Disability Rights Education & Defense Fund DREDF

July 27, 2015 **Via electronic submission to regulations.org**

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2390-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2390-P Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid (CMS) on its proposed rule for the Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (Medicaid managed care rule). DREDF is a leading national law and policy center that works to advance the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We are committed to increasing access to equally effective healthcare for people with disabilities, and eliminating persistent physical and programmatic barriers and healthcare disparities that adversely affect the length and quality of their lives.

As we have pointed out many times in our work, not all people with disabilities receive healthcare through Medicaid, but Medicaid is the only publicly funded provider of long-term services and supports and is a very significant or sole source of healthcare for many people with disabilities who experience discrimination in education and employment. Our comments below will not be addressing the full breadth of the proposed rule. Rather we are focusing on provisions with particular relevance to the physical and programmatic accessibility in healthcare delivery needed by people with various disabilities. DREDF has also signed on to the comments submitted by the Consortium for Citizens with Disabilities (CCD) and support their comments in addition to our own which follow.

§ 438.10 Information Standards

We acknowledge and support CMS's direction to states and MCOs to meet the effective communication needs of individuals with disabilities and Limited-English Proficiency (LEP), and we particularly applaud the agency's ground-breaking recognition of the need for accessibility information in MCO provider directories. At the same time, we have a number of recommendations for the Information Standards section that we believe will help focus state and MCO efforts on meeting the overall accessibility requirements presented in this section.

(a) Definitions – readily accessible

If the proposed rule seeks to establish the term "readily accessible" as a term that describes accessible information, we recommend that the term be broadened to apply to information provided in any form. Currently the definition appears to be limited to electronic information and services, while such phrases as "written materials must also be made available in alternative formats" and "auxiliary aids and services are available upon request and at no cost for enrollees with disabilities" are scattered throughout s. 438.10 to signal state and MCO requirements under Section 504 and Title II and III of the ADA. This will potentially result in inconsistent misreading of state and plan obligations to provide effective communication, and the false assumption that people with disabilities have varied rights to different formats depending on the covered entity's choice to provide particular formats in the first place. For example, the first basic rule under s. 438.10(c) states that all required information in the section must be provided in a manner and format that is "readily accessible," but the current definition applies only to electronic information.

Our recommendation is for one broad definition of readily accessible that encapsulates the effective communication obligations of states and Medicaid MCOs under Section 5t04 and the ADA. We recommend amending § 438.10 (a) as follows:

Readily accessible means compliance with effective communication obligations, free of charge and upon the request of a person with a disability, in accordance with federal accessibility laws. Readily accessible includes the use of accessible electronic methods that comply with Section 508 Guidelines or Web Content Accessibility Guidelines (WCAG 2.0 AA) that provide greater accessibility to individuals with disabilities, the timely provision of auxiliary aids and services, and the delivery of information through alternative formats within five calendar days of an original request or concurrently with the delivery of printed formats, giving primary consideration to the request of the individual with a disability unless meeting the request would result in an undue burden or a fundamental alteration of the program or service.

This definition, when applied consistently throughout § 438.10, will help MCOs to understand and consistently meet their accessibility obligations, and apply those obligations in conjunction with the information requirements in the proposed rule. Our definition establishes that:

- The alternative format choice of the person with a disability takes precedence over the state's choice in § 438.10(e) to provide potential enrollees with specified information in either paper or electronic form. As currently written, a state could potentially assert that a choice to provide materials in an electronic form means that it can bypass the alternative format and auxiliary aids and services obligations that apply to "all written materials" under § 438.10(d). Under § 438.10(c)(6), electronic information provided by the state must also be electronically accessible, but § 438.10(c)(6)(v) only narrowly indicates that electronic information must also be available "in paper form" without charge and upon request, which arbitrarily excludes the possibility of audio formats.

- ADA/504 rights accrue to individuals with disabilities who interact with the plan, regardless of their official status as enrollees or potential enrollees; for example, the Deaf parents of a minor enrollee have a right to sign language interpretation when discussing their minor enrollee's health conditions, treatment options and treatment authorizations with providers and plan representatives.
- States and MCOs need to establish policies and procedures to consider and respond to requests for reasonable accommodation and effective communication in accord with existing law, which gives priority to the preferred request of the individual with a disability.
- Requests for auxiliary aids and services and alternative formats need to be met in a timely manner, and all alternative format requests must be met within five calendar days. Currently the only timeliness obligation in the entire section appears to apply only to the state's obligation to provide a written format upon request when the state chooses to only provide information/materials in an electronic format: § 438.10(c)(6)(v).

Finally, we strongly urge CMS in this proposed rule to require states and MCOs to adopt data procedures and communication preference policies that will enable them to meet, on an *ongoing* basis, the alternative format/auxiliary aids and services request of individuals with disabilities once made. An enrollee who is blind, for example, should not bear the burden of having to be constantly alert to mailings she cannot independently see, just so she can make yet another request to receive the latest notice that she cannot identify or read in the same alternate format she has already previously requested. Moreover, even where a request has not been actively made, states and MCOs should bear responsibility for reaching out to potential enrollees and enrollees who *they know from the health record* are blind, visually impaired or Deaf to ask them if they would like an alternate format.

