



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

September 13, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Dear Administrator Verma:

The Consortium for Citizens with Disabilities (CCD) Health and Long Term Supports and Services Task Forces appreciates the opportunity to provide comments on the proposed rule regarding assuring access to covered services in the Medicaid program.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

Adequate access to services under Medicaid is especially important to people with disabilities. CCD has commented on numerous iterations of this rule, including the original notice of proposed rulemaking in 2011,¹ final rule with comment period in 2016,² request for information in 2016,³ and proposed rulemaking in 2018.⁴ People with disabilities rely on Medicaid for access to basic health care services and for services that ensure their functioning, independence, and well-being, including: nursing and personal care services, specialized therapies, intensive mental health services, special education services, and other needed services that are unavailable through other insurance. Access to these services is a matter of life, death, and independence for the millions of people with disabilities on Medicaid and the protections provided by the equal access statute are of particular importance to our community.

As we have commented before, the Centers for Medicare and Medicaid Services (CMS) can and should ensure that all Medicaid services, provided via waiver or state plan option, managed care

¹ http://c-c-d.org/fichiers/CCD_rate_review.pdf

² http://c-c-d.org/fichiers/Final-Rule-Comments_1-4-2016.pdf

³ http://c-c-d.org/fichiers/Final-RFI-Comments_1-4-16.pdf

⁴ http://c-c-d.org/fichiers/Access-Rule-Comments_Final_5-22-18.pdf

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.*,⁵ which left little recourse for individuals to seek redress for insufficient access to services outside of petitioning CMS for oversight and enforcement. CMS' current proposal would greatly reduce CMS' oversight of Medicaid services and we are concerned about and oppose the changes in this notice of proposed rulemaking.

CCD has long supported CMS taking regulatory action to enforce the provisions at 1902(a)(30)(A) to ensure that people with disabilities who rely on Medicaid have adequate access to health care and long-term services and supports by ensuring that service providers have adequate reimbursement rates. Too often the reimbursement rates do not reflect the actual cost of providing the services and supports. Inadequate reimbursement rates contribute to low wages and high turnover rates for the direct support professionals which is creating a nationwide crisis disrupting the lives of beneficiaries and putting their health and safety at risk.

Previous iterations of the rule, which excluded managed care and home and community-based waiver services, were insufficient 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 most Medicaid services.

CMS should maintain the current access monitoring process

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 has been 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.

⁵ 135 S.Ct. 1378 (2015)

Excluding waiver services has no legal basis

In previous iterations of this rulemaking, CCD and other Medicaid experts 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. CCD, Easter Seals, United Cerebral Palsy, Community Catalyst, Justice in Aging, the National Health Law Program, and others all urged CMS to include HCBS and managed care in access requirements.

Several of those groups also endorsed the comments of the National Health Law Program (NHeLP), which provided an extensive analysis of why 1902(a)(30)(A) should apply beyond strictly state plan benefits. The main points of the analysis were that 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 that section 1903(m) – as an actuarial soundness provision – does not obviate the need for 1902(a)(30)(A) in managed care. NHeLP also noted that exemption of HCBS waiver programs 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.⁶

Measuring access to HCBS is feasible

Measuring access to HCBS is not only legal, it is feasible. Several commenters, including leading policy research firm Mathematica Policy Research, submitted comments describing frameworks for measuring access to long-term services and supports (LTSS). Mathematica’s proposal built on a “Five A” framework: Availability, Accessibility, Accommodation, Acceptability, Affordability, and Realized Access. CCD does not take a position on the specific framework proposed by Mathematica but references the framework only to show that measures of access to HCBS are feasible for CMS to implement and are in development by policy experts. In measuring access, beneficiaries, family members, advocates, and service providers must have a meaningful role in designing and implementing the system in their state in order to ensure that the experiences of the beneficiary are the primary determinant of access.

CMS must require state to implement transparent and accessible complaint systems

We urge CMS to require that all states create a complaint process that includes: a centralized contact point for access-related complaints, regular beneficiary surveys, an ombudsman, and a mechanism for collecting access concerns from the state Medicaid Care Advisory Committee. We also urge CMS to require that the complaint process data not only be made available to CMS upon request, but also be made publicly available on a state website. We also recommend that CMS conduct regular audits of the complaint data for each state to ensure that the state processes are adequately capturing the problems facing beneficiaries.

⁶ <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1b-transparent-documentation.pdf>

CMS must provide greater oversight of access to care in managed care and HCBS

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,⁷ Kansas,⁸ and Texas⁹ have been well documented in their resulting inadequate access to services.

Inadequacy of payment rates is not limited to states using managed care. For example, Colorado follows a standard rate methodology for HCBS rate setting, but then applies a “budget neutrality” factor to reduce the rate.¹⁰ In a real example that Colorado gives, the rate they have determined to cover the costs of providing personal care is \$5.37. However, only \$4.25 is provided after the budget neutrality factor is added. Without incorporating HCBS into access monitoring, CMS has no way of knowing if these rates impede access to HCBS in Colorado, or if similar practices are used in other states.

These examples show that CMS must increase, not decrease, its oversight of access to care and adequacy of rates in managed care and fee-for-service, waiver and state plan services. CCD urges CMS to retain the structure of the current rule and expand it to include managed care and HCBS waiver services.

We appreciate this opportunity to comment. For any questions, please reach out to Rachel Patterson at rpatterson@efa.org or 301-918-3791.

Sincerely,

Allies for Independence
ALS Association
American Association on Health & Disability
American Association on Intellectual and Developmental Disabilities
American Network of Community Options and Resources
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of University Centers on Disabilities

⁷ <https://www.desmoinesregister.com/story/news/health/2019/07/10/iowa-medicaid-privatization-managed-care-companies-amerigroup-centene-iowa-total-care-mcos-increase/1691928001/>

⁸ <https://news.ku.edu/2017/09/20/kancare-enrollees-mental-illness-report-gaps-medicaid-managed-care-program>

⁹ <https://interactives.dallasnews.com/2018/pain-and-profit/part3.html>

¹⁰

<https://www.colorado.gov/pacific/sites/default/files/Rate%20Development%20and%20Methodology%20for%20Home%20and%20Community%20Based%20Services%20Presentation.pdf>

Autism Society of America
Autistic Self Advocacy Network
Center for Public Representation
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Family Voices
IDEA Infant Toddler Coordinators Association
Justice in Aging
Lutheran Services in America-Disability Network
National Association of Councils on Developmental Disabilities
National Council for Behavioral Health
National Disability Rights Network
National Down Syndrome Congress
National Health Law Program
National Multiple Sclerosis Society
National Respite Coalition
Special Needs Alliance
TASH
The Arc of the United States
United Spinal