



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

**Re: 42 CFR Part 447 [CMS-2328-NC] Medicaid Program; Request for Information (RFI)--  
Data Metrics and Alternative Processes for Access to Care in the Medicaid Program**

Dear Administrator Slavitt,

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Request for Information (RFI) on data metrics and alternative processes for access to care in the Medicaid program released on November 2, 2015.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We have been working to improve Medicaid programs for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as for use by other stakeholders. These tools include "[Strengthening Long-Term Services and Supports](#)"<sup>1</sup> and "[Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities](#)."<sup>2</sup> We also conceptualized and produced key data, including sanctions against MCOs, for the [Medicaid Managed Care Market Tracker](#)<sup>3</sup> that is housed on the website of the Kaiser Family Foundation.

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<sup>1</sup> Community Catalyst. Strengthening Long-Term Services and Supports. Retrieved from <http://www.communitycatalyst.org/resources/tools/mmltss>

<sup>2</sup> Community Catalyst. Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities. Retrieved from <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>

<sup>3</sup> Kaiser Family Foundation. Medicaid Managed Care Market Tracker. Retrieved from <http://kff.org/data-collection/medicaid-managed-care-market-tracker/>

The Medicaid program facilitates access to care for nearly 70 million Americans. Given the reality that state budgets will always be under pressure and in light of the recent Supreme Court decision in *Armstrong v. Exceptional Child Center*, which found that providers and beneficiaries do not have a private right of action to challenge Medicaid payment rates in federal courts, it is imperative that CMS undertake vigorous action to ensure timely access to medical care for all Medicaid beneficiaries. We appreciate the opportunity to provide comments on the RFI. We have included our detailed comments below, but want to highlight here the three areas we find most significant:

- **Strong national threshold and documentation requirements for access to care measures:** The access protections afforded by the Social Security Act are a federally guaranteed right that ought to be secured by at least minimum standards and minimum documentation requirements applicable across all states. Given that nearly 70 percent of beneficiaries are enrolled in managed care, we urge CMS to include Medicaid managed care to the scope of the implementation of these requirements. In addition, the ability to access care frequently depends on income, race, ethnicity, gender identity, sexual orientation, age, primary language and disability status. We strongly urge CMS to undertake stratification of data and reporting as one of the tools to assess the needs of Medicaid beneficiaries in their geographic service areas and make adjustments as to how they respond to those needs. CMS should consider [Community Catalyst's recommendations](#) on non-discrimination provisions under Section 1557 of the Affordable Care Act (ACA) as the framework to guide<sup>4</sup> the development national standards for access to care.
- **Standardized federal oversight and enforcement of access:** It is important that CMS establish a standardized federal enforcement scheme to review Medicaid access data as well as rate structures to ensure equal access to care for all Medicaid beneficiaries. CMS should set clear standards on rate setting to ensure that states set and maintain Medicaid rates at levels that assure adequate provider participation.
- **Robust appeals process:** It is important to put in place a robust mechanism for beneficiaries to address their concerns with access to services. Medicaid beneficiaries should be able to understand their complaints options and appeal rights and have access to both the complaint resolution process and formal appeals hearing for any concerns regarding access issues. States should be required to develop a dedicated informal process to resolve beneficiaries' concerns regarding access problems and make funding available for beneficiary assistance via an independent advocate or ombudsman. To ensure that beneficiaries have access to medical services in a timely manner during an appeal, we suggest that CMS require states to expedite review process for complaints or grievances of an emergency or urgent nature.

## A. Access to Care Data Collection Methodology

### 1. A National core set of access to care measures and metrics

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<sup>4</sup><http://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-Section-1557-Comments-RIN-0945-AA02.pdf>

Medicaid is a program that confers federal rights. Medicaid beneficiaries' ability to access health care should be guaranteed and such rights should not be left to the discretion of states nor applied inconsistently as 50% of its funding comes from the federal government. We believe that setting up a national core set of access to care measures and metrics is the first critical step to achieve these goals.

