



September 13, 2018

Administrator Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2406-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission, RIN:0938-AT41**

Dear Administrator Verma:

Thank you for the opportunity to comment on the Department’s proposed rule, *Medicaid program; Methods for Assuring Access to Covered Medicaid Services-Rescission*. We write with strong objection to the proposed rescission of the existing regulations on equal access.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. For the majority of people living with epilepsy, epilepsy medications are the most common and cost-effective treatment for controlling and/or reducing seizures, and they must have meaningful and timely access to physician-directed and person-centered care. Of the 3.4 million Americans living with epilepsy, around one third rely on Medicaid for health insurance coverage. People with epilepsy rely on Medicaid for access to basic health care services, their prescription medications and for services that ensure their independence and well-being, including nursing and personal care services, special education services, home and community-based services (HCBS), and other needed services that are unavailable through other insurance.

We and other health and disability advocates have commented on this area of federal regulation, most recently in 2018 when we urged CMS to not diminish its access monitoring by exempting states with high managed care enrollment. Instead, CMS has proposed eliminating access monitoring requirements entirely.

CMS can and should ensure that all Medicaid services, provided via waiver or state plan option, managed care or fee-for-service, are reimbursed at levels to ensure sufficient access for all enrollees. Maintaining strong agency oversight of this key provision of the law is even more critical following the Supreme Court decision in *Armstrong v. Exceptional Child Center, Inc.*, which left little recourse for individuals to seek redress for insufficient access to services outside of petitioning

CMS for oversight and enforcement. CMS's current proposal would greatly reduce CMS's oversight of Medicaid services and instead put into place an insufficient and opaque process.

Previous iterations of the rule, which excluded managed care and home and community-based waiver services, were ineffective because of that exclusion. Excluding managed care and home and community-based services (HCBS) excluded the majority of beneficiaries and some of the most crucial services needed by people with disabilities. However, we disagree with the conclusion to rescind the rule entirely and only rely on the State Plan Amendment (SPA) process. Instead, CMS should keep the rule in effect and expand it to include services provided through waivers, including managed care and HCBS so that it covers all Medicaid beneficiaries and nearly all Medicaid services.

### **I. CMS Must Monitor Access in Medicaid**

The proposed rescission abdicates CMS's responsibility to monitor access and provide beneficiaries and other stakeholders with a transparent way to address access issues created by low reimbursement rates. CMS also has not presented sufficient information, data or explanation to warrant abandoning the current access monitoring process at this time.

State Medicaid programs have long struggled to provide adequate access to covered Medicaid services. Regularly beset by budget pressures, many states have cut Medicaid provider reimbursement rates significantly, leaving providers with a thin profit margin and making it difficult for those Medicaid programs to attract a sufficient number and mix of providers to ensure that beneficiaries can access needed services. After the Supreme Court's decision in *Armstrong v. Exceptional Child Center*, there is little recourse to address reimbursement rates and access shortcomings in federal court, even where there is a clear violation of the Medicaid Act. Thus, CMS's role in monitoring and enforcing the Medicaid Act's equal access provision is more important than ever.

The final access rule became effective on January 4, 2016; the first Access Monitoring and Review Plans (AMRPs) were due in October of 2016, with the second round due three years later in October of this year. Many states received extensions and are on longer timelines. With only one cycle complete, CMS does not have enough information on the effectiveness of the AMRP process to determine that it is ineffective. CMS should wait until it has at least one more cycle of plans submitted in order to compare state progress.

The proposed rule states that after rescinding the 2015 final rule, CMS expects to issue a letter to State Medicaid Directors about information states may submit with state plan amendments (SPAs) to demonstrate their compliance with section 1902(a)(30)(A) when proposing changes to providers' payment rates. The proposed rule does not contain any information about this replacement plan, and we are concerned that it will not adequately ensure access to care for people with disabilities. We are also concerned that states will no longer be required to solicit input from stakeholders when making payment changes, reducing beneficiaries' representation in decisions impacting their access to care.

## II. CMS should expand current access monitoring to include HCBS and managed care

Rather than abandoning reviews of access, CMS should expand the process to include beneficiaries and services currently left out. In previous iterations of this rulemaking, disability groups have repeatedly asserted that CMS has the authority under section 1902(a)(30)(A) to apply access and adequacy requirements to the entire Medicaid program and not exempt waiver services. The current exemption of HCBS and managed care has no legal basis: 1902(a)(30)(A) is a broad Medicaid state plan requirement, the authority to waive specific sections of 1902 does not permit HHS to waive general 1902 requirements (including 1902(a)(30)(A)), and section 1903(m) – as an actuarial soundness provision – does not obviate the need for 1902(a)(30)(A) in managed care

The exemption of HCBS waiver programs also diverges from CMS’s own technical guidance. Page 258 of the Instructions, Technical Guide and Review Criteria for 1915(c) applications released in January of 2015 notes, in reference to 1915(c) services, that “1902(a)(30)(A) of the Act requires that payments for Medicaid services be consistent with efficiency, economy, and quality of care.” This language has been repeated on page 260 of the updated guide released in January of 2019. Technical assistance presentations from CMS to states on HCBS rate setting also reiterate this requirement.<sup>1</sup>

There is increasing documentation of provider rate cuts and access difficulties in Medicaid managed care. It is our experience that many managed care plans do not maintain adequate networks of providers, particularly of specialty care providers and providers of services for people with disabilities. Recent experiences of managed care implementation in Iowa,<sup>2</sup> Kansas,<sup>3</sup> and Texas<sup>4</sup> have been well documented in their resulting inadequate access to disability services.

We urge CMS to abandon the rescission proposal. Instead, CMS should continue to gather data through the existing Access Monitoring and Review Plan process and expand the program to include HCBS and managed care services.

Sincerely,



Philip M. Gattone, M.Ed.  
President & CEO  
Epilepsy Foundation

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<sup>1</sup> <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1b-transparent-documentation.pdf>

<sup>2</sup> <https://www.desmoinesregister.com/story/news/health/2019/07/10/iowa-medicaid-privatization-managed-care-companies-amerigroup-centene-iowa-total-care-mcos-increase/1691928001/>

<sup>3</sup> <https://news.ku.edu/2017/09/20/kancare-enrollees-mental-illness-report-gaps-medicaid-managed-care-program>

<sup>4</sup> <https://interactives.dallasnews.com/2018/pain-and-profit/part3.html>