When the duals integration project in California was initiated, Medicare and Medicaid-eligible individuals received notices 90, 60 and 30 days ahead of their requisite passive enrollment date. Upon pressure from advocates, the state indicated that upon request, it would provide dually-eligible persons with this set of notices in their requested alternative format, but the state indicated that they would not carry though the alternate format request made by the individual to any other post-enrollment Medicaid managed notices or information. It is critical, when states and MCOs are already investing very substantial amounts toward meeting health information technology goals, for these entities to proactively build in the technical and procedural capacity to **consistently** meet the information needs and broader accommodation needs of both individuals with disabilities and individuals with LEP.

(b) § 438.10(c)(4)(i) – Definitions for managed care terminology

We also urge CMS to include the following changes and additional terms that states must develop under § 438.10(c)(4)(i) for uniform adoption by MCOs.

- Behavioral health services - given the historical exclusion of mental health services by private insurance, failure to include such a definition creates the incorrect impression that such services are not covered.
- Continuity of care – this is a critical aspect of care for every Medicaid beneficiary with disabilities and plans must explicitly address beneficiary concerns on this front.
- Care coordination - these services should form the linchpin of managed care involvement in Medicaid service delivery and require uniform definition.
- The terms “Habilitation services” and “rehabilitation services” must be broadened to encompass devices as well as services. This is consistent with the need for habilitation and rehabilitation terminology under the essential health benefits that QHPs must cover, and use of the same terminology meets CMS’ goal of aligning exchange and Medicaid coverage whenever possible, though of course the Medicaid plan’s coverage of a specific habilitation service or device must follow Medicaid coverage practice rather than QHP regulatory practice.
- Health risk assessment – many Medicaid beneficiaries will be unfamiliar with this term and will benefit from a uniform foundational description of the concept.
- State’s with MCO, PIHP or PAHP contracts which also cover LTSS should be required to develop uniform definitions of adult day services, community-based providers, home and community-based services, in-home personal assistance, *Olmstead v. L.C.*, non-emergency transportation, and any other critical components of Medicaid LTSS within the state.
- We support CMS’s proposed definition of LTSS in § 438.2 as one that emphasizes the person-centered goals of LTSS rather than list off specific services. We believe the breadth of this approach is needed and best supports a potential evolution of managed care delivery of LTSS in ways that will meet the actual and most urgent and vital needs of Medicaid enrollees with long-term needs. For this reason, we recommend that CMS explicitly require states and MCOs to adopt the proposed rule’s definition of LTSS, or at least to direct states to develop a definition of LTSS under § 438.10(c)(4)(i) for uniform adoption by MCOs that is closely analogous to the definition proposed in § 438.2.

States may also benefit from a clear direction to seek guidance from best practices within and outside of the state pertaining to Medicaid coverage, rather than managed care or private insurance coverage which has not historically covered the above benefits.

(c) § 438.10(c)(6)

We applaud the requirement that where states and MCOs provide enrollee information electronically and through their websites, they must ensure that the information is fully accessible. We also strongly support the specific requirement that electronic information must be in a form that can be electronically retained and printed.

We recommend two additional clarifications to this section. First, there should be a direct requirement that the entire state or MCO website that contains Medicaid enrollee information be readily accessible, not just the enrollee information itself. Websites that have untagged pictures and illustrations, documents that are not formatted for screen readers, and inaccessible drop down menus are very difficult for people with various disabilities to navigate and use. That remains the case, even if *some* of the information on the website is readily accessible. States and Medicaid MCOs that develop their websites to draw in and provide information to their enrollees should be prepared to ensure that the entire website is equally available to *all* enrollees over time; competent webmasters and technical personnel are certainly capable of meeting this requirement when it is part of their job.

Secondly, § 438.10(c)(6)(iiii) should be amended to include an additional direction concerning forms and the enrollee's submission of information: "**, and any applications or forms can be filled online, electronically retained, printed, and securely submitted online.**" Individuals who are blind and who use computers often do not use or own printers. The capacity to retain an electronic copy of their Medicaid application or their filled out plan complaint form, for example, while submitting the complaint electronically, will remove some substantial barriers that make it difficult for blind and visually impaired individuals to participate fully and as independently as possible in the management of their own healthcare.

(d) § 438.10(e)

We disagree with giving states the options to provide information to potential enrollees in either paper or electronic format. We recommend that states should be directed to provide both, and may choose to give an individual potential enrollee only one format where the potential enrollee him or herself makes an earlier election to receive only a single format. We also recommend that there be an additional "catch-all" information category here, § 438.10(e)(xi), that enables a potential enrollee to request additional information besides the enumerated elements, in a paper or electronic format. Many people with disabilities need very particular details about the amount, duration and scope of such benefits as DME or mental health coverage or drug formularies, how and where to access such benefits, and any restrictions on enrollee choice of providers, before they can make a truly informed choice among Medicaid plans.

