July 5, 2011

Donald Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Attention: CMS-2328-P

RE: Proposed Rule: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (CMS-2328-P) Federal Register, May 6, 2011, p.26342)

Dear Administrator Berwick:

We, the undersigned organizations, are pleased to submit comments on the Proposed Rule, *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*, to create an ongoing process to assure that Medicaid beneficiaries in a given geographical area have access to care and services to the same extent that the general public does. We thank you for addressing this important statutory requirement through the Proposed Rule and for incorporating the MACPAC framework into the access review process. We agree that it is important to hold states accountable for equal access to care and services through a transparent, standardized process. We do not think, however, that the Proposed Rule is broad enough or strong enough to achieve that goal. We respectfully submit several general and specific suggestions to improve the Rule so that it will be a more effective tool for ensuring Medicaid-enrolled adolescents access to the preventive, primary, and specialty health care they require.

Adolescents enrolled in Medicaid are a particularly underserved population. Studies have shown, for example, that they have very low EPSDT screening rates[1], significant unmet needs for dental care and mental health care,[2] and persistent problems in getting needed referrals and accessing specialty care.[3] The reasons for this situation are many, but most importantly, provider payment rates for primary and preventive care for this high risk population have been historically low, the types of interventions that adolescents need sometimes are not reimbursed at all, and the sites of care adolescents may prefer often are not included in MCO networks. Nevertheless, the health needs of Medicaid-enrolled adolescents are considerable. To the extent that they are unable to access necessary care, their untreated or unmanaged health problems are likely to persist into adulthood and have significant costs for them and for the health care system.

General Comments and Suggestions

1. *Enforcement*: The Rule should establish enforcement mechanisms and penalties when payment rate changes cause a state to be out of compliance with Medicaid access requirements for care and services. When discussing corrective actions, the Proposed Rule refers to what states could or might do in response but does not make clear that a corrective action must be put into place within a given timeframe or that specific penalties would apply.

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[1] Centers for Medicare and Medicaid Services. *Form CMS-416: Annual EPSDT Participation Report*. Baltimore: CMS, April 16, 2010.

[2] MacKay AP, Duran C. *Adolescent Health in the United States, 2007*. Hyattsville, MD: National Center for Health Statistics, 2008.

[3] Special Analysis of the National Survey of Children's Health conducted by The National Alliance to Advance Adolescent Health, June 2011.

2. *Scope*: CMS should expand the scope of the Rule to include managed care as well as fee-for-service arrangements. Statutory requirements pertaining to Medicaid access apply to all Medicaid beneficiaries. Ensuring access to care only for those in fee-for-service arrangements, therefore, is not sufficient, especially given that the majority of Medicaid-enrolled adolescents and other children receive their services in managed care organizations.

3. *Beneficiary feedback*: The Rule should require states to obtain beneficiary feedback on access problems through surveys, including surveys of beneficiaries who did not utilize services or other objective data sources. Ombudsmen and hotline services, listed in the Proposed Rule as methods for obtaining independent beneficiary feedback, are not appropriate, particularly for adolescents, because these methods require that beneficiaries initiate the contact and are not representative samples of the Medicaid-enrolled population.

Access Reviews of Rate Reductions and Changes

Historically low Medicaid payment rates have had a long-standing, negative impact on the number of providers willing to participate in Medicaid, the number of providers willing to take new Medicaid patients, and, in some cases, the quality of care. Access to some medical specialists, such as child and adolescent psychiatrists, is severely limited for Medicaid beneficiaries in most states and typically requires unacceptably long waiting periods. Therefore, we support the provision in the Proposed Rule that would require States planning to reduce or restructure provider payments to submit an access review from the previous year and an analysis of the potential impact on access of such a change. However, we urge CMS to further strengthen this provision.

1. CMS should clarify that in *all* cases states planning to reduce or change their provider rates are required in the year prior to the proposed change to submit a review of access impact. Under the Proposed Rule states must submit access information only if the changes "could result in access issues," a determination that presumably would be left to state's discretion. This clarification would ensure that states will not make incorrect assumptions about the absence of access impacts where they may actually exist.

2. CMS should require states to ensure they are comparing identical services when they conduct access reviews of Medicaid payment reductions and changes. Often Medicaid services are different or more expansive than what is available under commercial coverage. The adolescent preventive care benefit under commercial coverage, for example, is not nearly as comprehensive as the benefit for Medicaid EPSDT screening services. Similarly, outpatient mental health benefits under commercial plans do not provide coverage for the types of Medicaid community-based interventions that may be needed by adolescents with significant mental health problems and complex family and environmental issues.

3. CMS should ensure that the reviews of the impact of a proposed Medicaid rate decrease or restructuring take into account not only average customary provider charges but the extent to which providers in the geographic area are requiring these charges to be paid in full. As increasing numbers and types of providers in some geographic areas are not accepting insurance, the sufficiency of Medicaid payments and the impact on access for Medicaid beneficiaries can only be properly assessed by including charges that are paid out of pocket. This issue is especially significant for child and adolescent psychiatrists. Addressing this issue in the review would acknowledge the increasing payment gap between public and private reimbursement and the actual payments providers are able to receive.

