May 22, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Public Comments on Medicaid Access Proposed Rule (RIN 0938-AT41, CMS-2406-P)

Dear Secretary Azar:

The co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force write in response to the proposed rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold, CMS–2406–P, RIN 0938–AT41. 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.

CCD has commented on numerous iterations of this rule—including the original notice of proposed rulemaking in 2011[1] and both the final rule with comment period[2] and the request for information in 2016.[3] 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 or

[1] Consortium for Citizens with Disabilities, *Letter Regarding: CMS -2328-P* (Jul. 5, 2011), http://c-c-d.org/fichiers/CCD_rate_review.pdf.
[2] Consortium for Citizens with Disabilities, *Letter RE: Final Rule Regarding Methods for Assuring Access to Covered Medicaid Services (CMS–2328–FC, RIN 0938–AQ54)* (Jan. 4, 2016), http://c-c-d.org/fichiers/Final-Rule-Comments_1-4-2016.pdf.
[3] Consortium for Citizens with Disabilities, *Letter RE: Request for Information regarding Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (42 CFR Part 447, CMS–2328–NC)* (Jan. 4, 2016), http://c-c-d.org/fichiers/Final-RFI-Comments_1-4-16.pdf.

820 FIRST STREET NE, SUITE 740 ♦ WASHINGTON, DC 20002-4243
TEL: 202.567.3516 ♦ FAX: 202.408.9520
WEBSITE: WWW.C-C-D.ORG ♦ E-MAIL: INFO@C-C-D.ORG

fee-for-service, are reimbursed at levels to ensure sufficient access for all enrollees. People with disabilities, who are often the last populations incorporated into managed care and remain in fee-for-service or continue to receive their disability-specific services via fee-for-service, represent the populations most affected by this proposed rule.[4] 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.[6] CMS' current proposal would reduce CMS' oversight of the services provided via fee-for-services and we are concerned about and oppose the changes in this notice of proposed rulemaking.

1) Exemption for States with High Managed Care Enrollment

We have several concerns about and must oppose CMS's current proposal to exempt states on the basis of a "risk-based managed care enrollment rate threshold."

First, CMS provides no data-based justification for this new threshold, relying on "experience in reviewing the [Access Monitoring Review Plans] AMRPs and working with states with high beneficiary enrollment in comprehensive, risk-based managed care." The final access rule became effective on January 4, 2016, and so has been in place for just over two years. Only one cycle of AMRPs have been submitted and CMS' recent guidance letter was released just six months ago. CMS does not provide specific examples or evidence of the reason for this new threshold, but simply states that "we now believe we have sufficient experience to establish a threshold for such states to be exempt from meeting certain access monitoring review requirements." Analysis by the Medicaid and CHIP Payment and Access Commission (MACPAC) in 2017 found numerous challenges to monitoring and ensuring adequate rates to ensure access, including data limitations, variation in adoption of measure, and lack of benchmarks.[7] Given these findings, CMS' unsupported statement appears arbitrary, and we oppose implementing such a threshold.

Second, this change also disproportionately impacts people with disabilities. CMS was specifically interested in this point in the final rule, acknowledging that:

> "many states carve out certain services from managed care capitation rates and continue to pay for those services through FFS. We also understand that many of the individuals who remain in state FFS systems may have complex care needs. We note

[4] MACPAC, *March 2017 Report to Congress on Medicaid and CHIP*, 130-146 (March 2017), https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf.
[5] 135 S.Ct. 1378 (2015).
[6] As we have previously commented, we disagree with CMS's decision to make the final regulations inapplicable to Medicaid managed care or to waiver services. As our colleagues at the National Health Law Program detailed in their comment letter on the final rule in 2016, there is no legal basis for this decision. National Health Law Program, *Comments on Medicaid Program; Methods for Assuring Access to Covered Medicaid Services* (Jan. 2016), http://www.healthlaw.org/publications/search-publications/nhelp-equal-access-regulation-comments. Specific rules that apply to particular services, such as the Home and Community-Based Services Rule, and the regulations governing Medicaid managed care do not provide a global and comprehensive assessment of whether or not the Medicaid system as a whole ensures sufficient access to services. MACPAC discussed this lack of a comprehensive access standard in their March 2017 report to Congress. *Supra* note 1.
[7] *Supra* note 1, at 130-146.

