



December 24, 2015

**VIA ELECTRONIC SUBMISSION**

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

**Attention: CMS-2328-FC  
Medicaid Program; Methods for Assuring Access to Covered Services**

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS-2328-FC, "Medicaid Program; Methods for Assuring Access to Covered Services," hereinafter referred to as "the final rule with comment period."

The Center for Children and Families is based at Georgetown University's Health Policy Institute with the mission of improving access to health care coverage among the nation's children and families, particularly those with low and moderate incomes. We focus much of our work on access to services in public programs.

*General Comments*

Application of Section 1902(a)(30)(A)

The final rule with comment period states that HHS' interpretation of section 1902(a)(30)(A) of the Social Security Act is that it specifically applies to payment for care and services available through fee-for-service (FFS) payments and excludes services provided under a demonstration waiver or through capitated payments to managed care entities. We disagree with this interpretation. The statutory language at section 1902(a)(30)(A) does not limit the provision to FFS, and the final rule with comment period does not provide sufficient justification for such a limitation. However, we agree with HHS that the best methods for implementing and enforcing section 1902(a)(30)(A) may differ by delivery system, and we support HHS' desire to avoid unnecessary duplication.

Comparable Access Frameworks for all Medicaid Delivery Systems

While the methods for implementing and ensuring access in Medicaid may vary by delivery system, we believe that all beneficiaries should have equal access regardless of the state's

preferred delivery system and therefore the different access oversight mechanisms must be comparable. It is not clear from the final rule with comment period whether HHS conducted a side-by-side comparison of the access requirements in the proposed rule on Medicaid managed care (80 FR 31097) and those included here in the final rule with comment period. Further, it is unclear how these two regulatory actions compare to the access enforcement in Medicaid waivers and demonstrations, which may vary widely from state to state and over time. We suggest that HHS conduct such a review and explain to states, beneficiaries, providers and other stakeholders how the various components work together in future subregulatory guidance. For example, it will be important to highlight which pieces are overarching, like the state comprehensive quality strategy proposed at §431.502 and the access standards that will follow the Request for Information CMS-2328-NC, separately from those elements that are unique to a particular delivery system.

As we compared the regulatory access frameworks in this proposed rule with comment period to those in the proposed Medicaid managed care regulations, we recognized similar themes but also noted some gaps. For example, the proposed rules on Medicaid managed care network adequacy at §438.68 presumably track those required in the access monitoring review plan at §447.203(b)(1)(ii) related to the availability of providers in the geographic area. But there does not appear to be a parallel provision for every access element. For example, the access monitoring review plan requires a comparison of Medicaid provider payments to payment available from other payers at §447.203(b)(1)(v), but there does not appear to be a similar payment comparison in Medicaid managed care. Medicaid managed care payments from the state to the issuer are governed primarily by actuarial soundness requirements, but there is not further oversight of the issuer's payments to participating providers that would allow for payment comparison between Medicaid managed care and other payers. Additionally, the final rule with comment period provides for a mechanism for additional review if the state or CMS receives a significantly higher than usual volume of beneficiary, provider or other stakeholder complaints. The proposed rule on Medicaid managed care, on the other hand, includes only an individual grievance process and does not reference a mechanism by which the volume of such grievances is monitored over time that would trigger additional oversight. This type of trend analysis is critical to understanding access. In the managed care context, this could be included as a required external quality review activity at §438.358(b).

As with managed care, HHS should ensure that the process by which access is measured in waivers and demonstrations is comparable and consistent across states and over time. HHS could establish a standard set of terms and conditions that parallel the access requirements for FFS and managed care. HHS could then add to these standard terms and conditions as needed depending on the particular characteristics of the waiver or demonstration, while ensuring that access is considered consistently regardless of the delivery system.

We suggest that HHS compare the access requirements to date for FFS, managed care and waivers and demonstrations and make any changes needed to ensure that all types of delivery systems are held to the equal access standards as described in statute.

Clarifying the Holding in *Armstrong*

We noted inconsistent descriptions of the holding in *Armstrong v. Exceptional Child Center, Inc.*, in the final rule with comment period and the accompanying Request for Information, CMS-2328-NC. HHS should clarify that the holding in *Armstrong* is that described in the final rule with comment period at 80 FR 67577 (November 2, 2015), which reads: “Earlier this year, the Supreme Court decided in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to **providers** to enforce state compliance **with section 1902(a)(30)(A) of the Act** in federal court.” (Emphasis added.)

### Additional Access Barriers

We also noted that the final rule with comment period does not specifically include monitoring requirements that address some common access barriers, such as affordability and language. Traditionally, Medicaid has offered considerable financial protection by limiting application of premiums and cost sharing to nominal amounts. But, even these limited financial obligations can present significant barriers to access, especially for beneficiaries with high needs. Additionally, recent demonstrations and waivers have imposed more cost sharing than previously allowed to many parent and other adult populations, making it even more important to monitor access barriers due to affordability.

