates did not have to independently support quality care because hospitals were obligated by their agreement to participate in Medi-Cal and by state licensing regulations to provided quality care. The court properly disagreed, and emphasized that the statute required that the Medicaid payments themselves be adequate to assure quality care and that quality cannot be assured unless rates cover provider costs.

The correctness of the Ninth Circuit's decision in *Orthopaedic Hospital* is demonstrated by the facts of that case. When the case was first being litigated, in 1992, the Medi-Cal hospital outpatient rates covered about 41% of hospital costs. By the time the case was decided in 1997, the percentage of costs covered was much lower. It is clearly not consistent with quality of care to reimburse this small a fraction of what it costs to provide quality care, even if quality is otherwise mandated by state regulation.

Finally, it is not sustainable in the long term to continually pay rates that are well below provider costs of furnishing quality care. Providers must shift unreimbursed costs to other payers and patients. This is becoming harder to do each year, as private payers are no longer willing to subsidize shortfalls in government program rates, and charge-based payers are exceedingly rare.

In sum, the only way for a rate to be consistent with quality of care as Congress has mandated is for the rate to cover the cost of furnishing quality care, albeit efficiently and economically. ***CHA therefore urges CMS to include in the final regulations a requirement that rates are reasonably related to the cost of furnishing care efficiently and economically.***

B. Sufficiency of Rates to Assure Adequate Access

The Proposed Regulations focus on requiring that states conduct analyses that would support that access to services for Medicaid beneficiaries will be adequate notwithstanding a change in payment rates or methodology. CHA agrees that this analysis is important and should be required.

However, an analysis of whether access actually is adequate, or is predicted to be adequate after a rate change, is not legally sufficient, or consistent with sound policy, where access exists for reasons wholly apart from the adequacy of rates. Under such circumstances, the availability of services as a matter of fact does not demonstrate that the rates themselves are adequate to enlist enough providers to assure equal access.

Hospitals often make their services available to Medicaid beneficiaries despite very low rates. Hospitals with emergency departments or that provide certain other services are required to furnish services to all patients regardless of payment source or payment level under the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") and similar provisions of state law. Further, it is the mission of many hospitals to furnish care to all patients who present themselves for treatment regardless of rates. Hospitals also often have contractual obligations to participate in Medicaid.

The Ninth Circuit in the *Orthopaedic Hospital* case emphasized these factors in finding that the Medi-Cal hospital outpatient rates violated the equal access clause of Section 30(A) even though there was not evidence of an actual access problem. The court stated:

> In this case there has been no assertion of a provider participation problem. However, as discussed above, any hospital that accepts any Medicare payments and operates an emergency department cannot opt out of providing emergency care for Medicaid patients, regardless of the reimbursement rates. 42 U.S.C. § 1395dd. Since most hospitals accept Medicare patients and operate emergency departments, and many hospitals have public service missions to provide care regardless of patients' ability to pay, currently provider participation by such institutions is assured.
>
> The compelling "other" reasons for provider participation by such institutions has allowed the Department to ignore the relationship of reimbursement levels to provider costs when determining whether payments are sufficient to ensure access to quality services. The result is that the Department has not sought to shift services to entities that could

> provide the services and to shift the cost to other patients. This technique of underpayment for services received is not economic, efficient or attentive to adequate access. It is neither economical nor efficient for the system as a whole. The Department need not follow a rigid formula of payments equal to an efficiently an economically operated hospital's costs regardless of other factors such as incentives and utilization controls. But the Department must undertake to determine what it costs an efficient hospital economically to provide quality care. Absent some justification from the Department, the reimbursement creates must ultimately bear a reasonable relationship to those costs. 103 F.3d. at 1498.

CHA believes that the reasoning of the Ninth Circuit is clearly correct. Section 30(A) requires that Medicaid payments themselves be adequate to enlist a sufficient number of providers to assure equal access. The fact that there may be adequate access due to legal obligations, hospital missions, and similar factors does not satisfy the statutory requirement that the payments themselves assure access where access exists in spite of and not because of the rates.

