AHCA AMERICAN HEALTH CARE ASSOCIATION
NCAL NATIONAL CENTER FOR ASSISTED LIVING

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahcancal.org

January 4, 2016

Mr. Andy Slavitt
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2328-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: AHCA/NCAL Response to Medicaid Program; Request for Information (RFI)—Data Metrics and Alternative Process for Access to Care in the Medicaid Program Federal Register, Vol. 80, No. 211, November 2, 2015 [CMS–2328-NC]

Dear Mr. Slavitt,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, and homes for individuals with disabilities. Thus, we play a critical role in Medicaid-financed long term services and supports (LTSS) delivery and programmatic development across delivery systems.

AHCA/NCAL applauds the Centers for Medicare & Medicaid Services (CMS) for finalizing the rule *"Medicaid Program; Methods for Assuring Access to Covered Medicaid Services."* The rule puts additional structures in place that are intended to make Medicaid fee-for-service payment rate development more data-driven and transparent to beneficiaries and providers. This framework for more transparency and accountability in the state plan amendment process for both beneficiaries and providers is especially important in the wake of the Supreme Court decision in Armstrong v. Exceptional Child Center, Inc. that Medicaid providers do not have a cause of action to challenge a state's Medicaid reimbursement rates.

We appreciate the opportunity to provide input through this request for information (RFI) related to assuring access to care in the Medicaid program and we look forward to our ongoing dialogue with CMS about access to care, guidance and enforcement of the provisions found in 1902(a)(30)(A) of the Social Security Act, and the interaction between rate adequacy, access to care, and quality.

Overview

AHCA/NCAL is encouraged by CMS thinking holistically about access measurement, regardless of whether care is delivered through fee-for-service, managed care, or other delivery system models. In addition, the questions raised in this RFI are a first step in opening the dialogue with stakeholders; CMS should continue with provider and beneficiary group engagement and feedback throughout its effort to put in place more standards to measure and ensure access to care in the Medicaid program.

Access to Care Data Collection and Methodology

The Medicaid program covers distinct populations with varying care needs. The service needs of a child, a working age adult, a person with a disability, and an older adult who needs assistance with activities of daily living are different. When assessing access to care for these distinct populations, the assessment measures must account for differences between populations being served, and be nuanced enough to ensure people receive the services to which they are entitled from the provider of their choice in both a reasonable amount of time and within a reasonable distance from their place of residence.

Access to Care Based on Needs and Choice. AHCA/NCAL supports efforts by CMS to ensure that a more structured process for reviewing access to LTSS, regardless of delivery system so beneficiaries (and if needed, their families) are able to make a decision about their care based on their service needs and choice across provider types that would be able to meet these needs. In its oversight role, CMS must ensure that as states develop their access standards, as well as assess beneficiary access; that providers and beneficiaries are included in the development of these standards; and that states demonstrate how they are responding to ideas and concerns raised by these stakeholder groups through this process.

Below are some key factors we believe should – at a minimum – be utilized to successfully examine access to nursing center services to ensure beneficiaries have choice of services and providers based on their needs and preferences within the continuum of long term services and supports:

1. Reviewing Medicaid and overall occupancy in centers with high quality rankings compared to those with lower rankings on a statewide and regional basis. The goal would be to determine if Medicaid beneficiaries have equal access to higher quality nursing centers;
2. Reviewing Medicaid and overall occupancy by region of the state to identify possible regional issues (using Metropolitan Statistical Areas and/or Health Service Areas). For example, are regional occupancy issues tied to lack of available workforce;
3. Surveying hospital discharge planners by region on difficulty of placing Medicaid patients or Medicaid patients with specific needs (such as ventilator/trach care) before and after rate changes;

4. Surveying patients and their family members of nursing centers that have closed as to the difficulty of finding alternate placement, ability to be transferred to a center of choice, and their satisfaction with any new center;
5. Surveying families and Medicaid beneficiaries who have recently been admitted to nursing centers as to difficulty in finding a center that could meet the patient's needs; ability to be transferred to center of choice; and satisfaction with the center;
6. Reviewing compliance and quality records of nursing centers with the highest Medicaid volumes in comparison to those with lower Medicaid volumes (if higher Medicaid volume centers already have poorer compliance records, a rate reduction would likely make a bad situation worse);
7. Mandating an impact analysis of rate cuts on ability of high Medicaid volume providers to meet staffing requirements and quality and safety standards; and
8. Mandating disclosure of cost coverage percentage for nursing center services.

