July 5, 2011

Donald M. Berwick
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Regarding: CMS -2328-P

Dear Administrator Berwick,

The Consortium for Citizens with Disabilities ("CCD") is pleased to submit comments to the Centers for Medicare and Medicaid Services ("CMS") on its proposed rule regarding "Methods for Assuring Access to Covered Medicaid Services." 76 Fed. Reg. 26342 (May 6, 2011). The proposed rule is designed, in particular, to assure that, when state Medicaid programs alter their reimbursement methodologies for providers of services, they comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A). Under this provision, commonly known as the "equal access" requirement, state Medicaid plans must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the service area.

42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

CCD applauds the Centers for Medicare and Medicaid Services (CMS) for issuing the notice of proposed rulemaking regarding methods for assuring access to covered Medicaid services. This regulation is a necessary step to ensure that CMS provides strong oversight of Medicaid rate setting by the states. CCD supports the regulatory

framework CMS has created to implement the statutory provision in Title XIX section 1902(a)(30)(A). The law provides this critical protection to both individuals with intellectual and/or developmental disabilities who require health care and long term services and to the service providers that require adequate reimbursement to provide high quality services and supports.

The NPRM provides numerous ways to strengthen and support states in meeting the requirement that rates are adequate to protect access to services for beneficiaries. CCD supports the increased transparency and accountability in the regulation. CCD offers the following general comments on the NPRM as well as some specific recommendations.

CCD believes it is very important for the regulations to clearly state that no state plan amendments lowering rates may be implemented prior to CMS review and approval. We further urge that the public notice and comment provisions in the NPRM should apply to rate reductions proposed by state legislatures. CCD disagrees with the decision to make the proposed regulations inapplicable to managed care plans. The majority of Medicaid beneficiaries are now enrolled in some form of managed care arrangement. It is our experience that many managed care plans do not maintain adequate networks of providers, particularly specialty care providers and dentists which may be due in part to inadequate rates of payment. CCD urges CMS to apply the proposed protections described in this NPRM to managed care arrangements.

Section 447.203 Documentation of access to care and service payment rates

Access review data requirements

CCD supports the suggestions in the preamble on page 26345 of additional data that will help inform the states whether or not enrollees needs are being met. In addition to the bulleted suggestions in the Preamble, CCD would add information about the number of individuals waiting for services from the state, the types of services and the wait times. Other critical measures may include progress measures for the state in meeting ADA and *Olmstead* obligations, services time frames such as the time from application to eligibility and the time from enrollment to services starting. CCD agrees that when this information is not readily available that states should do beneficiary surveys and use other means to gather the information. This should include consulting with organizations representing people with disabilities and service providers. The regulations should require states to describe how they will gather this additional information.

Access review Medicaid payment data

CCD supports basing provider rates on actual costs to the extent possible. A comparison to the actual costs should be a critical part of any analysis of rate sufficiency. If rates are well below costs, providers will not want to participate or will not be able to provide

quality services. CMS should require states to demonstrate that they have factored in the actual cost of providing the service when deciding the rates.

Stratification requirements

CCD strongly supports the stratification requirement. It has been our experience that rates vary among categories of providers. It will be critical to have the information broken down by state-government owned or operated, non-state-government owned or operated, and privately owned or operated.

Access review timeframe

CCD appreciates the inclusion of specific timeframes in the NPRM to ensure that rates are reviewed and access evaluated in a timely manner. We urge CMS to tighten up the deadlines and require states to complete the review of all covered services in two years and ensure that each covered area is reviewed every three years rather than the proposed 5 years. The proposed period of compliance in the NPRM is too long and too vague given how important the reviews are to ensuring beneficiary access.

Monitoring Procedures

CCD strongly supports the addition of monitoring procedures that will help ensure continued beneficiary access to services. CMS should further require that states monitor 6 months, 1 year and 2 years after the rate reduction to make sure there is no short term or longer term impact on access.

Mechanisms for ongoing input

CCD supports the requirements for ongoing beneficiary input and urges CMS to expand this section and call for ongoing input from all stakeholders including beneficiary advocates and service providers.