Accordingly, CHA urges CMS to adopt a requirement applicable to payment rates where there is not a direct correlation between access to services and payment rates, but where access results from legal obligations, provider missions, or other similar factors that are not related to rates. This rule would apply to hospital services, and perhaps to certain other services like emergency ambulance services where ambulance providers are required by law or contract to respond to emergency calls regardless of payments.

Under these circumstance, the regulations implementing Section 30(A) should require that payment rates be reasonably related to provider costs of furnishing services in order to assure that the rates are adequate to assure equal access. State Medicaid agencies should be required to have an independent review of provider costs before adopting or modifying rates through a SPA, and the cost analysis and justification for the rates in view of the cost analysis should be required to be submitted to and reviewed and accepted by CMS before it is approved and implemented.

C. Prohibition on Implementation of SPAs Before Federal Approval

Federal regulations require that the State Plan be amended to reflect material changes in payment methodology. See 42 C.F.R. §§ 430.12, 447.252, 447.256(a)(i). The Ninth Circuit and other federal courts in California have repeatedly held that even where proposed amendments to a State Plan have been submitted for federal approval, a state Medicaid agency may not implement the amendments until federal approval actually has been obtained. See Exeter, 145 F.3d at 1108; Oregon Ass'n, 5 F.3d at 1241; California Ass'n of Rural Health Clinics v. Maxwell-Jolly, F. Supp.2d , 2010 WL 4069467, *12-*13 (E.D. Cal. 2010) ("CARHC").

On October 1, 2010, CMS issued a letter to State Medicaid Directors stating unambiguously that CMS approval is required prior to the implementation of changes to state plans. This makes

sense if CMS approval is going to be meaningful. If states are able to implement Medicaid rate changes and other state plan revisions prior to CMS approval, the role of CMS will be greatly diminished in protecting the federal government's interest in Medicaid, and states will have a substantially reduced incentive to ensure that Medicaid program changes comply with federal law.

The State Medicaid Agency in California has repeatedly implemented changes to the Medi-Cal program, including rate reductions and rate limits, prior to CMS approval. Indeed, the state implemented in 2008 and 2009 five SPAs prior to CMS approval that were ultimately disapproved by CMS. Yet, the state implemented these rate cuts, reducing provider payments, has never refunded the payments withheld because of the cuts, and continued to implement some of the cuts even after the date of the disapproval. California's argument to the courts in cases challenging the implementation of SPAs prior to CMS approval has been that the federal regulations do not require prior approval. Although this argument has been rejected by the courts, ***CHA urges CMS to take this opportunity to state clearly in its regulations that states must obtain CMS approval prior to implementing a SPA, and that federal financial participation will be denied for any payments made pursuant to a revised payment methodology that has not been approved by CMS.*** This clarification expressly in the regulations is necessary for CMS to protect the integrity of its SPA approval process.

D. CMS Enforcement

Our experience in California (discussed above) teaches us that it is extremely important for CMS to have effective tools to enforce its rules concerning state Medicaid Plans. CMS must be able to promptly and appropriately sanction states that refuse to comply with CMS's requirements by implementing unapproved or disapproved SPAs. Absent effective enforcement, states will be encouraged to ignore CMS's requirements and cut or otherwise revise payment rates prior to submitting SPAs or obtaining CMS approval.

We understand that the enforcement authority provided to CMS under the federal Medicaid Act is to withhold federal payment when a state is not acting in compliance with its CMS-approved State Plan. ***We suggest that CMS adopt regulations which require CMS to withhold federal reimbursement of any state Medicaid expenditure made pursuant to a state payment method or rate that has not been approved by CMS.*** Further, we suggest that CMS regulations provide that if CMS discovers that a state has made Medicaid expenditures under a payment method or rate that has not been approved by CMS, including a payment method or rate that has been disapproved by CMS, CMS begin immediately to recover any federal reimbursement that had been made for such expenditures by offset or withhold from other amounts that may be due the state or through other means as may be available to CMS.

