



American Health Care Association

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July 5, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2328-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-2328-P: Comments on Medicaid Program: Methods for Assuring Access to Covered Medicaid Services Proposed Rule, 76 Federal Register 26342, May 6, 2011

Dear Ms. Mann:

The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) appreciate the opportunity to comment on the proposed rule, Medicaid Program: Methods for Assuring Access to Covered Medicaid Services Proposed Rule, 76 Federal Register 26342, May 6, 2011.

AHCA/NCAL is the nation's leading long term care organization. AHCA/NCAL and our membership of nearly 11,000 non-profit and proprietary facilities are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly, and disabled citizens who live in nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities.

Our comments largely focus on issues surrounding the proposal to create a standardized, transparent process for states to follow as part of their broader efforts to ensure legal protections under section 1902(a)(30)(A) of the Social Security Act. Those protections require that state payments for Medicaid services 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 [state] plan at least to the extent that such care and services are available to the general population in the geographic area."

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We also comment in support of the Centers for Medicare and Medicaid Services (CMS) proposal to recognize electronic publication as a means of communicating to the public state plan amendments (SPAs) for proposed rate setting policy changes, as long such publication is regularly updated and for *any* changes in rates, methods and standards.

Overall, AHCA/NCAL believes the proposed rule represents a genuine attempt to create a truly necessary process for states to follow as part of legal protection requirements under 1902(a)(30)(A) of the Social Security Act (§ 30(A)), and we commend CMS for their efforts. However, we are very concerned that the framework proposed by CMS will undermine § 30(A).

We provide below our recommendations followed by a discussion of our concerns.

### **AHCA/NCAL Recommendations**

- *AHCA/NCAL recommends that CMS include quality in its framework to assure access to care. Without quality, CMS' proposal likely would undermine the broader protections of § 30(A);*
- *AHCA/NCAL recommends that CMS include AHCA/NCAL's recommended elements (listed below) for reviewing access to nursing facility care. These additional elements are necessary because the MACPAC-recommended framework does not include long term care. As such, the data elements outlined in the proposed rule largely are not applicable for long term care;*
- *AHCA/NCAL recommends that CMS outline remedies for beneficiaries and providers when states proceed with a reimbursement change even though access or quality issues are implicated through state reviews;*
- *AHCA/NCAL recommends that CMS provide a structure that facilitates uniformity in access and quality measures;*
- *AHCA/NCAL recommends that CMS create a process that will allow providers to participate and comment as stakeholders prior to submission of SPAs;*
- *AHCA/NCAL recommends that CMS allow electronic public communication for reporting proposed rate setting policy changes for all changes in rates, methods and standards and not limit such communication to "significant" changes;*
- *AHCA/NCAL recommends that CMS develop processes for assuring access to quality Medicaid services under new models of service delivery, as well as under traditional models.*

### **Discussion**

#### **I. Introduction**

The preamble to the proposed rule notes that:

Section 1902(a)(30)(A) requires that, in order to receive Federal Financial Participation (FFP), States must set Medicaid service payment rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services

are available to Medicaid eligible individuals to the extent that they are available to the general population in the geographic area.

Even though the preamble notes the multi-pronged requirements of Medicaid service payment rates—consistent with efficiency, economy, and quality of care *and* sufficient to enlist enough providers—the proposed rule focuses only on the last prong, the sufficient available providers or “access” prong. This narrow focus on access is contrary to the explicit statutory language contained in § 30(A) and would undermine the Medicaid program. It is imperative that CMS imbed quality within the text of the final rule and mandate that states analyze access and sufficiency of providers within the context of quality.

In addition to failing to mandate that states analyze access within the context of quality, the proposed rule also fails to consider a number of other important issues as follows:

- Long term care is not addressed in the framework;
- Adequacy of payment is not properly measured;
- There is a lack of remedies for beneficiaries and providers;
- There is an absence of nationally uniform access and quality measures; and
- There is no consideration of new service delivery models such as accountable care organizations.