4. In addition, CMS should direct states to take into account provider capacity to take on additional Medicaid patients. If providers participating in Medicaid are taking discounted rates from the commercial sector as well, they may not be willing to continue to accept the level of payment that Medicaid has historically paid or is proposing to pay under a rate reduction plan.

Ongoing Access Reviews

The MACPAC framework for monitoring Medicaid beneficiaries' access to care and services is a good approach for assessing Medicaid rate sufficiency. We support this approach but, while acknowledging the need for flexibility and the variation in state data systems, we believe that CMS should provide greater direction to states about the core elements to be addressed in conducting their reviews. Our comments address specific issues important to measuring adolescent enrollee needs, provider and care availability, and utilization, and to the effective corrective actions that could be taken to remedy access problems identified.

1. With respect to monitoring enrollees' needs, CMS should encourage states to examine the needs of adolescents ages 12 to 21 as a distinct subgroup in the pediatric population. We strongly support the view of CMS that "the meeting of enrollee needs should be the primary driver to determine whether access to care is sufficient," and we think that data specific to the adolescent population would result in greater attention to the significant unmet health needs and persistent access barriers of this underserved population.

2. With respect to availability of care, CMS should articulate that child and adolescent mental health services are a high priority for monitoring access in recognition of the severe shortages of child and adolescent mental health professionals. Access problems for these services have been well documented[4] and should be examined as soon as possible in the five-year period. This would build on the important work at CMS, SAMHSA, and HRSA to increase the availability of mental health professionals and services in primary care settings.

3. With respect to utilization, CMS should encourage states to examine services important to adolescents and also to ensure that they are monitoring service utilization for adolescents as a distinct age group (12-21) and not as part of all children (0-21), including:
    - EPSDT visits; immunizations; screening for health risks, STDs, and depression; and follow-up of adolescents identified as requiring additional treatment or referral;
    - Mental health evaluations, psychotherapy, and medication management;
    - Substance abuse screening and counseling;
    - Family planning counseling and contraceptives; and
    - Preventive and restorative dental care.

    Monitoring the utilization of these services for adolescent is consistent with HEDIS and NQF quality recommendations, and existing Medicaid and commercial data sources are likely to have some if not all of this information.

4. With respect to corrective actions to address access issues, CMS has offered several excellent suggestions including incentives for the development or expansion of clinics in underserved areas, expanded appointment times, telemedicine, and integrated models of care. CMS should also encourage states to consider other corrective actions as well.
    - One is incentives to promote adolescent clinic or practice models that furnish integrated physical, mental, and reproductive health services to adolescents in a teen-friendly environment, since there is evidence to show that teens value this arrangement.[5]
    - A second is consultative models to support primary care providers in furnishing specialized services, such as mental health care diagnosis and treatment, since Massachusetts and other states have

[4] *Mental Health: A Report of the Surgeon General.* Washington, DC: Department of Health and Human Services, 1999.

[5] Fox HB, Philliber SG, McManus MA, Yurkiewicz SM. *Adolescents' Experiences and Views on Health Care*. Washington, DC: The National Alliance to Advance Adolescent Health, March 2010.

effectively designed regional mental health consultation models to address scarce mental health resources.[6]

- A third – to address states' failure to reimburse certain Medicaid covered services essential to adolescents -- is the recognition of additional reimbursement codes, such as preventive medicine counseling and risk factor reduction, medical nutrition therapy, telephone and on-line evaluation and management, team conferences, and modifiers for separate evaluation and management services on the same day as another service. Research has found that improved payment rates would allow more pediatricians to provide comprehensive adolescent counseling and treatment services through the use of interdisciplinary teams.[7]

We would welcome the opportunity to discuss our comments with you or your staff. If you require any additional information, or have any questions, please contact Harriette Fox at The National Alliance to Advance Adolescent Health (hfox@thenationalalliance.org) or Peggy McManus (mcmanus@thenationalalliance.org).

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American Academy of Child & Adolescent Psychiatry
American Congress of Obstetricians and Gynecologists
Family Voices
Healthy Teen Network
Mental Health America
National Assembly on School-Based Health Care
National Association of County and City Health Officials
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National Council for Community Behavioral Healthcare
Society for Adolescent Health and Medicine
TeenScreen National Center for Mental Health Checkups at Columbia University
The National Alliance to Advance Adolescent Health

[6] Information about The Massachusetts Child Psychiatry Access Project is available at www.mcpap.com.
[7] Fox HB, McManus MA, O'Connor K, Klein J, Diaz A, Wibbelsman C. *Pediatricians' Interest in Expanding Services and Making Practice Changes to Improve the Care of Adolescents*. Washington, DC: The National Alliance to Advance Adolescent Health, September 2009.