Also, given the diversity of the Medicaid population, culturally competent care and interpretation services are critical to ensuring access for all covered populations. We believe that the requirement at §447.203(b)(1)(iv) regarding characteristics of the beneficiary population may be interpreted to include factors such as limited ability to pay cost sharing and the need for interpretation services, but we suggest that HHS clarify that such considerations are required by this provision.

### Federal Oversight of Medicaid Access

Finally, while we agree that states have a critical role in monitoring access, we suggest that HHS also develop and clarify its responsibilities for enforcing the equal access requirement. State reviews will serve as a good starting point, but HHS must critically evaluate access in each state to ensure that the review is independent and that equal access is guaranteed regardless of where the beneficiary lives.

### *Access monitoring review plan timeframe (§447.203(b)(5))*

Under the proposed rule (76 FR 26342), states would have been required to conduct annual reviews such that all services were reviewed at least once every five years. Under the final rule with comment period, states must conduct annual reviews such that a subset of services are reviewed at least once every three years. While we think it would be useful to have a complete review of all Medicaid services, we recognize the burden is high and support HHS’ proposal to limit the services for which review is required but with reviews occurring more frequently. This limited ongoing review is satisfactory in part because of the provisions at §447.203(b)(5)(ii)(F) and (G) that require additional reviews under special circumstances, so we urge HHS to preserve each of these critical components.

The final rule with comment period requires ongoing review of five key service areas (primary care, physician specialist, behavioral health, pre- and post-natal obstetric and home health, described at §447.203(b)(5)(ii)(A)-(E)), along with services affected by a rate reduction or restructuring (§447.203(b)(5)(ii)(F)) and services receiving a substantially higher than usual volume of beneficiary or provider complaints (§447.203(b)(5)(ii)(G)). We understand that HHS selected these service categories based on Medicaid utilization, and in general, we support limiting the ongoing reviews to these service categories. However, we believe that the ongoing reviews must differentiate between pediatric and adult services because, oftentimes, access issues are different for children. For example, while primary care provider shortages are common for adult populations, specialty care provider shortages appear to be more common for pediatrics. Thus we recommend that the ongoing reviews at §447.203(b)(5)(ii)(A), (B), (C) and (E) include separate reviews of pediatric services. Additionally, we urge HHS to add an ongoing review requirement for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement, including pediatric dental coverage. Children make up more than half of Medicaid enrollees, and access to care is vital to their healthy growth and development. HHS could analyze CMS-416 data to determine how consistently children are accessing developmental screenings and promote strategies used in states with high screening and participation ratios to other states needing to make improvements in these areas. The CMS-416 data may also need to be expanded to capture more detailed information, as has been done with dental, to determine particular areas that must be improved.

We strongly support the requirement at §447.203(b)(5)(ii)(G) that requires review of additional types of services when the state or CMS receives a significantly higher than usual volume of complaints, but we believe this requirement needs to be more clearly defined. For example, it is unclear how CMS would receive complaints from beneficiaries, providers and other stakeholders and how such complaints would be monitored to trigger this review. It is also unclear what is meant by 'significantly higher' volume of complaints. Finally, it is unclear how this provision would address access concerns in places where the volume of complaints is already quite high. We suggest that CMS clarify this provision and the related provision for beneficiary and provider input to states at §447.203(b)(7) in subsequent guidance.

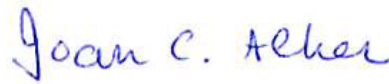
#### *Exempting states based on specific program characteristics*

HHS is specifically seeking comment on whether certain states should be exempt from the access monitoring review plan requirements based on specific program characteristics, such as high managed care enrollment. States that rely predominantly on managed care typically continue to serve beneficiaries with some of the highest needs in FFS like individuals with disabilities and children and youth with special health care needs. These beneficiaries may have the most difficulty accessing services, and their needs should not be overlooked. However, we recognize that it may be reasonable to allow for an exemption under certain circumstances. If such an exemption is permitted, we urge HHS to set a very high threshold to qualify. We also suggest that HHS require states to receive approval of such an exemption without allowing states to proceed based on having simply requested

an exemption. In applying for an exemption, HHS should require the state to describe its alternative plan for monitoring access in FFS so that HHS can ensure it meets the statutory standard.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker ([jca25@georgetown.edu](mailto:jca25@georgetown.edu)) or Kelly Whitener ([kdw29@georgetown.edu](mailto:kdw29@georgetown.edu)).

Sincerely,

A handwritten signature in blue ink that reads "Joan C. Alker". The signature is written in a cursive style and is positioned to the left of a vertical line.

Joan Alker