## **II. CMS Must Include Quality in its Framework to Assure Access**

In its discussion of the proposed rule, CMS explains, in part, its impetus for publishing the proposal, stating that greater guidance is needed for states in making changes to state Medicaid payments to demonstrate compliance with the “access clause” in § 30(A).

Since the enactment of § 30(A) in its present form in 1989, the Department of Health and Human Services (HHS) has not provided comprehensive regulatory guidance explaining how state compliance with § 30(A) is to be implemented or measured. In recent years, CMS has requested additional information from states in evaluating proposed provider payment rate changes, and has requested that states provide assurances that access would not be affected by payment reductions. In its discussion of the proposed rule, CMS notes that “only a few states indicated that they relied upon actual data to make the determination,”<sup>1</sup> and that states tend to rely on “historical levels of provider enrollment and their belief that providers would not disenroll based on a reduction in payments.”<sup>2</sup> CMS further notes that states tend to lack a systematic approach to gather data on the access impact of rate cuts or measure impact on an ongoing basis.<sup>3</sup>

### ***Emphasis on Access to Care Alone is Flawed***

The proposed rule would revise current Medicaid payment method rules to require that, in addition to documenting payment rates, state Medicaid programs must document access to care. In states’ access reviews, they “must document using data trends and factors, an analysis that

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<sup>1</sup> 76 Fed. Reg. 26348 (May 6, 2011).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

demonstrates *sufficient access to care*, considering, at a minimum:” (1) the extent to which enrollee needs are met; (2) the availability of care and providers; and (3) changes in beneficiary utilization of covered services. The access reviews would also need to include beneficiary data and Medicaid payment data, defined as the payment percentile of Medicaid payments in relation to estimated average customary provider charges as well as estimated Medicare payments or commercial payments.

In emphasizing only the access prong of § 30(A), the proposed rule fails to correctly interpret the statutory text of § 30(A). The first place to look for the correct interpretation of a statutory provision is to the text of the statute itself.<sup>4</sup> **The Proposed Rule defies the text of § 30(A) by focusing only on the last clause of § 30(A), the “sufficient access to care” clause, to the exclusion of the preceding clause, which includes efficiency, economy, and quality of care.**

Section 30(A) contains four distinct metrics for determining rates’ adequacy: efficiency, economy, quality, and access, requiring rates to be “consistent” with the first three metrics and “sufficient” with the last metric. The conjunctive “and,” as used in § 30(A), denotes a requirement that states’ Medicaid rates must satisfy all four metrics, not just the access metric, as the proposed rule indicates. As a consequence, rates that provide only sufficient access do not satisfy the text of § 30(A) if those rates are inconsistent with efficiency, economy, and quality. It is important to note that the inverse is also true: rates are inadequate if they are consistent with efficiency, economy, and quality, but are insufficient to provide equal access. **As a consequence, in order to satisfy the text of § 30(A), the proposed rule must be modified to include the review of rates to ensure consistency with efficiency, economy, and quality of care.**

It may be possible that CMS focused on access in its proposed rule because it believed that mandating access would implement the entire statutory text without requiring an independent evaluation of rates’ consistency with efficiency, economy, and quality. If so, this logic is flawed.

### ***Tenuous Link between Reimbursement Rates and Provider Participation***

For example, the link between reimbursement rates and provider participation is quite tenuous in some sectors of the health care industry. The Emergency Medical Treatment and Active Labor Act (“EMTALA”) imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual’s ability to pay.<sup>5</sup> Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions.<sup>6</sup> Because Medicare-participating hospitals that offer emergency services are required to serve Medicaid patients whether the hospitals participate in Medicaid or not, it is rational for the hospitals to participate in Medicaid for even nominal compensation in order to receive reimbursement for some portion of their costs for care

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<sup>4</sup> It is an axiomatic principle of administrative law that the unambiguously expressed intent of Congress articulated by a statute trumps an agency promulgated regulation. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) (if Congress has “spoken to the precise question at issue” directly and clearly, courts must give effect to the “unambiguously expressed” intent of Congress).