Under this approach, for example, if a state proposed to reduce hospital outpatient payment rates by 10%, and implemented this reduction prior to CMS approval, CMS would deny federal reimbursement for all expenditures made by the state for hospital outpatient services at the reduced rates.

We believe this approach would impose the necessary discipline on state Medicaid agencies to ensure that payments are made only in compliance with CMS-approved State Plans. We also do not believe it would impose a significant burden on the states. If a state proposes a well thought out and supported payment change CMS would presumably approve the state plan fairly quickly, and the state would be permitted to implement it beginning the first day of the calendar quarter in which the applicable SPA was submitted.

However, without this type of clear sanction, CHA believes it is likely that state will continue to flaunt CMS requirements, and implement rate changes, often budget driven changes, that are unsupported and unsupportable, without CMS approval. Providers will then be paid at rates that are unlawful, and that CMS has not validated will maintain access to quality services. This is clearly inconsistent with the federal government's interest in the effective operation of state Medicaid programs.

E. Transparency of State Process

The Proposed Regulations include provisions directed at increasing the transparency of state activity relating to access and SPAs directed at payment reductions and modifications. These are a step in the right direction, but do not go far enough.

The full participation of beneficiaries, providers, and other stakeholders in the development, review, and approval of SPAs is essential to ensure that CMS has complete and accurate information to evaluate a proposed SPA and determine whether the SPA should be disapproved. State Medicaid agencies are naturally inclined to submit supporting material in connection with SPAs designed to make the best case to approve the SPA rather than to present a complete unbiased and objective view. CHA has found that this material is often incomplete or simply erroneous, and that the conclusions that the state Medicaid agencies draw from the material are frequently not supported.

An early example is reflected by the case of *California Hospital Association v. Schweiker*. In that case CHA and others challenged the validity of a 6% limit on the growth of reimbursement for inpatient hospital services under the Boren Amendment. The state had developed an analysis as support for the 6% limit. The court ultimately found that the state's analysis was entitled to little weight. The court found that the state had intentionally omitted from its analysis data which did not support the state's conclusion. The court determined that the state's assurance of compliance with the Boren Amendment that were based on the state's analysis was invalid because "the assurance was based upon an effort to develop the best case for the State Plan Amendment, considering only those factors favorable to the State Plan Amendment and intentionally failing to consider and excluding equally relevant factors which were unfavorable. The assurance therefore has no reasonable basis."

There are other similar examples that have emanated from California. In 1995, California changed the way it which it computed a "median" per diem limit on reimbursement for distinct part nursing facility services. This change was challenged in state court under the Boren Amendment. The state court found that the state's analysis, which had largely been provided to

CMS, did not support the rationale that the state proffered for the rate change, and invalidated the change. In the more recent cases that have followed from California's reductions to Medi-Cal rates since 2008, it has been CHA's experience that the state Medicaid agency has routinely offered to CMS and the courts flawed analyses, often done after the rates were either enacted or implemented, in what appeared to be an attempt to justify action the state had already taken.

To ensure that CMS has a complete picture when it is evaluating a proposed SPA modifying Medi-Cal payments, we recommend the following:

1. ***State Medicaid agencies must be required to give public notice of all proposed state plan amendments affecting payments no later that when the proposed SPAs are submitted to CMS.*** Because the impact of changes in rate methodologies may not be transparent, and because adequate payments are essential to the successful operation of a Medicaid program, CHA suggests that all proposed changes to payment rates or payment methods by subject to the public notice requirement.

2. ***The public notice must include at a minimum the proposed SPA and either all material submitted by the state Medicaid agency in connection with the proposed SPA or information on how interested parties may promptly obtain such material.***

3. ***The state must provide contemporaneous public notice of all written communications between CMS and the state concerning the proposed SPA***, including without limitation CMS requests for additional information and state responses to such requests. The public notice must either provide a copy of the communication or information on how interested parties my promptly obtain the communications.

