National
Family Planning
& Reproductive Health Association

June 30, 2011

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

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

To Whom It May Concern:

The National Family Planning & Reproductive Health Association (NFPRHA) submits these comments on the "Methods for Assuring Access to Covered Medicaid Services" proposed rule (CMS-2328-P), published in the Federal Register on May 6, 2011.[1] NFPRHA commends the Centers for Medicare & Medicaid Services (CMS) for the promulgation of this rule, which would ensure sufficient provider reimbursement rates that will, in turn, help ensure patient access to care.

NFPRHA is a membership organization representing the nation's dedicated family planning service providers. Its membership is made up of state and county health departments, private non-profit health centers, Planned Parenthood affiliates, hospitals, and other organizations that provide comprehensive family planning services—contraception, counseling, education and preventive health care—to millions of women and men annually. These providers often serve as the only health care provider for many of the women and men they serve, primarily low-income, uninsured and underinsured Americans.

Each year, publicly supported family planning services help women to prevent 1.9 million unplanned pregnancies, which would have resulted in 860,000 unintended births and 810,000 abortions.[2] Medicaid is the major source of funding for family planning in the United States, accounting for 71 percent of all family planning dollars spent in the U.S. in 2006, up from 20 percent in 1980.[3] Medicaid's role in providing health care to the poor and low-income has only grown during the recession, and will expand significantly further in the planned expansion of full-benefit Medicaid to individuals with incomes up to 133% of the federal poverty level in 2014.

[1] Portions of the discussion and recommendations in these comments were adapted with the permission of the National Health Law Program (NHeLP).
[2] Guttmacher Institute. (2009, February). "Facts on Publicly Funded Contraceptive Services in the United States."
[3] Gold RB, et al., *Next Steps for America's Family Planning Program*, New York: The Guttmacher Institute, 2009.

NFPRHA strongly supports CMS' efforts to increase state accountability in assuring access to high-quality Medicaid services. Sufficient provider payment rates are an important element of ensuring providers' ability to provide access to Medicaid beneficiaries. The proposed regulation would require states to consider the ability of patients to access care when proposing Medicaid provider reimbursement rate reductions and on an ongoing basis, in order to ensure that rates are not falling so low as to undermine sufficient provider participation. The proposed regulation would create a process for states to use in determining whether their reimbursement rates provide "equal access" to Medicaid services under Section 1902(a)(30)(A) of the Social Security Act. This process will allow CMS to better enforce the equal access requirement, thereby protecting providers' ability to serve poor and low-income patients.

The need for strong CMS oversight of Medicaid provider rates is more important than ever. The recession has driven millions of new patients into Medicaid, many of them seeking services at already-stretched safety-net providers, such as publicly funded family planning centers. As providers have struggled to accommodate an influx of new patients, a number of states have sought ways to cut costs from their Medicaid programs, such as by cutting already-low provider reimbursement rates. Historically, lawsuits by Medicaid enrollees and providers have been able to keep some pressure on states to prevent them from cutting provider rates without properly considering the impact on access to care. However, the pending Supreme Court consideration of *Douglas v. Independent Living Center* makes CMS's enforcement role all the more critical. The proposed rule will aid CMS in overseeing that state decisions and processes regarding Medicaid provider reimbursement rates are sufficient to ensure provider participation, thus ensuring patient access to care.

NFPRHA believes, however, that in light of the current and future challenges of meeting the growing needs of the Medicaid program, the proposed rule could be strengthened. NFPRHA respectfully offers the following suggestions for improvement: 1) the proposed regulation should be expanded to include Medicaid managed care organizations; and 2) the timeline for rate reviews should be shortened.

The Proposed Regulation Should Be Expanded to Include Medicaid Managed Care Organizations

In the Preamble to the proposed regulation, CMS asserts that Section 1902(a)(30)(A) discusses "access to care for all Medicaid services paid through a State plan under fee-for-service and [does] not extend to services provided through managed care arrangements."[4] Thus, CMS has made the proposed regulation inapplicable to managed care rates. NFPRHA strongly disagrees with this decision and urges CMS to apply the proposed regulation to managed care plans.

Over 70 percent of Medicaid enrollees are enrolled in some form of managed care.[5] This percentage is likely to grow as states look to managed care as a means of controlling Medicaid costs to reduce budget deficits. Despite legal requirements that capitation payments made by states to managed care plans be "actuarially sound," there are consistently complaints from Medicaid enrollees and

[4] 76 Fed. Reg. 26342, 26344.
[5] Kaiser Family Foundation, *Medicaid and Managed Care: Key Data, Trends and Issues* (February 2010).

consumer-based organizations about the failure of managed care organizations to maintain adequate networks of providers. Indeed, many managed care organizations—while receiving capitation payments from the state—pay providers on a fee-for-service basis. Payments to these providers can often be low, undermining their ability to participate in Medicaid. The capitation payments made to managed care organizations should not operate as a shield between fee-for-service payments made by managed care organizations and the protections of Section 1902(a)(30)(A). If the proposed regulation is to succeed in ensuring equal access, then the benchmarks for access and CMS oversight must be applied to managed care plans.

Other provisions of the Medicaid statute and the proposed regulation set a standard of actuarial soundness for capitation payments under managed care risk arrangements. However, there is nothing in Section 1902(a)(30)(A) that would prevent its equal access requirement 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 acting as the states' agents in providing care to enrollees should pay adequate rates to the providers in their networks to assure adequate access.

The Timeline for Rate Reviews Should Be Shortened

NFPRHA supports CMS' decision to require rate reviews on an ongoing basis rather than only when a state chooses to implement rate reductions. History has shown that many years can go by without rate adjustments by states, and in that time Medicaid rates can fall far behind the rates paid by other payers. This requirement is a welcome step toward ensuring sufficient provider reimbursement rates, and must be retained in the final regulation.

As currently drafted, the proposed regulation requires 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. Consequently, if the regulation becomes effective in February 2012, then the 5-year review period would not begin until January 2014. Rates for some services would not be reviewed until the end of 2019, almost 9 years from now.

Given that states should already have been assuring that their rate structures comply with Section 1902(a)(30)(A), and that under the regulation's proposed timeframe many states would not begin their reviews until after the implementation of the Affordable Care Act's (ACA) expansion of full-benefit Medicaid eligibility up to 133% of the federal poverty level, this is simply too long to wait.

NFPRHA therefore recommends that the timeframe of all first-cycle reviews should be concluded by the end of the second full calendar year following the effective date of the final regulation. NFPRHA also recommends that the 5-year review period for subsequent cycles be shortened to 3 years.

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NFPRHA appreciates the opportunity to comment on the Methods for Assuring Access to Covered Medicaid Services proposed rule (CMS-2328-P). Should you have any questions, please feel free to contact Robin Summers at rsummers@nfprha.org or 202-293-3114.

Respectfully submitted,

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