<sup>5</sup> See 42 U.S.C. § 1395dd (2000).

<sup>6</sup> *Id.*

provided under EMTALA. As a consequence, using only the access metric, it would be very unlikely that state access reviews would ever show that emergency room reimbursements violate § 30(A) because hospitals, in practice, usually do not opt out of serving Medicaid patients. Thus, rates for Medicaid hospital reimbursement could sustain equal access to emergency room services but could simultaneously be entirely inconsistent with efficiency, economy, and quality.

### ***The Role of Cost-Shifting***

In addition, it is possible that low Medicaid rates might not drive providers out of the market because providers sometimes use cost-shifting techniques—overcharging some patients, while undercharging others, such as Medicaid beneficiaries. Cost-shifting allows providers to serve Medicaid patients for below-cost compensation without suffering a net loss. Thus, cost-shifting allows providers to continue to serve Medicaid beneficiaries for below-cost compensation without suffering a net loss. This practice permits equal access even if Medicaid rates are not consistent with economy, efficiency, or quality.

### ***The Overriding Importance of the Quality of Long Term Care***

Further, it has been difficult for long term care providers to historically develop a case whereby Medicaid beneficiaries arguably did not have “sufficient access to care” based upon state Medicaid reimbursement rates. Long term care providers are sometimes prohibited from “discriminating” against Medicaid beneficiaries as a condition of participation in a state’s Medicaid program.<sup>7</sup> Thus, in the long term care setting, because Medicaid reimbursement for long term care might sustain sufficient access to care, a review of quality of care may be more important than a review of access to care. Quality of long term care is important because, for example, long term care remains largely segregated, with Medicaid beneficiaries disproportionately represented in nursing homes that are more likely to have been identified and sanctioned for poor performance.<sup>8</sup> Thus, as the proportion of residents in a facility covered by Medicaid increases, the quality of care decreases. This strongly argues for including quality in the methodology states use to modify their Medicaid reimbursement rates or reimbursement methodology to nursing facilities.

Many states and CMS currently measure and report quality measures for nursing home residents, many whom are Medicaid beneficiaries. In fact, on average about two-thirds of long stay nursing home residents qualify for Medicaid benefits. When considering quality and access in developing Medicaid payment policies, states should consider changes in acuity and case mix both state wide and within facilities. Understanding and interpreting outcome, process or structural measures of quality are difficult without such information. States should also be required to incorporate quality measures and “standards” set by measures in their Medicaid reimbursement rates and methods. For example, CMS is launching a Quality Assurance/Performance Improvement (QAPI) for nursing homes. Similarly, CMS set staffing level targets in their 5 star quality rating system. States should incorporate these quality targets into their Medicaid reimbursement rates or methods of reimbursement.

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<sup>7</sup> See 42 C.F.R. § 483.12(c)(4); see e.g. Ohio Rev. Code Ann. § 5111.31.

<sup>8</sup> David Grabowski, Joseph Angelelli & Vincent More, Medicaid Payment and Nursing Home Adjusted Quality Measures, *Health Affairs* 23:5 243-251 (Sept./Oct. 2004).

It is important to note that in discussing the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended framework, which CMS uses as its base for its suggested state-conducted access reviews, the proposed rule does not mention quality of care. However, the March 2011 MACPAC report that explains this framework does focus not only on access, but also on quality of care. For example, in the chapter discussing the recommended framework, the report notes, “[B]ecause Medicaid continues to be one of the nation’s largest payers of health coverage, it is critical that payment policies support high-quality, efficient care.”<sup>9</sup> The report also states, “The framework incorporates notions of appropriate services in appropriate settings to maximize the value and quality of care received.”<sup>10</sup> However, inconsistent with the MACPAC report, the proposed rule centers solely on access and mentions quality only in passing.