In addition to occupancy levels and specialized services, states should also consider the proximity of a nursing center resident's support system, as well as other elements such as the ability of health care professionals to provide the care a beneficiary requires, the availability of necessary ancillary services such as therapy or transportation, culturally competent communications, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities.

Due to the complex and varying needs of populations requiring LTSS, in states with Medicaid managed LTSS, AHCA/NCAL believes that these beneficiaries would be best served by states employing an "any willing provider" approach, which would allow beneficiaries, along with their families and caregivers, to select services from any LTSS provider that satisfies the state's requirements of participation criteria. At a minimum, states should analyze the networks of managed care entities to ensure adequate provider capacity to meet beneficiary access needs using data points including state certificate of need formulas and beneficiary/family member travel time/driving distances.

Geographic Areas. Geographic areas should be defined through this process at the state level. In addition it may be useful for states to measure the ability of LTSS providers to allow beneficiaries to enter services within a specific timeframe as a measure of access.

Consistency Across Delivery Systems. As a publicly financed entitlement program, access standards for the Medicaid population should apply across delivery systems, based on the needs of the specific population being served. Beneficiaries and their families should receive full information about the choices of services and providers available to them, regardless of whether all of these providers are in the payer's network, if applicable. In addition, if payers promote certain providers over others,

the factors included in this decision should be disclosed to the beneficiary and their family.

Access to Care Thresholds/Goals

CMS is at the beginning phases of its work regarding developing standards for assessing access to care. Decisions relating to thresholds should be based on state and local factors, including meaningful engagement with provider and beneficiary groups, and should be data driven. Any threshold should be specific to the service being assessed based on the needs of the population(s) accessing that service and should take into account each state's existing regulatory construct (such as certificate of need (CON) computations).

Alternative Processes for Access Concerns

Based on the appeals process in the Medicare program, AHCA/NCAL has the following initial suggestions for CMS as it works to develop a process to address beneficiary access concerns:

- **The hearing officers be independent and objective.** In order to assure that the results from a hearing or proceeding are arrived at objectively and with independent judgment, they should be appointed by an agency independent from the state Medicaid agency. In addition, those who review access hearings for people requiring LTSS should have a deep understanding of the specific needs of people who require these services, the Medicaid program, and the full array of services and providers included in LTSS.
- **Funding should be adequate to avoid backlogs.** This has been a challenge in the Medicare space, with the current processing time Medicare appeals being well over a year.[1]
- **Provisions regarding expedited appeals should include living arrangement disruption as an indicator warranting an expedited appeal resolution.** For people who require LTSS, this disturbance could create stress and harm to beneficiaries and their families. Therefore, we recommend that CMS require that expedited appeals be made available in cases that include potential loss or disruption of residence, and that once a notice of appeal is filed, that there be a "stay" allowing the beneficiary to continue to receive the service pending the outcome of the appeal.

[1] According to the Office of Medicare Hearings and Appeals, the average processing time in fiscal year 2015 was 547.1 days.
http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html

Access to Care Measures

Care Based on Needs and Preferences. AHCA/NCAL supports people receiving care in the most integrated setting appropriate for their needs and preferences. As states focus on providing access to home and community based services, beneficiaries who are most appropriately served in a nursing center setting should not be inadvertently denied access to this level of care. Therefore, in its oversight role, CMS should ensure that beneficiaries have access to care based on their needs and preferences across the continuum of long term services and supports. When submitting a state plan amendment or during development of managed care program, CMS should ask the state what specific steps it is taking to ensure this and how beneficiaries will be educated about their choices. In addition, ensuring continuity of care and preserving existing beneficiary/provider relationships should be a factor in assessing access, and could be collected as a part of the feedback states collect from providers and beneficiaries that CMS has access to, as indicated in the final rule.

