January 4, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted via www.regulations.gov.

RE: Final Rule Regarding Methods for Assuring Access to Covered Medicaid Services (CMS–2328–FC, RIN 0938–AQ54)

Dear Administrator Slavitt:

The Consortium for Citizens with Disabilities (CCD) Health Task Force appreciates the opportunity to provide comments on the final rule addressing access to covered Medicaid services. CCD is a coalition national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

CCD Health Task Force submitted comments on the proposed rule in 2011 and we are glad to see that CMS incorporated our recommendation to shorten the access review timeframe in the final rule. We are pleased with the requirements for a state access monitoring review plan and that the experiences of beneficiaries will be a primary determinant of access.

However, we continue to have concerns about the final rule.

1) Application of the Rule to Medicaid Managed Care and Waivers

As we stated in our prior comments, we disagree with the decision to make the final regulations inapplicable to Medicaid managed care. We concur with the National Health Law Program's analysis and recommendations on this point. An estimated 75 percent of Medicaid beneficiaries are now enrolled in some form of managed care arrangement.[1] 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.

[1] Sara Rosenbaum, *Medicaid and Access to Care: The CMS Equal Access Rule*, Health Affairs Blog (Nov. 19, 2015) available at http://healthaffairs.org/blog/2015/11/19/medicaid-and-access-to-care-the-cms-equal-access-rule/.

We also disagree with the decision in the current rule to not apply these rules to services provided under 1915(c) waivers and 1115 demonstration waivers. This is another special area of concern for people with disabilities, since many of the critical services on which they rely are provided through those waivers. We concur NHELP's legal analysis on this point as well. We would also draw CMS' attention to the ANCOR comments on this point.

We urge CMS to apply the protections of the equal access statute to both managed care and waiver and demonstration services.

2) Olmstead

We agree with CMS' statement that states can rebalance their long term services and supports consistent with the Olmstead decision to better ensure access and to provide better care. We would also urge CMS to explicitly require states to include an analysis of compliance with the Olmstead decision in the access plan, access reviews, and when states propose rate reductions or modifications for home and community based services.

3) Special Exemption Process

We recommend that CMS not exempt any states from access planning requirements based on "high managed care enrollment" or other factors discussed on page 67583. The fact that states have utilized such disparate payment structures for Medicaid is another policy reason for CMS to apply this statute to all Medicaid services and not exempt Medicaid managed care or waivers. The proposed exception is particularly concerning to CCD since many states specifically carve out people with disabilities from managed care programs and those services should be subject to this rule. Especially following the Armstrong decision, CMS should ensure that these regulations apply as broadly as possible to ensure that there is a remedy available.

4) Service Categories for Ongoing Review (§447.203(b)(5))

As we said in our prior comments, we appreciated the original proposal that all covered services be reviewed within three years, although we did suggest a shorter timeline. While we support the new shorter time line, we are disappointed that CMS reduced the number of services that must be reviewed within the new timeline of three years. The proposed set of five specific areas for ongoing access reviews is too limited. At a minimum, CMS should also include the Early and Periodic Screening, Diagnostic, and Treatment benefit; Home and Community Based Services and Long Term Services and Supports; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and transportation services as additional areas for access reviews. We urge CMS to return to the original proposal of requiring an analysis of all Medicaid services, although we urge CMS to maintain the three year timeline.

5) Triggers for Additional Review (§447.203(b)(5)(G) and §447.203(b)(6))

We support the two triggers of beneficiary complaints and rate restructuring or reduction for additional review. We do have some concerns, first about the beneficiary complaint trigger: The

vague language of "a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints" does not provide enough guidance—especially since many states do not have prior complaints to bases their "normal" levels upon. This is also problematic because states will be establishing complaint processes and the proposed rule does not provided substantial guidance at § 447.203(b)(7) about what that system should look like. 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, 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 publically 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. We also disagree with CMS' decision to not establish "a formal process at the federal level" for complaints.[2] If CMS plans to allow beneficiaries and stakeholders to raise concerns directly with the agency in circumstances when the state has failed to address their concerns adequately, then CMS should create a national call center or electronic complaint database so that complaints can be filed at both the state and national level, ensuring that CMS has relevant information.

We strongly support the second trigger requiring access review when provider rates are reduced or restructured. Given the serious access issues that have arisen for people with disabilities when state systems transition to managed care, as CMS is well aware, we urge that such a review be required when rates are restructured to managed care in addition to general changes.

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).

Thank you,

The CCD Health Task Force Co-Chairs

Mary Andrus
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Rachel Patterson
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[2] Final Rule, p. 67591.