To the extent that the Medicaid access rule addresses none of the § 30(A) prongs other than sufficient access to care, long term care providers may have a difficult time arguing against approval of state plan amendments by CMS in what may be their exclusive remedy.<sup>11</sup> This would largely leave institutional providers without a remedy in ongoing budget battles in state capitals to maintain Medicaid rates that allow long term care providers to survive. More importantly, the impact on Medicaid beneficiaries in need of long term care services could be disastrous.

**To summarize, the proposed rule’s focus on only the equal access element in § 30(A) neglects to emphasize § 30(A)’s requirement that “payments are consistent with efficiency, economy, and *quality of care*.” By focusing only on the access prong of § 30(A), CMS ignores the explicit statutory language of § 30(A). Further, the proposed rule’s sole emphasis on equal access could undermine the broader protections of § 30(A) and harm Medicaid beneficiaries and Medicaid providers alike.** States should incorporate changes in acuity and case mix as well as requirements implied by national and statewide quality measures reported by CMS and states when revising their Medicaid rates and reimbursement methodologies for nursing homes.

Thus, AHCA/NCAL recommends that, in order to comply with all elements of § 30(A), CMS modify the proposed rule so as to require state Medicaid programs to demonstrate that Medicaid beneficiaries have “equal access” not just to care, but *quality* care, addressing quality in both clinical and patient centered care.

### **III. The MACPAC-Recommended Framework Does Not Address Long Term Care; CMS Should Use Additional Measures for Long Term Care**

In its March 2011 report, MACPAC unveiled an initial framework for examining access to care. As discussed above, the Commission states in the report that “The framework incorporates

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<sup>9</sup> MACPAC March 2011 Report to the Congress on Medicaid and CHIP, Mar. 2011, Ch. 4, *available at* <http://www.macpac.gov/reports>.

<sup>10</sup> *Id.*

<sup>11</sup> As mentioned in Part II.C *supra*, the Supreme Court could rule against federal court jurisdiction over Medicaid access cases, ostensibly leaving CMS’ state plan amendment approval process as the only remedy to inappropriately low Medicaid reimbursement rates.

notions of appropriate services in appropriate settings to maximize the value and quality of care received.”<sup>12</sup> Additionally, the impact of services (i.e., health outcomes) is an important part of the framework.

The Commission goes on to explain that the framework is “tailored to reflect Medicaid and CHIP policies, special characteristics of the program’s enrollees, and factors these populations may face when seeking and obtaining appropriate care.”<sup>13</sup> It is evident that the Commission was deliberate in its construction of the framework and goals it wishes to achieve for specific populations receiving Medicaid and CHIP services.

Thus, it is extremely important to note that, the Commission is very clear in its acknowledgement that the three-part framework, which it recommends for examining access to care, does not address hospital, ancillary, or long term care and other services and supports. **Rather, it clearly states that the framework put forth in the March report focuses on primary and specialty care providers and services.**<sup>14</sup>

**Contrary to MACPAC intentions, however, CMS has adopted the MACPAC framework in its proposal for examining beneficiary access across all Medicaid services.** In the proposed rule, CMS outlines several data elements that states could review to demonstrate sufficiency of access.<sup>15</sup> However, many of the suggested elements are not applicable to long term care. For example, to measure beneficiary access, CMS’ suggestions largely center on physician appointments, transportation, and emergency room use. Additionally, for measuring availability of care and providers, CMS suggests states review, for example, the availability of care and services through Medicaid fee-for-service as compared to commercial managed care or other commercial insurance access standards. The care provided to most nursing facility residents is paid for under Medicaid fee-for-service. Medicaid managed long term care is not widely available, nor is commercial insurance that pays for long term care services and supports (i.e., long term care insurance).

Since the measures in the framework largely were not intended for long term care and its use is not applicable for that sector, AHCA/NCAL recommends that CMS utilize additional measures to address long term care in its framework.