(e) § 438.10(g)(3)

This subsection indicates that MCOs are deemed to have provided enrollees with all required information if the MCO "mails a printed copy of the information to the enrollee's mailing address." However, this makes little sense if the enrollee cannot read print and has already requested an alternate format from their MCO. In those cases, the proposed rule will deem the MCO to have provided information to an enrollee when it is effectively providing the information in a format that it knows the enrollee cannot use. We suggest the following amendments to two of the subsections:

(i) mails a copy of the information to the enrollee's mailing address **in the alternate format requested by the enrollee; mailing a printed copy of the**

information to the enrollee's mailing address will be adequate provision of the information if the MCO has documented past efforts to effectively notify that enrollee of his or her right to readily accessible information.

(ii) Posts the information on the Web site of the MCO . . . and advises the enrollee in the alternate format of his or her choice that the information is available on the Internet and includes the applicable internet address, provided that enrollees with disabilities who cannot access this information online are provided **readily accessible alternatives to online access.**

(f) § 438.10(h)(1)(vii)

DREDF enthusiastically supports the new information requirement for MCO provider directories to include information on the accessibility of network provider offices/facilities. People with various disabilities and functional limitations need accurate information about provider accessibility in order to receive effective healthcare services. Even though the ADA and Section 504 have placed accessibility and accommodation obligations on healthcare entities for well over two decades, physical and programmatic barriers remain pervasive.

For many years the disability community has only had anecdotal evidence of inaccessible healthcare service delivery, but increasingly studies and reports corroborate numerous ongoing issues. One of the first large-scale studies took place in California, specifically among providers who participate in managed care networks. California regulations have long required MCOs to administer a "facility site review" (FSR) of their primary care provider networks. Basically the FSR procedure involves sending a plan representative, often but not necessarily a registered nurse, to provider sites to review a selection of files and such things as the temperature at which medications are stored. The FSR was performed on Primary Care Providers (PCPs) as they joined and every 3 years thereafter, perhaps taking a few hours per visit per site, depending on the size of the facility. Beginning around 2005, disability advocates began working with some of the state's MCOs to voluntarily include a physical access survey (PAS) as part of the MCO's administration of the FSR. The PAS focused on physical/structural accessibility but also included two equipment questions, one on height-adjustable exam tables and one on accessible scales. The plans agreed to participate because they were already reviewing their network offices, and it was impressed upon them that accessibility is important to the quality of care that members with disabilities receive; if the plan knew the accessibility of their providers, they could provide this information to members with disabilities and help them find accessible providers as needed.

Ultimately, 4-5 California plans administered a 55-question PAS with their FSR over an approximate 5 year period, from 2006-2010, obtaining results from over 2300 PCP office sites of varying sizes. The survey results were obtained by 3rd party reviewers trained in structural access requirements, everything from measuring toilet seat heights to determining the weight permitted in exterior doors and analyzing accessible equipment. The survey results were validated, analyzed and published in 2012, establishing that an accessible weight scale was present in 3.6% of the sites, and a height adjustable examination table in 8.4% of the sites.[1] Other high prevalence access barriers were in bathrooms and examination rooms.

More recent research shows that accessibility is no better among specialists. A research team led by Dr. Tara Lagu attempted to find referrals for a fictional female patient with mobility disabilities and chronic conditions. Of the 256 specialty practices that were called, 56 (22%) reported that they could not accommodate the patient, 9 (4%) reported that the building was inaccessible, 47 (18%) reported inability to transfer a patient from a wheelchair to an examination table, and 22 (9%) reported use of height-adjustable tables or a lift for transfer. Gynecology was the subspecialty with the highest rate of inaccessible practices (44%).[2] Researchers were sometimes simply and openly informed that the practice could not provide healthcare services "because the patient uses a wheelchair."

We go into considerable detail on this issue because we fully support CMS's comment at 80 FR 31162 that "meaningful access for [enrollees with disabilities] is available only when they can utilize the full scope of services at a provider's office." We believe that inclusion of this new element in provider directors is justified when Medicaid MCOs must now serve people with long-held disabilities, functional limitations and chronic conditions, as well as older low-income individuals with newly acquired disabilities.

These individuals and their families need basic information about provider accessibility to avoid wasted trips, incomplete exams, pain and embarrassment. They need accurate information from the beginning so they do not arrive at an appointment only to discover that the office was mistaken and the exam table does not really lower or bone density scans do not result in accurate images when a patient remains seated in a wheelchair. We are hopeful that the Access Board's work on voluntary medical equipment accessibility standards will elevate provider awareness and compliance when the standards are eventually issued, and that the standards will eventually be adopted into regulation by the Department of Justice who will ideally add scoping requirements, but thousands of Medicaid beneficiaries need this information *now*.

While we wholly support the requirement for accessibility information in the provider directory, we do have some strong concerns with the current wording of the requirement.

First, we are disturbed by the limitation to accessibility for "people with physical disabilities." CMS's comments on this subsection raise the need to ensure that "enrollees with limited vision and other impairments can reasonably access that information online as well as on paper, as well as in the delivery of services," and

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[1] Physical Accessibility in Primary Health Care Settings: Results from California On—Site Reviews Nancy R. Mudrick, Mary Lou Breslin, Mengke Liang, and Silvia Yee, Disability and Health Journal 5 (2012) 159-167.