At least once a year, state Medicaid agencies should be required to collect, analyze and disclose data on access levels for all types of providers, including both fee for service and managed care. Those include, but are not limited to primary and specialty care services for adults and children, ancillary services, long-term care (LTC), home and community-based services (HCBS) and services for behavioral health and substance use disorders. Because the ability to access care frequently depends on beneficiaries' income, race, ethnicity, gender identity, sexual orientation, age, primary language and disability status, we strongly urge CMS to reinforce the data collection requirements under section 4302 of the ACA by requiring states to stratify data collection. Stratified data collection and reporting has the double benefit of providing CMS/State Medicaid agencies/Medicaid plans with an accurate assessment of the needs of Medicaid beneficiaries in their geographic service areas and the adjustment necessary to respond to those needs. Where quantitative data is not available, states should be required to deploy qualitative methods such as focus groups or interviews as well as tracking consumer complaints to determine whether beneficiaries receive timely access to needed care.

In addition, we encourage CMS to conduct annual independent reviews through a number of methods such as secret shopper surveys of the Medicaid provider network, beneficiaries' complaints, focus groups or interviews to evaluate access levels, identify gaps and undertake interventions. Findings should be made available to the public so that researchers and consumer advocates can conduct further analysis and make recommendations for improvements.

## **2. Specific indicators for access to care measures and metrics**

We suggest that CMS continue to use a variety of measures such as the number of participating physicians, geographic location, travel time, appointment wait time, office wait time and utilization rate to evaluate access adequacy as no single approach will paint a complete picture. In addition, CMS should consider adding the following indicators to the national core set of care measures and metrics:

- (1) Rates of emergency care utilization for non-emergency medical conditions;
- (2) Hospitalization and readmission rates for beneficiaries with ambulatory care-sensitive medical conditions to measure adequate access and effectiveness of primary care access;
- (3) Patient experience of care to evaluate whether beneficiaries receive needed care in a culturally and linguistically appropriate manner;
- (4) Data related to beneficiaries' out-of-network cost-sharing; and
- (5) Measures to assess discriminatory practices that create barriers which prevent beneficiaries from accessing medically necessary care (e.g. exclusion of providers that serve high-risk populations or specialize in conditions that require costly treatment and utilization controls).

**Specific indicators related to behavioral health including mental health and substance use disorders:** We recommend that CMS consider the variations in access to physical/surgical health versus behavioral health. Data collection, analysis and reporting in this area should account for three major types of variation:

- (1) Variation in access to these services generally;
- (2) Variation in access to services for acute care compared to recovery support; and
- (3) Variation in access to institutional services compared to community-based services.

Many states currently use the [Mental Health Consumer Survey Reports](#) to collect patient experience data specific to behavioral health care and behavioral health.<sup>5</sup>

**Specific indicators related to variations in access for children:** It is important to ensure that children, particularly children with special health care needs, have access to appropriate provider types and pediatric specific settings. Most notably, children need access to pediatric specialists and sub-specialists, including pediatric mental health providers and pediatric-focused dentistry, vision, and habilitative care providers. To strengthen pediatric access, CMS should:

- (1) Measure access using a broad set of objective pediatric-specific measures that are consistent across carriers and developed with the input of experts in pediatric health care;
- (2) Collect data that captures variations in access to pediatric care settings relative to adult-only settings and variations among related services;
- (3) Assess family engagement impact on pediatric access; and
- (4) Analyze care transitions for children with chronic or complex health (including behavioral health) conditions.

**Specific indicators related to variations in access for people with disabilities:** People with disabilities are a diverse group, including children, adults of all ages, people with vision or hearing loss, as well as people with physical, mental health, developmental, or intellectual disabilities. Therefore, in addition to physical accessibility, it is important to ensure programmatic accessibility (i.e. appropriate scheduling, accessible communication about medical information, and ensuring appropriate provider/staff training and knowledge) that is responsive to the needs of each individual.<sup>6</sup> We recommend CMS to require states to conduct:

- (1) Regular assessments of provider competency, as well as assessments of physical barriers within provider practice locations and equipment, such as the use of appropriate exam tables or diagnostic equipment. This assessment data should be made publicly available and used to make improvements;
- (2) Provider and staff training on the Americans with Disabilities Act (ADA) and the independent living philosophies and practice; and

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<sup>5</sup> <http://www.nri-inc.org/---!state-consumer-surveys/cp26>

<sup>6</sup> <https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/dccassessmenttool.pdf>

- (3) Beneficiary focus groups to better understand what is working and where improvements need to be made.

