AMERICAN LUNG ASSOCIATION.

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May 22, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold (CMS 2406-P)

Dear Secretary Azar:

The American Lung Association appreciates the opportunity to submit comments on Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold.

The American Lung Association is the oldest voluntary public health organization in the United States, representing the 33 million Americans living with lung disease, including asthma, lung cancer and COPD. Medicaid plays an especially vital role for patients with lung disease. Almost one-quarter of people with COPD are enrolled in Medicaid or qualify as dual eligible[1], and more than half of all children with asthma receive their healthcare coverage through Medicaid and CHIP.[2]

In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, the changes in the proposed rule, exempting some states from reporting on access to healthcare when provider payment rates are reduced, do not meet this standard.

Payment and Patient Access

Medicaid enrollees are, by definition, low income. This is a population that does not have access to quality and affordable healthcare other than through the Medicaid program. The federal government recognized this important fact and requires Medicaid payments to providers be *"sufficient to enlist enough providers so that care and services are available under [each state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."*[3]

In November 2015, the Centers for Medicare and Medicaid Services (CMS) issued regulations that require states to create and submit an Access

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Monitoring Review Plan (AMRP) to monitor data and collect stakeholder input to ensure Medicaid enrollees have sufficient access to treatment. These plans are required to specifically monitor access if provider payment rates are cut.

Provider payment is not synonymous with patient access, but it is paramount to ensure access to treatment and services exists. In its June 2012 Report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) said, "Access is more than linking providers to Medicaid and CHIP enrollees; it is ensuring that enrollees obtain appropriate health services that are of high quality and that result in better health outcomes." The report went on to say, "Experiences of different subgroups in gaining access to care may vary and be completely different from service to service."[4]

The current rule requires states to monitor patient access and report on five different categories of service: primary care services, physician specialist services, behavioral health services, prenatal and postnatal obstetrics services and home health services. Requiring states to monitor access to these key services after a payment decrease will allow the state, HHS and the public to see if fewer providers are willing to see patients for the lower reimbursement rate.

Medicaid has historically had lower provider payments than private insurance or Medicare. A 2017 MACPAC report to Congress found that Medicaid enrollees experience longer wait time for providers and have more trouble finding a provider that will treat them compared to those with private insurance. The report continued, "Medicaid enrollees have more difficulty than low-income privately insured individuals in finding a doctor who accepts their insurance and making an appointment." Payment drives patient access to treatment. The current rule allows state the flexibility to make changes to payment rates, while also monitoring any impact on patient access.[5]

<u>Concerns with Exemption for States with High Managed Care Enrollment</u>
Under the proposed rule, states with over 85 percent of individuals enrolled in Medicaid managed care organizations (MCOs) would no longer be required to develop and maintain an AMRP. The Lung Association believes that access to care for all populations served by the Medicaid program should be regularly and thoroughly monitored with opportunities for input from patients and other stakeholders regardless of the proportion of individuals enrolled in MCOs.

In states that rely heavily on MCOs, the populations remaining in traditional Fee for Service (FFS) are often vulnerable populations – including children with special health care needs, individuals with disabilities, and the elderly. For example, while Louisiana had 92 percent of its Medicaid population enrolled in managed care as of July 2017 and would qualify for the new exemption, just 41 percent of the aged and disabled eligibility group was enrolled in an MCO.[6] Access to care for these patients is particularly important to monitor due to their complex health needs. The Lung Association is concerned that access to care for these patients may fall through the cracks if the 85 percent exemption or an exemption at any other MCO enrollment threshold remains in the final rule.

States that enroll a high percentage of individuals in MCOs often carve out certain services that remain covered by traditional FFS. Over 40 percent of Medicaid beneficiaries receive at least some of their care through FFS.[7] Access to these carved out services would no longer be monitored through an AMRP in states that meet the 85 percent exemption, making it more difficult to determine if patients receive the care that they need. For example, Maryland, a state that had 89.2 percent of Medicaid

recipients enrolled in MCOs as of July 2017 and would qualify for the new exemption, carves out tobacco cessation. Maryland has 70,140 smokers enrolled in their Medicaid program, a rate of 30.3 percent.[8] These smokers need access to tobacco cessation treatment to quit to avoid costly and deadly diseases, such as cancers, COPD and heart disease.