[2] Access to Subspecialty Care for Patients With Mobility Impairment: A Survey, T. Lagu et al., Ann Intern Med. 19 March 2013;158(6):441-446. *See also* Accessible Medical Equipment for Patients with Disabilities in Primary Care Clinics: Why Is It Lacking?, J. Pharr, Disability & Health J. April 2013, 6(2): 124-132; Predicting Barriers to Primary Care for Patients with Disabilities: A Mixed Methods Study of Practice Administrators, J. Pharr and M. Chino, Disability & Health J. April 2013, 6(2):116–123.

discuss accommodations for "deaf and hard or hearing enrollees who may need in-person ASL interpreters as well as the use of TTY/TDY lines and/or relay services." In disability rights law we typically see ADA obligations, for example, broken down into structural/ physical accessibility and reasonable accommodations and policy modifications. There can also be a broad division of disability "types" as physical or mental. The proposed rule seem to contemplate a full range of accommodations (i.e., ASL is an auxiliary aid or service that is provided as a reasonable accommodation or policy modification, rather than an issue of structural or physical accessibility), but *only* for people with physical disabilities.

However, if a provider has to provide an electronic disc of post-surgery self-care instructions instead of a sheaf of papers to an enrollee who is blind, it would be entirely arbitrary to decide that the provider need not provide that same CD to someone with a learning or print disability who could equally benefit, but does not necessarily have a "physical" disability. Even more importantly, federal laws absolutely cover people with a full range of disabilities, and obligate covered entities to provide accommodations to anyone with a disability, including those who have a "physical or mental impairment that substantially limits" such major life activities as learning, reading, concentrating, thinking, communicating, and so forth. The current wording of § 438.10(h)(1)(vii) erroneously implies that ADA/504 rights are somehow privileged in their application to people with physical disabilities, and providers need not provide information about, or bother with, the accommodations that are relevant to people with mental or intellectual disabilities.

If a patient with autism or a mental disability requires more time for an examination, that accommodation request is as much a legal obligation as a request for additional time that comes from someone who has a physical disability that affects their speech, but as currently written, the rule implies that only the latter example counts when it comes to getting the "full scope of services at a provider's office." Information about the kinds of programmatic accommodations that people with mental disabilities might need, such as extended appointment times or appointment windows, or policies that will allow someone with post-traumatic stress disorder or another mental health disability to be accompanied by their service animal, cannot be independently collected in the same way as a door width can be measured, but that does not mean it would not be possible for a trained 3rd party MCO representative to gather this information through brief interviews as part of a network site review. Inclusion of the full breadth of accommodations needed by people with physical and mental disabilities will help educate providers about their broader ADA/504 obligations, as well as help states to collect baseline accommodation information that can be placed in directories.

We recommend amending § 438.10(h)(1)(viii) as follows:

(viii) Whether the provider’s office/facility **provides physical access, accessible equipment, reasonable accommodations and policy modifications, and effective communication for people with physical or mental disabilities**.

This wording generally matches the phrasing used in § 438.68(c)(viii) to describe an element that must be considered by the state when developing time-distance network adequacy standards. However we recommend replacing "Medicaid enrollees with physical or mental disabilities" with "people with physical or mental disabilities' because the former phrase seems to exclude family members or guardians of minor Medicaid enrollees (or adults with significant intellectual disabilities for example) who may have disabilities that require accommodation, in contradiction of federal disability rights law. We also recommend this change in phrasing for § 438.68(c)(viii), as well as for § 438.206(c)(3). All three provisions should be consistent in their reference to physical accessibility, accessible equipment, reasonable accommodations and policy modifications, and effective communication for people with physical or mental disabilities.

In addition, we strongly urge that the proposed rule establish parameters for both how MCOs collect accessibility information on their provider network, and for how states will monitor and ensure the accuracy of accessibility information. People with disabilities will not receive the full scope of services at MCO providers' offices unless they have access to reliable, consistently measured and updated information on the accessibility of all kinds of MCO provider offices, including PCPs, specialists, hospitals, pharmacists, LTSS providers, behavioral health facilities, and treatment centers such as dialysis or mobile diagnostic centers. Research has established the human tendency to overlook the need for accessibility or accommodations that one does not need oneself. One study found significant discrepancies between provider self-reporting about office accessibility via a telephone survey, and a subsequent site accessibility analysis made by a team of surveyors that conducted an on-site assessment of parking, building entrance, examination room, and restroom accessibility at the same site.[3]

California's experience with MCO administration of the FSR and PAS proves that it *is* possible to obtain reliable and consistently measured accessibility information about a provider network. An expanded physical access survey is now a mandatory component of the California FSR.[4] All Medicaid managed care plans, including the dual integration plans, must administer the PAS to both their network PCPs, specialists and ancillary providers, as mandated under both the special terms and conditions approved under the state's last 1115 waiver renewal and the three-way contracts in the duals project. Moreover, the fact that all MCOs must administer a consistent survey tool has enabled plans to enter agreements with one another that will allow one plan's survey of a provider office/facility that contracts with multiple plans to fulfill the FSR obligation of all the plans with respect to that specific office. This fosters efficiency and avoids a provider having to undergo multiple FSR evaluations in a given period. Additional targeted training of the MCO FSR administrators would enable them to administer a component directed at obtaining information about reasonable accommodations and policy modifications in provider offices.