Below are key factors that we believe could be utilized successfully to examine access to long term care:

***Key Factors for Nursing Facility Services:***

- Mandate a review of Medicaid and overall occupancy in facilities with high quality rankings compared to those with lower rankings on a statewide and regional basis.

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<sup>12</sup> MACPAC March 2011 Report to the Congress on Medicaid and CHIP, Mar. 2011, Ch. 4, *available at*: <http://www.macpac.gov/reports>.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> 76 Fed. Reg. 26345-26346 (May 6, 2011)

The goal would be to determine if Medicaid beneficiaries have equal access to higher quality nursing facilities;

- Mandate a review of Medicaid and overall occupancy by region of the state to identify possible regional issues (using MSAs and/or HSAs);<sup>16</sup>
- Survey hospital discharge planners by region on difficulty of placing Medicaid patients or Medicaid patients with specific needs before and after rate changes;
- Survey patients and families of nursing facilities that have closed as to the difficulty of finding alternate placement; ability to be transferred to facility of choice; and their satisfaction with any new facility;
- Survey families and Medicaid beneficiaries who have recently been admitted to nursing facilities as to difficulty in finding a facility that could meet the patient's needs; ability to be transferred to facility of choice; and satisfaction with the facility;
- Review compliance and quality records of nursing facilities with the highest Medicaid volumes in comparison to those with lower Medicaid volumes (if higher Medicaid volume facilities already have poorer compliance records, a rate reduction would make a bad situation worse);
- Mandate an impact analysis of rate cuts on ability of high Medicaid volume providers to meet staffing requirements and quality and safety standards;
- Mandate disclosure of cost coverage percentage for nursing facility services (see discussion below).

***Key Factors for Home and Community-based Waiver Services:***

- Mandate a review of each state's Medicaid waiver services to determine if there a sufficient number of providers throughout the state or covered geographic region to deliver quality HCB services as contained in the state's waivers.

**IV. CMS Should Include Adequacy of Payments as a Major Factor in an Analysis of Access to Long Term Care Services**

***Need For Adequacy of Payment Rates***

We believe any analysis of access to long term care services must place substantial importance on the adequacy of payment rates related to the cost of care. In MACPAC's March report, payment policies and practices are an important component of one of the prongs (availability) of their recommended three-part framework. Payment rates are an important factor—if not the

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<sup>16</sup> "Metropolitan Statistical Areas" or "Health Service Areas."



most important factor—in provider availability. Providers simply cannot properly operate and provide quality care without adequate payment, which will have significant impacts on not only access but also staffing and safety.

CMS states in the proposed rule that the “changes to the regulation text at §447.203(b)(1)(iii)(B) would require that the [access] review must include: (1) an estimate of the percentile which Medicaid payment represents of the estimate average customary provider charges; (2) an estimate of the percentile which Medicaid payment represents of one, or more, of the following: Medicare payment rates, the average commercial payment rates, or the applicable Medicaid allowable cost of the services, and (3) an estimate of the composite average percentage increase or decrease resulting from any proposed revision in payment rates.”<sup>17</sup>

### *Need For Aggregate Cost Coverage Standard*

AHCA/NCAL believes the standard should be aggregate cost coverage. That is, Medicaid reimbursement should be compared to Medicaid allowable costs, and the percentage of cost coverage for nursing facility services should be disclosed. In addition, CMS should consider the impact Medicaid rate cuts will have on high volume Medicaid providers.