4. ***The public notice must be posted on the state Medicaid Agency's website in a section of the website reserved for state plan amendments and related material that is easily located.*** The public notice should also be included in state publications generally used by states to provide notice to the public of actions of state agencies.

5. ***The state must make all data and other information relating to a proposed SPA available upon request to interested parties.***

Without access to this information, proposed SPAs may be submitted to CMS and reviewed by CMS without any awareness on the part of beneficiaries, providers, and other members of the public that the proposed SPA was submitted. Further, CMS may be given supporting material by the state Medicaid agency that is incomplete or erroneous, but that CMS does not know is incomplete or erroneous, because it has not been subject to public review and comment.

The foregoing recommendations are intended to be in addition to existing requirements for public participation and notice set forth in the federal Medicaid Act and implementing regulations.

F. <u>Public Participation in CMS Review Process</u>

As a critical component of enhancing transparency and assisting CMS in its review of proposed SPAs effecting payments, it is critical that beneficiaries, providers, and other stakeholders have an opportunity to provide information to CMS directly prior to a CMS decision to approve or disapprove a SPA. The public should have the opportunity to submit this information after the state submits a SPA and makes the proposed SPA and supporting information available, and before the 90 day period for the initial CMS review expires. Additionally, the public should have the opportunity to submit additional information to CMS after any additional information is provided to CMS by the state Medicaid agency, and before the CMS approval or disapproval decision is made.

CHA recommends the following:

1. ***Any interested party who wishes to provide information to CMS in connection with a proposed SPA affecting payments may advise CMS in writing that it intends to provide such information within 15 days of the submission of the proposed SPA to CMS by the state Medicaid Agency.*** This deadline would be extended in the event the state Medicaid agency fails to provide timely public notice of the submission of the SPA.

2. ***CMS would then advise any party expressing a desire to submit information of a deadline to submit such information.*** This deadline would in no event be less than 60 days from the submission of the proposed SPA or any additional information concerning the proposed SPA submitted by the state Medicaid agency.

3. ***CMS make available to interested parties upon their request on an expedited basis any Proposed SPA submitted by a state, and any communications between CMS and the state Medicaid agency concerning the proposed SPA, including without limitation CMS requests for additional information and the state's responses to such requests.***

III. Additional Important Comments

In additional to the major comments that CHA believes go to the heart of the SPA approval process concerning Medicaid rate changes, CHA makes the following important comments.

A. Access Reviews

CHA commends CMS for including the requirement for periodic access reviews for each covered benefit in the Proposed regulations. We have the following comments:

1. The state should be required to include in its review all of the Medicaid payment data described in proposed section 447.203 (h)(1)(B)(2) unless the state demonstrates that for a specific services the data is not reasonably available. ***In particular, the state should be required to include in its access review an estimate of the percentile which Medicaid payments represent of Medicare allowable costs for hospitals and other providers where access would not be expected to be directly correlated to payment rates.*** The Proposed Regulations requires the inclusion of only one of the three estimates identified in this provision.

2. ***The estimates in 447.203(h)(1)(B) should be required to separately show percentiles with and without supplemental payments.*** Medicaid disproportionate share payments and other similar payments that are designed in part to help reimburse providers for uncompensated care should be excluded from the estimates. Further, where there are multiple types of supplemental payments for a particular service, the estimates should be made separately with and without each supplemental payment. It is important to isolate the impact of supplemental payments because they are frequently targeted at only a few facilities statewide, or are limited in duration or scope, so that the analysis can be skewed by the inclusion of such payments. Additionally, where supplemental payments are generated by a provider fee, the net impact of the supplemental payments only should be included after deducting the amount of the provider fee so that the true economic impact of the supplemental payments will be reflected in the analysis.

3. ***For hospitals, it should be made clear that the data analysis should be performed separately for acute inpatient hospital services and hospital outpatient services.*** Additionally, the data analysis should be further separated with respect to acute inpatient services between medical services, psychiatric services, rehabilitation services, and long term acute services to the extent possible. Further, data for skilled nursing services furnished by hospital distinct parts should also be reported separately.