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[3] Perceived accessibility versus actual physical accessibility of healthcare facilities. Sanchez J, Byfield B, Brown TT, LaFavor K, Murphy D, Laud P. Rehabil Nursing. 2000;25:6-9.

[4] The policy behind the administration and development of the PAS is captured in a 2012 California Department of Health Care Services All Plan Letter, available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-006.pdf. The PAS itself is attached to this letter. A 2014 DHCS All Plan Letter provides the history of the FSR and also includes the FSR as an attachment, available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf.

While MCOs in California are administering the FSR and PAS, the gathering of survey information has not necessarily let to the publication of accurate and current information on PAS results in provider directories. MCOs are not given a uniform or model way of reporting accessibility information, and there appear to be few resources devoted to state monitoring of PAS results. Similarly, the PAS administration has not necessarily lead to improved accessibility among provider networks. Some FSR issues may lead to a corrective action plan for MCOs, but provider network inaccessibility does not trigger corrective actions or lead to any mandate to improve network accessibility.

Section 438.206(c)(3) in the proposed rule is meant to support the requirement, in § 438.68(c)(1)(vii), that a state's network adequacy standards consider "the ability of healthcare professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities." As such, § 438.206(c)(3) echoes the prior network adequacy section and requires MCOs to "ensure" that network providers "provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. Section 438.206(c) in turn holds the state responsible for ensuring that each MCO contract contains the MCO's obligation to ensure accessibility in its provider network.

We recommend that § 438.206(c)(3) explicitly incorporate the provider directory requirements of § 438.10(h)(1)(viii) as follows:

(3) *Accessibility considerations*. Each MCO, PHP, and PAHP must ensure that network providers provide **physical access, accessible equipment, reasonable accommodations and policy modifications, and effective communication for people with physical or mental disabilities. MCOs shall ascertain, on an ongoing basis, the extent to which network providers are currently capable of meeting their accessibility obligations and shall make this information available through provider directories, in accordance with § 438.10(h)(1)(viii).**

The suggested amendment would strengthen the relationship between the information requirements and network adequacy, and give states a concrete way to monitor MCO efforts to increase needed accessibility among their provider networks. We also recommend that the rule explicitly recognize MCO efforts to improve accessibility and reduce accessibility barriers within their provider networks, including efforts to implement health information technology that would allow enrollee accommodation needs to be captured in electronic health records and allow provider office accessibility to be updated by enrollees, by counting such efforts in the MLR numerator as activities that improve healthcare quality.

A review of 45 C.F.R. §158.150 and §158.151 shows the degree to which activities that clearly improve clinical care and healthcare quality for people with various disabilities, such as the removal of physical accessibility barriers and the provision of reasonable accommodations and policy modifications, do not fit neatly within established clinical and evidence-based parameters that historically have been developed for and applied within a disability-free population. The same analysis holds true for disability-specific best practices that implicate LTSS, such as the implementation of *Olmstead* training and the rebalancing of institutionalization and home and community-based services that is required under that Supreme Court decision, and these are core MLTSS principles recognized by CMS in the proposed rule. We strongly urge CMS to consider and enunciate how the MLR could be used to help incentivize and encourage MCO activities that will remove accessibility barriers among providers and encourage and maintain community integration among enrollees with disabilities, including MCO collection of accurate information on accessibility within provider networks.

(g) Accuracy of information provided to enrollees and potential enrollees

This final recommendation does not relate to any current subsection in the proposed information requirements provisions. Rather this is a call for an overarching requirement in the section that requires states and MCOs to monitor and validate the *accuracy* of the information provided to enrollees and potential enrollees, and especially the information provided in the provider directories.

The California State Auditor released a very recent and scathing review on the Department of Health Care Services' (DHCS) oversight of the state's managed Medi-Cal plans. In the public letter that opens the report, and on the specific point of the accuracy of provider directories, the report stated that:

> . . . flaws in Health Care Services' process for reviewing provider directories have resulted in it approving provider directories with inaccurate information. Specifically, our review of provider directories for three health plans—Anthem Blue Cross, Health Net and Partnership Health Plan—found many errors in directories, including incorrect telephone numbers and addresses, or information about whether they were accepting new patients. However, Health Care Services' review of these same directories had not identified these inaccuracies before it approved the directories for publication.[5]

The error rates of the provider directories varied from 3.1% at Partnership to 23.4% at Anthem Blue Cross of incorrect information in one or more of the information aspects reviewed (i.e., provider name, telephone number, address, practice type, accepting health insurance, accepting new patients).[6] The state auditor noted that DHCS does not require Medi-Cal managed care plans to use a specific method to verify provider network information, and does not itself have any kind of methodology for ascertaining the accuracy of the provider directories that are submitted to DHCS for approval every six months.