### **3. Specific indicators to measure access to long-term services and supports (LTSS), including home and community based services (HCBS)**

We recommend that CMS establish a stakeholder workgroup with at least 50% consumer or consumer advocate representation as well as representatives from the direct care workforce to help develop appropriate access measures for LTSS. As noted in CMS' proposed regulations for Medicaid managed care, quality and access measures for community-based LTSS are in their formative stages. Extensive consumer engagement is important to ensure that measures are developed to truly protect consumer access to care. That workgroup, or CMS officials if CMS decides not to establish a workgroup, should consider the following factors:

- (1) The extent to which consumers receiving LTSS are able to meet their goals and preferences for community living and participation in work, relationships and community activities;
- (2) The extent of any waiting lists for LTSS services;
- (3) How quickly LTSS services are started following care assessment, as well as what services are used and the number of missed visits ;
- (4) Complaints, appeals and grievances regarding access to LTSS. For HCBS, it is especially important to track appeals and grievances related to insufficient paid hours of direct care and the pressures unpaid family caregivers feel to take on services previously covered by Medicaid;
- (5) The time and distance from the consumer's community to a nursing facility or other institutional LTSS site;
- (6) The time and distance from the consumer's home to any community based LTSS;
- (7) The choice of LTSS providers – there should be at least two in every type of service; and
- (8) Any provider network standards for LTSS developed by CMS for Medicaid managed care.

Because of the labor-intensive nature of LTSS, particularly HCBS, CMS should incorporate economic factors and significant policy factors (e.g. minimum wage and overtime requirements, direct service worker shortages, training and professional development costs, etc.) into review of access to care. There is [evidence](#) that wages and overtime, extent of training and professional development, and turnover of direct service workers as well as vacancy rates all influence the availability of an adequate pool of workers to serve consumers.<sup>7</sup> Furthermore, some states and localities have matching services registries, and the data from these entities could shed additional light on access to services for consumers for the type of care provider they need.. Finally, we encourage CMS to collect data on whether payment rates are adequate to ensure access to services (workforce being a key factor in the success of Money Follows the Person program<sup>8</sup>)and

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<sup>7</sup> <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/monitoring-dsw.pdf>

<sup>8</sup> <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/money-follows-the-person.html>

in order to more fully understand the ability of states to comply with the new minimum wage and overtime rules.

We believe that measuring access to HCBS differs from measuring access to acute medical care. Access to HCBS must be measured at the local level because of the very nature of the services (a direct one-on-one relationship) and the history of long waiting lists for services under the waiver programs. In addition, the attainment of personal goals and preferences is a key element of person-centered services in HCBS and must be measured to ensure access to care is meaningful.

It is essential to track access to HCBS in both fee-for-service and in managed care delivery systems. Because managed care delivery systems add an additional layer between the consumer and the provider, it is essential to assess whether that management layer is creating any inappropriate impediments to care access. Consumers may also lose access if providers are unaware of the shift to managed care, or how the shift affects their billing procedures. Where the systems exist in parallel within a state, access should be separately assessed and compared in each of the two systems. For states transitioning from a fee-for-service to a managed care system, measuring access issues during and after the transition is critical because of the likelihood that access will be disrupted.

Measurement can include whether the managed care companies and providers are adhering to provisions for continuity of care. In addition, we recommend the use of surveys of consumer experience and the compilation of consumer complaints, grievances and appeals.

In addition to the indicators described above, we recommend the following metrics to track access to HCBS:

- (1) Unpaid family caregivers well-being: CMS is beginning to require states to conduct assessments of unpaid family caregiver needs/burden for beneficiaries in HCBS services, a change we consider good practice. Unpaid caregivers, common for many consumers who are also receiving Medicaid paid HCBS, can experience a much greater burden and become ill themselves if access to HCBS services is restricted or lacking. States can track the well-being of family caregivers as an indicator of poor access to services, particularly if states match indicators of caregiver well-being with the intensity of services received by the enrollee. High caregiver burden and low or reduced intensity of services could indicate issues with access. CMS could require states to report this information to CMS.
- (2) Findings from surveys of consumers (such as the HCBS Experience Survey and the National Core Indicators, Aging and Disability survey) to determine whether beneficiaries are getting services that meet their goals, needs and preferences for community living.