4. ***The access data in proposed section 447.203(b)(1)(iii)(B) should include not just overall estimated percentages, but a breakdown of the estimated percentages by numbers or percentages of providers.*** For example, rather than just showing that say 80% of hospital inpatient costs are covered by the payments, the data should show the percentage of hospitals where the coverage percentage is 100% or more, the percentage where the coverage percentage is at least 90%, etc. This will provide much more meaningful data than simple a single overall coverage estimate.

5. ***The Proposed Regulations should be clarified to state that the access reviews must be conducted to examine access and related data in the different geographic regions throughout the state*** as Section 30(A) requires access be adequate in each geographic region of the state.

6. The Proposed Regulations state that states must have ongoing mechanisms for beneficiary input on access. ***CHA recommends that the regulations also have mechanisms for provider input on access.*** Providers often have valuable information on access to care in their communities as well as the impact of rate changes on the availability of services. The input of providers is critical to an informed access analysis.

7. CMS proposes states undergo an access review every five years and that they release their public findings. ***CHA recommends CMS reduce the interval from at least once***

every five years to at least once every three years. The proposed intervals of five years are far too long to ensure access.

B. MACPAC Data

The proposed rule advises states to use an access framework developed by the Medicaid and CHIP Payment and Access Commission ("MACPAC") in its 2011 Report to Congress. This framework is limited, however, and does not address access to hospital services.

The MACPAC report presents a framework for examining access to care. This framework has three main elements: enrollees and their unique characteristics, availability, and utilization.

However, MACPAC acknowledges that its initial framework "focuses on primary and specialty care providers and services and does not specifically address hospital, ancillary, long-term care or other services and supports." (Report, p. 126.) This distinction is important with respect to hospital services. As discussed above, Medi-Cal beneficiaries may have "de facto access" to hospital services, totally independent to reimbursement levels.

This dynamic skews the framework proposed by MACPAC. Because availability to hospital services is largely due to factors other than rates, changes in the other elements may have little affect on beneficiary access to hospital services. As acknowledged by MACPAC, its initial framework is not well-suited for hospital services. Accordingly, ***CHA recommends that CMS not attempt to apply the MACPAC framework to hospital services.*** This lack of a readily usable analytical framework for access to hospital services supports CMS recommendation above that a key factor to determining the adequacy of hospital rates under Section 30(A) is whether the rates are reasonably related to hospital costs.

C. Managed Care

In its introduction, CMS states that:

> We note that section 1902(a)(30)(A) of the Act, and the requirements of this proposed rule, discuss access to care for all Medicaid services paid through a State plan under fee-for-service and do not extend to services provided through managed care arrangements. Managed care entities are subject to separate access review procedures that are set forth in 42 C.F.R. part 438 to ensure network sufficiency and procedures for beneficiaries to obtain needed services. We are currently undertaking a review of State managed care access standards and are considering future proposals to address access issues under managed care delivery systems.

CHA respectfully disagrees with CMS' conclusion that the requirements of this proposed rule should not extend to services provided through managed care arrangements. Currently, approximately 71 percent of Medicaid beneficiaries are enrolled in some form of managed care,

with approximately 47 percent of these in managed care organizations. (MACPAC, Report to the Congress: The Evolution of Managed Care in Medicaid, p. 13 (June 2011).) States must be held to their responsibility to ensure that all Medicaid beneficiaries maintain access to services, even if they are enrolled in a managed care plan. *See* 42 U.S.C. § 1396u-2(a)(1)(A)(ii), (b)(5), and (c)(1)(A)(i). *See also*, 42 C.F.R. § 438.206(b)(1), which requires states to ensure that managed care organizations maintain "a network of appropriate providers that is . . .sufficient to provide adequate access to all services" covered by the network. Many of the data measures and data sources useful to measure access to care for fee-for-service beneficiaries will be equally useful to measure access for managed care beneficiaries.