With regard to provider directories, the state auditor recommended that by September 2015, DHCS develop detailed written policies and procedures for staff that would enable them to select a random sample from each directory that is of sufficient size to identify the accuracy of the entire directory, maintain at least three years of documentation on

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[5] Opening Public Letter, California Department of Health Care Services Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care, Report 2014-134 (June 2015); available at: https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf.

[6] California Department of Health Care Services Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care, *ibid*. at 27.

DHCS reviews and provider directory verifications, and retain at least three years of communications with health plans concerning directory errors and approvals. The auditor concluded that if DHCS finds significant errors in a plan's directories, the department must work with the plan to identify reasons for the inaccuracies and processes to eliminate them. DHCS accepted these recommendations as well as the proposed timeline for action.[7]

We have gone into some detail on the above report not because we want to highlight California as doing a worse job than other states. In fact, DREDF believes that inaccuracies among MCO provider directories is an all too common problem with which all states continue to grapple. We recognize that CMS may seek to emphasize state flexibility over the regulation of Medicaid managed care delivery in such relatively new areas as LTSS network adequacy, but the foundational role of accurate provider directory information to an enrollee's ability to understand, navigate and successfully gain access to managed care benefits is well-known. Even in the realm of private insurance regulation, the National Association of Insurance Commissioners (NAIC) is, this very week, considering inclusion of the following provision in their model network adequacy act:

"8A(b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request."[8]

Medicaid beneficiaries, who overall deal with more significant disabilities, a greater incidence of chronic conditions, and a diminished quantity and selection of providers, have an even greater need for accurate information in Medicaid managed care provider directories. We support CMS's proposal to require MCOs to post provider directories and formulary information online in a machine readable file and format that federal and state agencies, as well as third parties, could easily "read" for accuracy checks and for the development of creative consumer applications. We appreciate that this may spur greater accuracy in provider directories. At the same time, we believe there is still a clear need for a straight "old fashioned" directive to MCOs to post accurate information in the first place, with procedures in place to ensure accuracy. The rule should also require all States, under §§ 438.207 and 438.604, to obtain provider directory verification data from MCOs and develop clear methodologies for auditing provider, formulary, and other plan information, in line with the recommendations made in the California state auditor's June 2015 report.

§ 438.68 Network Adequacy Standards

DREDF strongly supports the proposed rule's move toward requiring at least minimum standards to address network adequacy among states that contract with MCOs to delivery Medicaid. We consider time and distance standards to be an acceptable

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[7] *Id*. at 52.

[8] "Section 8A Discussion Language", available as one of several documents provided for the review of the NAIC Network Adequacy Review Subgroup July 23, 2015 Conference Call, available at: http://www.naic.org/documents/committees_b_rftf_namr_sg_150723_section_8a_discussion_draft.pdf.

means of establishing network adequacy as long as plans and states are required to take into account real life parameters, such as the availability of public or plan transportation and provider office/facility accessibility, that have an impact on how enrollees actually get to providers and whether they gain access to effective services. Provider-to-enrollee ratios may not always capture these nuances of network adequacy.

However we suggest that provider-enrollee ratios can be an important additional check for network adequacy, especially if they are sufficiently linked to relevant geographic areas that take into account such factors as rural character and the location of regional specialty treatment centers, and are also formulated at a sufficiently granular level to capture the specialist providers needed within the Medicaid population. The proposed rule notes the important distinction between adult and pediatric specialists; we both fully support this recognition within the current rule and cite it as an example of the kind of specialist granularity needed by Medicaid eligible adults and children. Other examples include physiatrists and other complex rehabilitation specialists, geriatricians, and providers who have experience working with people with developmental disabilities. In addition, a granular provider-to-enrollee ratio that encompasses provider types such as anesthesiologists and radiologists that typically work in hospitals, but are not necessarily always part of the MCO provider network that includes the hospital, would allow the state to monitor the relationship between Medicaid provider networks and balance billing by out-of-network providers in emergency situations, for example. We recommend that the network adequacy section include specialist provider-to-enrollee ratios for states to further define and use as a measure of MCO network adequacy. Enrollee-to-provider ratios are also a critical recommended component when it comes to in-home personal care assistance, where the necessity for an enrollee to have a *choice among providers* must be built into any assessment of network adequacy.

In response to the request for comments on whether CMS should set actual time and distance standards for the states, we think there are a number of advantages to CMS doing so. These include establishing a common national baseline to protect consumers. A national standard will also allow for comparable data among states on how MCOs meet those baselines over time, and on how states have developed and applied exceptions and their impact on enrollee access to care over time. Even with CMS setting actual time and distance standards, the general approach outlined in the rule builds in flexibility by giving states explicit permission in § 438.68(b)(3) to have varying standards for the same provider type depending on geographic area, as well as the authority in § 438.68(d) to establish exceptions to *any* of its provider-specific network standards. Given those parameters, establishing actual time and distance standards for states to adopt cannot be considered draconian by any means.