## **B. Access to Care Thresholds/Goals**

### **1. Thresholds for Medicaid access to care**

We believe that CMS should set some thresholds that serve as a national floor for Medicaid access to care. Given that Medicaid beneficiaries are some of the most vulnerable consumers and have some of the most complex health care needs, it is important that they can access appropriate care. Currently, state-by-state standards and oversight is varied and can be confusing for consumers and stymie improvement. Because of this, we believe national standards are important in guaranteeing consistency. As noted before, there is substantial federal investment in Medicaid and federally conferred rights that should be enforced across states. Many other types of health plans have set standards by CMS, including existing network adequacy standards applied in Medicare Advantage (MA), Marketplaces for qualified health plans (QHPs), and Medicaid managed care. We strongly urge CMS to set a national level of protection with clear, quantitative access standards as it is critical to ensuring adequate access to covered benefits for Medicaid beneficiaries. At a minimum, states must follow federal minimum thresholds, but *should* also come up with stronger access standards to accommodate regional and geographic variation. We believe thresholds should be set with regards to specific minimum standards in the areas of geographic access, provider-patient ratios, and timely access to care to ensure consistency and continuity for beneficiaries across the country. The standards we recommend are detailed in the [comments](#) we submitted to the Centers for Medicare & Medicaid Service on July 27, 2015 regarding Medicaid and CHIP Managed Care Notice of Proposed Rulemaking (CMS 2390-P).<sup>9</sup>

In addition to geographic access, provider-patient ratios, and timely access to care, we strongly urge CMS to also set national standards for the following categories:

- (1) Provider directories: To ensure beneficiaries have the most up-to-date information available to make informed decision in seeking appropriate care, we suggest provider directories should be updated every 15 days with a minimum accuracy rate of at least 97%. All Medicaid plans should be required to use a uniform provider directory template that includes information on: 1) whether providers are accepting new patients; 2) the languages spoken by each provider; 3) specialty and subspecialty providers; 4) language assistance services that are available at the provider's facilities and information about how beneficiaries can obtain such services; and 5) the physical accessibility of the provider's facilities, in relation to the ADA.
- (2) Timely access to out-of-network providers in a number of cases such as:
  - The only plan or provider available to the beneficiary does not provide the service the enrollee seeks because of moral or religious objections;
  - The enrollee seeks emergency care after not being able to obtain non-emergency services;
  - A needed provider type, in terms of the provider's training, experience, or specialization (including ability to perform particular services, such as surgery for those with gender dysphoria), is not available in-network; and
  - In areas (including rural, urban and suburban) where beneficiaries have limited plan choice.

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<sup>9</sup> <http://www.communitycatalyst.org/resources/comment-letters/document/Community-Catalyst-Final-Comments-Medicaid-Managed-Care-2015.pdf>

- (3) Timely access to essential non-medical services including community integration, language services and non-emergency medical transportation.

Given that nearly 70% of beneficiaries are enrolled in managed care, we urge CMS to include Medicaid managed care according to the scope of the implementation of these requirements.

## 2. Oversight and enforcement

We believe that CMS has an important role in oversight and enforcement of access standards. While we understand CMS' rationale of state flexibility, we urge CMS to establish a standardized federal enforcement scheme to review Medicaid access data as well as rate structures to ensure equal access to care for all Medicaid beneficiaries. CMS should set clear standards on rate setting to ensure that states set and maintain Medicaid rates at levels that assure adequate provider participation. As recommended by many consumer advocacy organizations including the National Health Law Program (NHeLP),<sup>10</sup> CMS should review access rate data, preferably within 90 days of receipt, to determine whether there are any access problems that warrant corrective action. A clear deadline should be provided for states to develop a corrective action plan, preferably within 90 days after CMS' discovery. In addition, states' corrective action plan should be subject to CMS' approval. In case of CMS' disapproval, states should resubmit a revised plan within 60 days in accordance with CMS' direction.

In addition, CMS should establish several avenues for how Medicaid access thresholds should be used. We believe that there should be active network monitoring and periodic federal-level reviews at a minimum of once per year. As the Government Accountability Office (GAO) observed with respect to Medicare Advantage, monitoring is an important tool that is underutilized.<sup>11</sup> This should apply to Medicaid as well. We recommend that CMS take the following actions to strengthen network oversight, accuracy and enrollee empowerment:

- (1) Conduct periodic reviews of network information;
- (2) Set minimum requirements for enrollee notification letters for any network changes;
- (3) Supplement automated data collection with real-time assessment of the accuracy of network data in applications that Medicaid plans submit; and
- (4) Take steps to verify provider information and measure ongoing networks against any promulgated Medicaid access criteria. Plan providers may change at any time, so CMS cannot be assured that networks continue to be adequate and provide sufficient access for beneficiaries until agency collects evidence of compliance on a regular basis.