Section 447.204 Medicaid provider participation and public process to inform access to care

CCD strongly supports these new provisions and believes that the state must maintain a record of the volume of public input and nature of the state's response to the input. This should be a requirement and not a suggestion. CCD strongly urges that the regulations be clear that if CMS determines that rates are modified without the analysis the agency **shall** (not may) disapprove the proposed state plan amendment if it would have a negative impact on beneficiary access. CCD believes it is very important that if a state is found not to have done the analysis then CMS must either disapprove the amendment or require corrective evidence.

Section 447.205 Public notice of changes in statewide methods and standards for setting payment rates

CCD urges CMS to further modify this section by requiring the public notice for any proposed change. We agree with the discussion in the Preamble that the term "significant" is too vague and should be removed. Medicaid rates have historically been so low that any proposed reduction in rates should trigger the public notice requirements.

CCD also recommends that:

(1) the review process for state plan amendments and waiver and demonstration projects should provide for heightened scrutiny of Medicaid rate actions that affect providers of home and community based services. Such benefits are more cost-effective than institution based services under Medicaid. In addition, the Olmstead Supreme Court decision requires services to be provided in the least restrictive setting. As such, home and community based services should receive additional scrutiny from CMS when states propose to reduce rates for these services;

(2) CMS consider exceptions to the claims of home and community based providers from state coordination of benefits arrangements in circumstances where application of those arrangements may result in loss of access to such care in medically underserved or rural areas and create a significant likelihood of shifting increased costs to the federal government for such care; and

(3) CMS buttress the proposed rule either by adding provisions or undertaking separate rulemaking that would:

a. create meaningful public access to copies of the approved state Medicaid plans and pending state plan amendments;

b. furnish similar meaningful oversight of Medicaid managed care rates: and,

c. require states to employ methods and procedures to ensure meaningful access to Medicaid benefits when states propose to eliminate or reduce coverage of optional benefits they currently cover.

Equal Access Safeguards For Cuts To Optional Benefits

In addition to changes in rate setting for providers, elimination or reduction of optional benefits currently covered by a state Medicaid program is another way that states can use to reduce their Medicaid expenditures. Home and community base care, as well as many outpatient rehabilitation therapies and devices such as durable medical equipment, prosthetics, orthotics, and supplies, are considered "optional" benefits under Medicaid despite the fact that

Medicaid beneficiaries rely on these benefits to improve their functioning and live as independently as possible. In order to ensure access to these services when states file state plan amendments or waiver or demonstration project requests that seek to reduce or eliminate Medicaid coverage of currently-covered optional benefits, we recommend that CMS take the following steps:

1) Issue a proposed rule on benefit modifications akin to the "equal access" proposed rule on rate setting that will help ensure that state proposals to reduce or eliminate Medicaid benefits are transparent and publicly accountable;

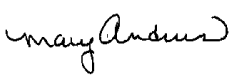
2) In reviewing state plan amendments or waiver or demonstration project requests that seek to reduce or eliminate optional benefits, CMS should issue guidance to state Medicaid programs that CMS will examine such requests with heightened scrutiny and require additional justification if such benefit modifications would:

    a) Impact benefits that impact the functional status and level of independent living of Medicaid beneficiaries; or

    b) Impact federal Medicaid matching funds in a manner that would increase federal Medicaid expenditures, presumably for more costly institutionalized care.

CCD appreciates the opportunity to offer comments on behalf of the Health Task Force. If you have questions please contact Julie Ward (ward@thearc.org).

The CCD Health Task Force Co-chairs



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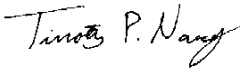

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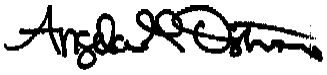

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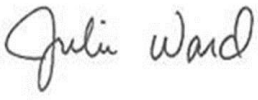

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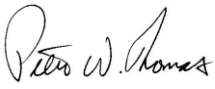

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