Having stated this, we do recommend some additional safeguards on the state flexibility measures outlined immediately above. If the state wants to build in variance in its standard for a particular type of provider, it needs to be transparent and provide actual data justifying the variance rather than simply point to geography as a self-explanatory reason. At a minimum, the state should know and provide information on the number of the type of provider in question practicing in the geographic area for which variance is sought, obtain feedback from enrollees, Medicaid providers and any fee-for-service Medicaid beneficiaries in the area, and address strategies and timelines for practically improving provider network adequacy in those areas for which lower time and distance access standards are sought. Similarly, the exceptions process should also contain these latter two additional elements. Exceptions should be explicitly limited to geographic exceptions rather than be available, for example, to a particular MCO, or if other specific circumstances are envisioned, those should be explicitly enumerated. Exceptions should clearly be reserved for circumstances that are unusual and/or less than ideal, and as such, include in the process a requirement for all stakeholders to work together on improvements that would ultimately allow the "normal" provider network standards to apply.

Moreover, CMS should within the rule or in later sub-regulatory guidance provide states with examples of when an exception would be called for, as well as examples of the kind of tailored exception that would enable the state to examine the benefits of MCO Medicaid delivery in the area while maintaining the minimum consumer protections that network adequacy standards are supposed to provide in the first place. Finally, CMS should require state to consider, as part of their exceptions process, additional measures that MCOs can be contractually required to be provide when exceptions are granted, such as facilitate care by appropriate out-of-network providers in the area that *would* meet time-distance, and/or facilitate appropriate accessible transportation for enrollees to in-network providers that fall outside of typical time-distance standards.

In the proposed rule, CMS provides a helpful overview that contrasts the network adequacy standards applicable in the marketplace with network adequacy standards applied in the MA program. Ultimately, CMS concludes that the Medicaid managed care rules should align more closely with Marketplace and QHP rules rather than the detailed approach undertaken in the MA program. This decision, however, is based on an analysis that appears to overlook the needs of a Medicaid population which has healthcare needs that are at the very least more closely aligned with Medicare beneficiaries than marketplace participants; in fact, Medicaid enrollees likely have greater and more complex healthcare needs than both the average Medicare Advantage or QHP enrollee. QHPs are not building provider networks that need to meet the often overlapping physical, behavioral and LTSS needs of the lowest income people with disabilities of varying ages. Medicaid MCOs need to do so, and many of them are trying to do so with limited experience in managing and administering LTSS. While not entirely analogous, the situation raises network adequacy and care continuity concerns very similar to those highlighted in a report analyzing the capacity of Medicare-Medicaid plans involved in the duals integration projects where some states had limited experience with capitating Medicaid and Medicare, and some states had little or no experience administering Medicaid or Medicare in state.[9]

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[9] Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries: What Prior Experience Did Health Plans and States Have with Capitated Arrangements?, R. Weiser and M. Gold, Kaiser Family Foundation (April 21, 2015), available at: http://kff.org/medicare/report/demonstrations-to-improve-the-coordination-of-medicare-and-medicaid-for-dually-eligible-beneficiaries/?utm_campaign=KFF:%20General&utm_content=14249003&utm_medium=social&utm_source=twitter.

Even if CMS decides that states have primary responsibility for administering and monitoring the Medicaid managed care program, and therefore reserves for itself a regulatory role that "relies heavily on attestations and certification from the applicable health plan, with supporting documentation, about the adequacy of the network," that decision in itself only necessitates a more prescriptive approach to the state role. This need not entirely eliminate flexibility. CMS can establish a framework that require states to take a proactive role in designing, monitoring and implementing model network adequacy standards without dictating every facet of that role.

Following on this, our recommendation is that states, at a minimum, must be required to actually **take into account and address** the factors enumerated in § 438.68(c), not merely "consider" them. A state could presumably consider the inadequate ability of healthcare professionals within MCO provider networks to communicate with LEP enrollees, and then simply decide that it does not want to expend the resources it might take to ensure that MCOs have a sufficient provider network in this regard. Or a state might consider that it currently lacks sufficient information about the number and type of healthcare professional taking new Medicaid patients throughout the state, and therefore take no steps to address this potentially great failing in its network adequacy standards.

DREDF emphasizes that we unequivocally support the inclusion of physical and programmatic accessibility in provider offices as a key factor in determining provider network adequacy. We are only recommending a stronger mandate for states to incorporate this and the other § 438.68(c) factors in the development of their network adequacy standards. It has been our experience that the greater the change sought, the more the change must be directed. Health disparities linked to race, ethnicity, language and disability status are deeply imbedded in our healthcare system. The requirement for provider networks standards to address the inaccessible status quo among provider is a change that is very important to the disability community and one that is deeply needed. The proposed rule must support that change so it can happen not only in states that have begun to address the problem already, but in states, and among MCOs, that have not even begun to consider the impact of inaccessibility on effective care.