Comparison of Payments. AHCA/NCAL believes that any analysis of access to LTSS must place substantial importance on adequacy of payment rates related to the cost of care. Payment rates are an important factor in provider participation. Providers simply cannot properly operate and provide quality care without adequate payment. CMS should collect information about payment rates to nursing center from all publically financed programs (including Medicaid managed care payers), regardless of delivery system. This will help to assure access to care, as well as provide a full picture of how rate methodology changes will impact nursing centers when CMS reviews these state plan amendments, as payment rates can impact access to care for beneficiaries. 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 center services should be disclosed.

When considering Medicaid rate changes and its impact on access, CMS should consider the impact these cuts will have on high volume Medicaid providers. With an aging demographic, there will be an increased demand for LTSS in the coming years. In the absence of adequate rates, providers may make the decision to not participate in the Medicaid program. This will result in Medicaid beneficiaries experiencing access problems and being unable to receive timely services from providers in close geographic proximity based on their needs and preferences. Ensuring there is a robust process for reviewing rate methodology changes that will help to ensure access to care for beneficiaries by holding states accountable to pay rates to providers that in turn allow providers to meet their obligations set out by the state, which can include items such as meeting required staffing levels and quality benchmarks.

Certificate of Need. Under CON, states seek to constrain excess beds and cost while ensuring access to services of sufficient quality to meet the needs of residents. Most

states are already monitoring access to nursing center services to some degree due to CON statutes or moratoria on the construction of centers.[2] Further, the federal survey and certification process that nursing centers are already subject to allows states to know how many centers/beds exist and their occupancy levels. If the state develops an access monitoring review plan for nursing center services, it is likely to seek to use existing data and processes, such as those used for CON, to inform its approach. CMS may wish to ask states whether they have considered, and what feedback the state has received from provider and beneficiary groups related to, drilling down into its existing information and develop monitoring standards as part of it monitoring plan that are more detailed, such as considering the numbers and locations of specialized centers/beds such as those for Alzheimer's or ventilator-dependent residents, as well as the need for these services among Medicaid beneficiaries.

Geographic Access. In addition to occupancy levels and specialized services, states should also consider the proximity of a nursing center resident's support system. The rule does not define standards for measuring medical services available to the general population in a geographic area, nor does the rule define these terms. Rather, it is left to the states to determine what these terms mean within the context of the local health delivery system in each state. Travel standards for time and distance are common elements of access monitoring for acute care services. Reasonable access in terms of time and distance for family members of a nursing center resident should also be taken into account in the state's access monitoring plans and in CMS' oversight role. In addition, it may be useful for states to measure the ability of LTSS providers to allow beneficiaries to enter services within a specific timeframe as a measure of access.

Lags in Eligibility Determinations. Another access to care measure should be delays in eligibility determinations being made. For people who qualify for the Medicaid program through one of the aged, blind, and disabled (ABD) eligibility pathways, this process remains complex, despite improvements made for other eligibility groups. The requirements for extensive financial and functional assessments for the ABD population, as well as the involvement of multiple agencies, have confounded attempts to address ABD eligibility. In a number of states, this includes long lags between application and final decisions about eligibility, especially for determinations of disability and level of care, as well as lapses in services when beneficiaries must re-certify eligibility.

In the managed care space, delays and disruptions can occur during changes in enrollment that occur when LTSS is carved out of the Medicaid managed care program. For example, in states with managed care programs that cover only

[2] As of 2014, about 36 states retained some type of CON program, law, or agency. See P.L. 145-2014 Report, Indiana Family and Social Services Administration, October 2015.available at http://in.gov/fssa/files/HEA_1391_10.1.15.pdf

primary, acute, and post-acute care services, enrollees may receive coverage for a short-term skilled nursing stay (less than 100 days) through the Medicaid managed care plan, however, if the beneficiary needs to receive LTSS following the post-acute care stay, those benefits are covered through fee-for-service. Delays in obtaining, processing, and confirming eligibility create significant disruptions to payment, leaving the nursing center to assume the costs of providing needed care.

If you have questions about any of our comments, please contact Mike Cheek at mcheek@ahca.org.

Sincerely,

[Transmitted Electronically]

Michael W. Cheek
Senior Vice President, Reimbursement & Legal Affairs