Second, CMS should review complaints, appeals and beneficiary experience surveys, as well as conduct secret shopper surveys and network audits, and issue compliance actions to states that fail to meet the access standards. CMS should use this data to identify patterns of complaints as

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<sup>10</sup> NHeLP's comments on CMS-2328-P regarding Medicaid Program: Methods for Assessing Access to Covered Medicaid Services submitted on June 17, 2011. <http://www.healthlaw.org/issues/medicaid/nhelp-comments-on-proposed-rule-governing-medicaid-rate-setting#.VndpoKRljIU>

<sup>11</sup> Government Accountability Office (2015). Medicare Advantage: Actions Needed. <http://www.gao.gov/assets/680/672236.pdf>

well as how they are tracked and resolved to signal access problems that may demand remedial action.

Third, independent of any proposed changes in rates, states should be prospectively measuring access by establishing a baseline. States should not be allowed to reduce provider rates without up-to-date data that show no current access problems. States must also monitor what happens to access upon rate changes and have a corrective action plan if access is impacted, which may include, but is not limited to raising provider rates.

### **C. Alternative Process for Access Concerns**

We recommend that CMS set a national floor that ensures consistent definitions of dispute terminology, data quality, dispute resolution processes and coordination among agencies as recommended in the Office of Inspector General [report](#) on Dispute Resolution for Medicaid Managed Care Beneficiaries.<sup>12</sup> Medicaid beneficiaries should have access to both the complaint resolution process and formal appeals hearing for any concerns regarding access issues. One of the advantages of a complaint resolution process is that it is often faster than a formal appeal and timeliness often matters. However because it varies state by state, beneficiaries may not have adequate safeguards for timeliness or accessibility.

Overall, dispute resolution systems can be strengthened in several ways for beneficiaries to better navigate the process. To ensure beneficiaries have access to medical services in a timely manner during an appeal, CMS should require states to:

- (1) Expedite review process for complaints or grievances of an emergency or urgent care:
  - Denial of emergency care service must be reviewed and resolved within three (3) hours of the denial;
  - Urgent complaints or grievances relating to matters which could place the enrollee at risk or which could seriously jeopardize the enrollee's health or well-being must be resolved within 48 hours or less;
  - Non-urgent complaints and grievances must be resolved within 30 days from the initial formal grievance filing;
  - Beneficiaries should be allowed to receive care from out-of-network services for emergency and life-threatening situations.
  
- (2) Ensure beneficiaries understand their complaints options and appeal rights:
  - All written and oral materials regarding the complaint process, including posted notices, descriptions of the complaint processes, complaint forms, and decisions must be made available orally and in writing in the recipient's primary language and in alternative formats, including TTY and telecommunication devices for the hearing impaired, braille, large print and cassette.
  - Membership handbooks and materials should be translated in each prevalent non-English language. Specifically, we recommend that beneficiaries with low levels of health care knowledge and/or limited English literacy should have the option to

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<sup>12</sup> <http://oig.hhs.gov/oei/reports/oei-09-99-00450.pdf>

submit complaints by phone with assistance from a consumer liaison. Where appropriate, Medicaid personnel, rather than the enrollee, should be responsible for determining whether complaints or appeals relate to specific areas governed by state or federal law (e.g.: mental health parity, non-discrimination) and resolved accordingly. All written materials for potential beneficiaries and beneficiaries must include prominent taglines in at least 15 non-English languages.

- (3) Develop a dedicated informal process for addressing access problems, such as an access hotline or ombuds program.
  - Through various forms of notice, this centralized contact point should be known to consumers, consumer advocates, providers, health plan customer services, and state and county Medicaid agency staff. Besides helping beneficiaries troubleshoot specific problems, the informal process should serve as a feedback loop to the state by recording, compiling and reporting complaints to identify patterns in access problems and make recommendations for improvements.
  - Funding must be available for beneficiary assistance via an independent advocate or ombudsman. This assistance should include representing individuals, hearing beneficiary access to care complaints/appeals, conducting systemic advocacy, and educating consumers and others.
  
- (4) Collect consistent information about appeals and grievances, and require them to review the information as part of ongoing monitoring. We recommend that states be required to produce annual reports on appeals and grievances for each of their Medicaid plans as part of ongoing monitoring and so that consumers have better information about the quality of these plans when they enroll.