> that states already have significant flexibility within the final provisions of the rule to choose measures within their access monitoring review plans that are tailored to state delivery systems. This could allow, for instance, a state with high levels of managed care enrollment to focus on specific care needs of the populations that remain in FFS after a managed care transition."[8]

We concur with CMS that people with disabilities, or the specific services that they rely on, are more likely to be carved out of Medicaid managed care and as such, are more likely to be part of the traditional fee-for-service payment system in states that would qualify for exemptions from certain reporting requirements under this proposed rule. Given the reduced guardrails provided by the rule and the complexity of the individuals served and the need to ensure sufficient access to services for them, we believe this change would disproportionately harm people with disabilities.

Finally, the 85 percent threshold for managed care enrollment seems completely arbitrary and does not account for the diversity of the populations that currently receive Medicaid managed care services. As the Medicaid managed care penetration rate data compiled by the Kaiser Family Foundation shows, only 12 states have over 85 percent rates of Managed care for people with disabilities and older adults—compared to 18 states for the total Medicaid population.[9] In contrast, 30 states have penetration rates above 85 percent for children's services.[10] Nor does the proposal for an all-population threshold address access to specific services that are often carved out of managed care arrangements, such as home and community based services for certain populations, behavioral health services, prescription drugs, and inpatient hospitalization services.[11] An 85 percent flat threshold does not account for the differences between managed care penetration within either population or service, and would leave people with disabilities and complex health needs – those most likely to be carved out or to rely on carved-out services – with few means to address access to care barriers in states with high general penetration rates for managed care. We urge CMS to rescind this proposal.

2) Exemption for Payment Rate Changes and SPA Submission Information

Similarly, we are concerned about and oppose the proposal to exempt certain rate reductions "within a state plan service category [if they are] … less than 4 percent of overall spending on the category within a single SFY and less than 6 percent over 2 consecutive SFYs," especially in conjunction with reduced transparency in the SPA process.[12] Medicaid often pays extremely low rates and even a small rate reduction can jeopardize access to services people with disabilities rely on for their

[8] CMS, *Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, Final Rule* (Nov. 2015) 80 Fed. Reg. 211, 67583.
[9] Kaiser Family Foundation, *Medicaid Managed Care Penetration Rates by Eligibility Group* (Jul. 2017), https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/.
[10] *Id*.
[11] Truven Health Analytics, *The Growth of Managed Long-Term Services and Supports Programs: 2017 Update*, 19 (Jan. 2018) https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf.
[12] CMS, *Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, Proposed Rule* (Mar. 2018) 83 Fed. Reg. 57, 12698.

functioning, independence, and well-being.[13] The threshold does not take into account inflation, which could easily compound or even double cuts. In addition, CMS offers no justification for the change beyond the limited experience the agency has so far had with one cycle of ARMPs. Given the lack of evidence, this decision also appears arbitrary.

While we understand CMS' concern that states have "received little or no feedback" on the SPA applications, we believe this lack of feedback is likely related to the acknowledged "difficulty" that states have had "anticipating the effects of rate changes on Medicaid beneficiaries' access to care."[14] CMS offers no explanation of what kind of outreach or engagement that states have been undertaking as part of this process—the informational bulletin issued in 2016 lays out the required notice requirements, but also provides suggested options for the states.[15] Since CMS offers no additional context, it seems likely that if states had difficulty analyzing and predicting the impact of rate changes that their efforts to solicit meaningful public input may have been compromised. In addition, we are uncertain how CMS expects to "rely in part on the information received through the public input process to help understand the potential effects of proposed rate changes that exceed the thresholds proposed in this proposed rule" if there has so far been limited feedback. Instead of codifying these thresholds, we urge CMS to rescind the proposal.

3) Creation of Benchmarks and Standards for Reviewing Medicaid Access

We concur with our colleagues at the National Health Law Program that CMS should develop and utilize standardized reporting metrics and benchmarks to measure access throughout the Medicaid program. But in particular, before adopting changes that would weaken oversight of the fee-for-service system, CMS should focus specifically on developing metrics and benchmarks that address rates and access issues for people with disabilities, including those related to home and community based services and other disability-specific services.

Thank you for the opportunity to comment on this important regulation and if you have any questions please contact any of the co-chairs.

Sincerely,

Bethany Lilly
Bazelon Center for Mental Health Law

Julie Ward
The Arc of the United States

Dave Machledt
National Health Law Program

[13] *See e.g.*, Report to the President, *America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy* (2017), https://www.acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF.
[14] *Proposed Rule*, *supra* note 12, at 12698.
[15] CMS, *Informational Bulletin, Federal public notice and public process requirements for changes to Medicaid payment rates* (Jun. 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib062416.pdf.