The cost coverage standard is used in an annual study conducted since 1999 examining shortfalls in Medicaid funding for nursing home care.<sup>18</sup> The most recent report shows the average daily reimbursement shortfall for 2010 was projected at \$17.33 per Medicaid patient day, more than a 90% increase since 1999. This represents a total of \$5.6 billion in unreimbursed Medicaid nursing home care costs. The Medicaid reimbursement outlook for the future is even bleaker, with unprecedented state budget deficits and the expiration of federal stimulus funds as of July 1, 2011. Along with the expiration of stimulus funds, Medicaid prompt payment requirements for hospitals and nursing facilities will also expire. The expiration of prompt payment protections could take us back to a time from the not-to-distant past in which Medicaid payments to nursing facilities were significantly delayed, particularly in California.<sup>19</sup>

In the proposed rule, CMS states the strategy for assessing access would not focus solely on provider payment rate changes and the state plan process, but assess ongoing performance. We agree that such a strategy should not be solely focused on provider payment rates; however, as demonstrated by the annual Medicaid funding shortfall study above, States have failed in their ongoing performance of providing adequate reimbursement rates to provide quality care to the nation’s frail and elderly. This is a period in Medicaid ripe for serious access problems due to underfunding and other payment policy and administrative barriers.

AHCA/NCAL recommends that any new process for assessing access must utilize payment adequacy and cost coverage as a central element in state reviews.

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<sup>17</sup> 76 Fed. Reg. 26351 (May 6, 2011).

<sup>18</sup> *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2010, Eljay, LLC.

<sup>19</sup> In 2008, nursing facility providers in California, as well as other providers, operated without payment for several weeks due to a budget impasse that left the state without a budget for approximately three months. Some nursing facility owners took out second mortgages on their own homes just to pay their employees.

## **V. CMS Should Outline Remedies for Beneficiaries and Providers**

CMS proposes a system under which federal approval of rate cuts is conditioned on certain procedural steps, including an access review of the services whose payment rates are to be cut, ongoing monitoring, mechanisms for beneficiary input, and a corrective action plan to address access issues. States that proceed with rate cuts in absence of such a review risk state plan amendment disapproval and compliance actions including the partial or full loss of federal financial participation.

However, if a state nonetheless proceeds with a provider rate reduction that implicates access (or quality), in advance of the CMS review process, there would need to be remedies available to beneficiaries and providers. Would beneficiaries and providers be expected to pursue private remedies in the courts? While the proposed rule requires states to have a mechanism for beneficiary input on access to care, such as hotlines, surveys, ombudsman or other equivalent mechanisms, the proposed rule does not indicate what remedies beneficiaries and providers will have if their input indicates an access or quality deficiency and the state proceeds regardless.

AHCA/NCAL recommends that CMS outline remedies for beneficiaries and providers in the final rule.

## **VI. CMS Should Move Toward Nationally Uniform Access and Quality Measures**

The proposed rule allows state Medicaid programs to develop their own access measures as long as they adhere to the MACPAC access framework: (1) the extent to which enrollee needs are met; (2) the availability of care and providers; and (3) changes in beneficiary utilization of covered services. CMS' rationale for this decision rests, in part, on the local variability of conditions that collectively shape health care access. Is it important, however, that federal and state policymakers be able to understand how comparable local conditions yield different access results.

The rationale for local variability of conditions that shape health care access does not apply to quality measures. In all health care settings, providers, payors and regulators are adopting national standardized measures of quality. Quality of care should not vary based on different regions of the country. Medicaid beneficiaries should expect to receive and CMS should expect to pay for services that result in the same quality outcomes regardless of the state a person resides.

Thus, as Medicaid moves toward more uniform eligibility standards for the poorest adults, it could be important that access (and quality) measures be uniform in some way. CMS should require states to use quality measures or targets that have been approved by national organizations such as National Quality Forum (NQF) and justify when proposing new or different quality measures and targets. Similarly, CMS should ask states to utilize CMS measures of quality such as those reported on Nursing Home Compare. To be sure, some states that have public reporting programs now require the use of nationally endorsed measures by NQF or link to Nursing Home Compare.

Also, as CMS moves toward setting standards for Quality Assurance and Performance Improvement (QAPI), CMS should require states to incorporate QAPI standards or certification into their Medicaid payment methodology. Likewise, standards set forth in national programs that certify quality systems (e.g. Baldrige or NCQA Medical Home) should be incorporated into Medicaid payment plans for nursing homes. State plans should consider the cost of meeting these quality standards when adjusting their Medicaid reimbursement rates and methodology.