Monitoring access within FFS also remains important in states with high MCO penetration because of the impact that FFS payment rates have on MCO payments, and therefore on access to care for patients enrolled in MCOs. FFS payment rates are often used to determine the size of the capitation payments that MCOs receive. Some states also use FFS provider payment rates as a floor for the rates that MCOs pay providers under their plans. The implications of rate changes in FFS on rates and patient access in managed care therefore need to be fully considered. While the current rule provided an opportunity for patients and other stakeholders to provide input on these and other similar implications, this opportunity for input would be lost in many states under the 85 percent exemption in the proposed rule.

Concerns with the Changes to the Provider Payment Rate Reduction Threshold

The proposed rule also creates a new exemption for proposed provider payment rate changes of less than four percent in one year or less than six percent over two years. For a provider payment rate change of this size, a state would no longer have to collect public input on the change and submit its most recent AMRP with a specific analysis of the change's impact on access to care, instead providing an "alternative analysis, along with supporting data" that is not adequately defined. This policy does not consider whether baseline payment rates may already create access problems and could incentivize states to consistently reduce payment rates just below the new thresholds without fully analyzing the cumulative impact that the changes have on access to care for lung disease and other patients.

This exemption could have a particularly negative impact on access to specialty care for lung disease patients. The exemption is structured so that as long as a rate change is less than four percent within a state plan service category overall, a state can cut rates by greater than four percent for certain specialties and still qualify for the exemption. This could allow states to cut rates for specialists that lung disease patients to levels that could jeopardize their access to care. Asthma, COPD, and lung cancer patients need pulmonologists, allergists, oncologists, and other specialists to help them find the best treatments and manage their conditions. Any changes that could impact their access to these providers should go through a full analysis and public process with opportunities for patient input, as is required under the current rule.

Lack of Information to Change the Current Rule

The Lung Association appreciates HHS's efforts to minimize the burden on states. However, there has not been the requisite experience with the current rule for HHS to propose such drastic changes at this point. The original rule was published in November 2015 and the initial deadline for AMRP submissions was October 1, 2016. The current rule has not been effect for two full years. The short time the current rule has been in effect does not allow for enough data to be collected to make thoughtful and data-driven improvements to measuring access to services within the FFS Medicaid program.

One of the changes proposed would waive the need to report on access to services if a provider rate was cut by six percent over less over two years. Because the current rule has not yet required states to

report data on two years, HHS cannot have the data to show a six percent decrease over two years does not create a decrease in access to providers. There is no reason to believe six percent is nominal. Six percent is an arbitrary number and does not guarantee that Medicaid enrollees will have access to quality and affordable healthcare.

The proposed rule's exemption for annual payment decreases of four percent or less over a year is not backed up data either. A four percent decrease in Medicaid payments is not a nominal amount. The current rule provides states with the flexibility to decrease payment rates at any amount, however the current rule balances state flexibility with protecting Medicaid enrollees' access to quality healthcare by requiring the state to report on how their payment decrease does not impact patient access.

These comments include numerous citations to supporting research, including links to the research for the benefit of HHS in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

The American Lung Association encourages HHS not to finalize this proposed rule and instead to continue to require all states to submit AMRPs for any payment decrease to allow both HHS and the public to monitor Medicaid patients' access to quality healthcare. There is still more to be learned from the current rule about the impact of provider payment on patients' access to quality healthcare. Thank you for the opportunity to provide comments.

Sincerely,

Harold P. Wimmer
National President and CEO

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

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[1] 2016 NHIS
[2] https://www.cdc.gov/asthma/asthma_stats/Health_Care_Coverage_among_Children.htm
[3] Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239). Found at: https://www.congress.gov/bill/101st-congress/house-bill/3299/text
[4] Medicaid and CHIP Payment and Access Commission (U.S.). (2012). Report to the Congress on Medicaid and CHIP. Washington, DC: MACPAC, Medicaid and CHIP Payment and Access Commission. Found at: https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-612/

[5] Medicaid and CHIP Payment and Access Commission (U.S.). (2017). Report to the Congress on Medicaid and CHIP. Washington, DC: MACPAC, Medicaid and CHIP Payment and Access Commission. Found at: https://www.macpac.gov/publication/march-2017-report-to-congress-on-medicaid-and-chip/

[6] https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/

[7] https://www.healthaffairs.org/do/10.1377/hblog20180402.153675/full/

[8] DiGiulio A, Haddix M, Jump Z, et al. State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage — United States, 2016. MMWR Morb Mortal Wkly Rep 2016;65:1364–1369. DOI: http://dx.doi.org/10.15585/mmwr.mm6548a2

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance

must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.