CHA further disagrees that Section 30(A) does not ever extend to services provided through managed care arrangements. Section 30(A) requires that a "State plan for medical assistance . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." CHA believes that in a state like California, where the State has independently sought to establish rates paid from Medi-Cal managed care plans to non-contracted hospitals providing emergency and post-stabilization services (Cal. Welf. & Inst. Code § 14091.3), Section 30(A) requires the State to assure that those payment rates to providers are consistent with efficiency, economy, quality of care and access.

CHA's experience in California's demonstrates the importance of holding states to beneficiary access standards in managed care. In California, Medi-Cal managed care plans have reduced the rates for which they are willing to contract as a result of the federal and state regulation of permissible payment rates from Medi-Cal managed care plans to non-contracted providers of emergency and post-stabilization services. The managed care plans take advantage of the hospitals' legal duties to provide emergency care without regard to the ability to pay to ensure access. Many plans never effectuate transfer of emergency patients when they are stabilized because: (1) many emergency visit (like healthy deliveries) are short stays and (2) because the low post-stabilization rates (which are lower than the payment rates for emergency services) create a financial incentive for plans not to transfer their patients to in-network providers. Some plans delegate payment for services to capitated entities and attempt to use these delegation contracts to force contracted providers to accept the non-contracted rates for services provided to beneficiaries assigned to a capitated delagatee.

The only way to balance this regulation of rates is to ensure that managed care plans continue to have complete networks that afford access to the full range of hospital services. However, CHA's experience in California is that the enforcement of these access standards with regard to Medi-Cal managed care plans has been inconsistent. ***The access standards in these regulations, including the information required to be submitted by states in proposed section 447.203(b), should apply equally to beneficiaries enrolled in Medicaid managed care plans*** to help states meet their obligation to determine when a plan's network fails to afford sufficient access.

D. Remediation of Access Issues

The Proposed Regulations quite appropriately requires state Medicaid agencies to monitor beneficiary access and to submit corrective action plans to CMS in the event the state agency identifies an access issue. The Proposed Regulations, however, are not clear concerning the implementation of remediation efforts.

Where an access issue is identified, it is important that remediation efforts begin immediately, that the corrective action plan is subject to CMS's review and approval, and that CMS enforce compliance with the approved plan. ***Accordingly, CHA recommends:***

1. ***To the extent an access problem is linked to a rate reduction or other change in payment method, the rate reduction or other change will be halted immediately and payments will be made in accordance with the state Medicaid plan prior to the rate reduction or methodology change.***

2. ***CMS will review the corrective action plans, and the plans must be subject to CMS approval in the same manner as a SPA. Upon approval, the corrective action plan should become a part of the state plan.***

3. ***CMS should sanction a state that fails to implement a CMS-approved corrective action plan by withholding federal reimbursement for expenditures made by the state that are inconsistent with the corrective action plan.***

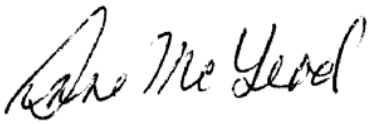
IV. CONCLUSION

CHA appreciates the effort of CMS in promulgating the Proposed Regulations. CHA believes that regulations which ensure beneficiary access and adequate payments rates, which provide for a transparent rate setting process and meaningful opportunity for provider and beneficiary participation, and which require states to comply with federal requirements and contain concrete and certain enforcement mechanisms, are essential to the ongoing effectiveness of state Medicaid programs.

State Medicaid programs' ability to live up to the original commitment of Congress in enacting the Medicaid Act, to "mainstream" poor Americans who could not afford to pay for health care, is as critical now as it has ever been. The expansion of Medicaid and reliance on Medicaid programs as a key element of national health care reform magnify the importance of ensuring that these regulations are sufficient to promote the health of the Medicaid program, which is dependent on adequate payments to ensure quality of care and access to services.

CHA appreciates the opportunity to provide comments on the proposed rule. If you have additional questions, please contact me at amcleod@calhospital.org or (916) 552-7536; or my colleague Alyssa Keefe, vice president federal regulatory affairs at akeefe@calhospital.org or (202) 488-4688.

Sincerely,



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