AHCA/NCAL recommends that CMS provide a structure, outlined above, that facilitates uniformity in access and quality measures that considers the balance of state flexibility with ensuring efficient, economical, quality, and accessible care.

## **VII. Electronic Public Reporting Is Preferable and Should be Utilized for All Changes in Rates, Methods and Standards**

AHCA/NCAL commends CMS on its proposal to recognize electronic publication as a means of communicating to the public about SPAs for proposed rate setting policy changes. CMS states in the proposed rule that the current regulatory language, which requires publication in a State register similar to the Federal Register, the newspaper of widest circulation in each city with a population of 50,000 or more, or the newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more, was drafted prior to widespread accessibility of the web and development of State government web sites.<sup>20</sup> As such, the agency is updating the regulation through the proposed rule to consider electronic methods of publication using a state website. If a state website were used, it would need to be updated regularly, with a date of release of the initial publication and with the preservation of the initial publication in its original proposed form.<sup>21</sup>

There are weaknesses in the SPA process, and this means of communicating is sorely needed. We believe that it will further the goal of transparency in the SPA process. Addressing transparency, we recommend that CMS create a process that will allow providers to participate and comment as stakeholders prior to submission of an SPA.

CMS also is soliciting public comment on the use of the term “significant” in §447.205(a).<sup>22</sup> The current public notice regulation calls for notice of “significant” changes in methods and standards, which has resulted in some confusion among States in determining when it is appropriate to publish notice. CMS admits that because the term “significant” is not defined, and because the impact of payment changes is not always objectively clear, States are not always clear on when it is appropriate to notify the public of changes to rate-setting methods and standards. The agency suggests one option would be to remove the reference to significance and clarify that *any* changes in rates, methods and standards require public notice.

AHCA/NCAL strongly supports CMS’ suggestion to remove the reference to significance and clarify that any changes in rates, methods and standards require public notice.

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<sup>20</sup> 76 Fed. Reg. 26347 (May 6, 2011).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

## VIII. CMS Also Should Consider Access Under New Service Delivery Models

Given that there is a strong and urgent push for new models of health care delivery and payment, AHCA/NCAL believes that CMS should include, along with processes that examine access under current models, processes that would assure access and quality under new models such as accountable care organizations. For example, cost reports—important now—are for tasks that might not be needed in the future.

Health care reform, under the Patient Protection and Affordable Care Act (ACA) with its focus on bundled payments, medical homes, value-based purchasing and accountable care organizations likely will result in greater collaboration and coordination among primary, acute and post-acute care providers as they move together toward more efficient and effective quality care. States will need to assess these providers in their effectiveness in meeting the new goals of quality, efficiency and economy of care in a coordinated manner. To evaluate only access in silos and ignore the new goals and models is short-sighted and inappropriate. There clearly is a need to develop new evaluative approaches that better match new models of coordinated and collaborative care. For example, integrated care, clearly the wave of the not-to-distant future, should not be measured in silos, but rather by outcomes of integration.

Additionally, considering implementation of various provisions in the ACA, any analysis of Medicaid rates should include the economic impact of new federal and state mandates and changes in the cost of labor, especially since such mandates in the ACA will raise provider operating costs in 2014. Since rates are usually set prospectively, incorporating this requirement might help states understand the need to deal with these costs.

AHCA/NCAL recommends that CMS have two tracks to assure access to quality Medicaid services—one track for current models and one track for new models of service delivery, as required under the ACA

### Conclusion

This issuance is an important proposal from CMS, and, based on the discussion above, we ask CMS to seriously consider AHCA/NCAL's recommendations. We look forward to working with you on this critical undertaking. We would gladly meet with you to discuss these issues and our recommendations. If you have any questions, please contact Steven Gregory at [sgregory@ahca.org](mailto:sgregory@ahca.org).

Sincerely,



Steven Gregory  
Director, Medicaid Reimbursement and Research