#### **D. Access to Care Measures**

As noted throughout the letter, we strongly urge CMS to take this opportunity to enforce the data collection requirements under section 4302 of the ACA requirements of data collection stratification. In addition, we want to highlight a number of concerns about the measures and metrics suggested in the RFI and offer recommendations for improvements.

##### **1. Measures for availability of care and providers**

In general, we support CMS' suggested measures for availability of care and providers. However, we are concerned that metrics based on whether clinicians report accepting any or new Medicaid beneficiaries could paint a misleading picture of access if the number of beneficiaries they accept is small. Particularly with respect to family planning services, it is not enough to determine whether a provider takes Medicaid patients if the scope of the services provided to Medicaid beneficiaries is limited. It is therefore critical to supplement these metrics with data about waiting times for appointments and beneficiary and clinician reports about scheduling problems.

We also recommend CMS consider the ratio between the number of full-time<sup>13</sup> and part time providers accepting Medicaid patients and the number of full-time and part time providers practicing in the service area as one of the measure to assess the availability for care and providers. We recommend CMS apply this formula for a wide range of providers and services covered in the Medicaid program, including but not limited to:

- (1) Primary care providers (including but not limited to family physicians and practitioners, general physicians and practitioners, internists and pediatricians);
- (2) Specialty care providers for each specialty covered in the Medicaid program;
- (3) Mental health and substance use disorders services;
- (4) Dental care providers; and
- (5) Essential non-medical services such as language services, non-emergency medical transportation and physical and programmatic accessibility.

In addition to the suggested measures above, CMS should conduct secret shopper type verification to verify self-reported information.

## **2. Measures for beneficiary reported access**

We believe that beneficiary reported access data yields a more accurate picture of beneficiary ability to access care. We believe that information on travel time/distance, the length of wait for new Medicaid beneficiaries to schedule an appointment, and the wait time upon arriving at a scheduled appointment is accurate to indicate lack of access. In addition, a combination of information like ‘there are no dentists in a 100 mile radius who accept Medicaid patients’ can be helpful for policy makers to identify and address deficiencies in access to care.

Because of Medicaid’s low provider reimbursement rates compared to other insurance programs including Medicare and private insurance, we suggest CMS include measures that provide information on the number, length and quality of office visits to detect the possibility that low reimbursement rates endanger access and care quality.

## **3. Measures regarding service utilization**

In addition to the areas proposed in the RFI, we encourage consideration of several additional measures:

- (1) A data component that looks at service utilization in relation to Medicaid reimbursement rates;
- (2) Tracking actual utilization of follow-up on specialty referrals to assess whether beneficiaries have appropriate access to specialty care;

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<sup>13</sup> A full-time employee for any calendar month is an employee who has on average at least 30 hours of service per week during the calendar month, or at least 130 hours of service during the calendar month.  
<https://www.irs.gov/Affordable-Care-Act/Employers/Determining-if-an-Employer-is-an-Applicable-Large-Employer>

- (3) Separate consideration of both mental health and substance use disorders services utilization, rather than just “behavioral health” broadly.

#### 4. Comparison of payment

We appreciate CMS’ effort to make states more accountable for assuring sufficient access to care for their Medicaid populations, both when proposing provider rate reductions and on a regular basis to make sure rates are not falling below levels necessary to assure adequate provider participation. As Medicaid rates have historically been so low, we believe that rate reductions could compromise access and quality. Therefore, we recommend that any State Plan Amendment proposing a rate reduction must be accompanied by a proof of no access problem and a monitoring plan.

We also recommend that CMS set a threshold for provider payment rates with a phase in approach from 75% to 95% of the Medicare or commercial rate. CMS should use this benchmark to set a presumption of compliance such that states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.

Specifically with regard to HCBS, we recommend CMS look at the adequacy of HCBS rates by comparing rates paid to independent providers and to home care agencies.

We also recommend CMS conduct an analysis evaluating the impact of "Medicaid primary care parity" (or the "Medicaid primary care fee bump") on access to care. The program has ended, but as of January 2015, at least 16 states indicated an intention to continue the fee increase with a mixture of state and federal enhanced funding. CMS should take this opportunity for a more forward thinking program allowing states to use enhanced federal funding for primary care to reward practice and quality improvement.<sup>14</sup>

Thank you for this opportunity to provide comments on this RFI, and for keeping consumers a priority as you continue your important work on ACA implementation.

Respectfully submitted,



Rob Restuccia  
Executive Director  
Community Catalyst

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<sup>14</sup> [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=137](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=137)