We also strongly recommend that CMS require states to adopt a mix of enforcement mechanisms in place for ensuring that MCOs are meeting provider network standards. States could be asked to implement at least three additional methods other than document review among a choice of conducting enrollee surveys,[10] reviewing encounter data, calculating and reporting HEDIS measures related to access, undertaking and reporting a systematic evaluation of consumer service calls, and evaluating and publicizing the advocacy and assistance provided by the beneficiary support systems proposed in this rule. In addition, we would like to recommend that CMS mandate state incorporation of secret shopper efforts as an enforcement mechanism. We think there

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[10] We note the baseline work that has been performed using a modified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey among people with physical disabilities. *See* Enabling a survey of primary care to measure the health care experiences of adults with disabilities. S.E. Palsbo *et al.*, Disabil Rehabil 2011 7;33(1):73-85. Epub 2010 Jun 7.

is no other way to truly capture the enrollee experience, and particularly the enrollee experiences of typically underserved populations who experience health disparities because of personal characteristics such as race/ethnicity, language, or disability status except through credible proxies who actually undergo processes for seeking information, obtaining services, and requesting accommodations from MCOs and providers.

Our final recommendation on network adequacy concerns institutional LTSS providers. CMS must clarify how skilled nursing facilities (SNFs) and other LTSS facilities that provide services through enrollees taking up residence fit within the LTSS division established in § 438.68(2). Currently states are directed to establish time and distance standards for LTSS providers "in which an enrollee must travel to the provider to receive services,' while network adequacy standards other than time and distance are required for LTSS provider types "that travel to the enrollee to deliver services." Residential LTSS facilities conceivably could be characterized as the latter and not subject to time and distance standards since, once an enrollee resides there, various services do typically "travel to the enrollee" within the residence. Nonetheless, we recommend time and distance standards for LTSS residential facilities of a sufficient degree to maximize enrollees choice of a nursing or residential facility that will enable them to maintain some degree of contact with their prior communities and network of family and friends where desired.

Three Additional Topic Areas: Data, Stakeholder Engagement, and Proposed Institution for Mental Diseases' (IMD) Exception

Our final three recommendations pertain more generally to MLTSS and the needs of people with disabilities beyond the specified focus on physical and programmatic accessibility that is evident in the above comments.

(a) Data: §§ 438.206, 438.207, 438.604

CMS must include specific directions to states relating to data capture and review of each state's proposed LTSS network adequacy standards as they are administered in practice. It will be vitally important to capture information around the incorporation, actual referral to, and use by enrollees of community-based LTSS (i.e., information cannot be a simple matter of MCOs recording the entering of a contract with such CBOs). Since this is such relatively new and untrodden territory, CMS needs to lead the way not necessarily in establishing the standards themselves, but in establishing the required parameters for capturing and maintaining data that will allow for comparison within and among states on how managed Medicaid LTSS provider networks are meeting the needs of enrollees, where gaps exist, and how network adequacy standards can help MCOs to recognize and address the LTSS needs of their members.

The current proposed requirement in § 438.207(b) allows each State to set its own document format for how MCOs comply with the requirement to offer appropriate and sufficient LTSS provider networks, and establishes only a minimum baseline for when such documentation must be submitted to the state. Given the key importance of LTSS services to Medicaid beneficiaries who depend on those services, the fact that community-based LTSS providers often do not have the financial resources to survive lengthy periods of diminished revenue while they determine how to enter and manage service contracts with MCOs, and the reality that most states and MCOs likely do not yet know or understand the kind of "significant changes" in LTSS capacity and services that would trigger a need for additional documentation under § 438.207(b)(3), we recommend far greater direction from CMS on MLTSS documentation submission and review in particular. Submission frequency may eventually relax to an annual rate once sufficiency is established, but the earlier stages of network development must be more closely tracked and absolutely require the benefit of close and informed stakeholder input.

(b) Stakeholder Engagement: §§ 438.70, 438.110

DREDF supports the new provision in the rule that requires states to solicit and address the views of beneficiaries, providers, and other stakeholders on the design, implementation, and oversight of a state's MLTSS program. However, we are dismayed that CMS has not taken the opportunity to establish in regulation the more specific and necessary conditions for stakeholder participation that were set out in the agency 2013 guidance in implementing managed care.[11] Individuals who use and rely on LTSS have irreplaceable insights into the kinds of standards, implementation controls and accountability measures that will be needed in MLTSS, but as individuals who deal with multiple functional limitations, chronic conditions and low income, they are also often unable to participate on a level playing field in the stakeholder process. It is one thing to give state's flexibility in determining the frequency of meetings and who exactly must be in the stakeholder group. It is quite another to, as is currently implied in § 438.70, give states the "flexibility" to determine whether and how to extend accommodations and supports that most beneficiaries will need to meaningfully participate in stakeholder meetings.

We recommend that §§ 438.70 and 438.110 clarify that states and MCOs must ensure that enrollees with various disabilities are equally welcome within the stakeholder process, and will provide such needed reasonable accommodations and policy modifications as accessible transportation, agendas and meeting materials provided ahead of time in alternative formats, auxiliary aids and services, any additional costs associated with personal assistance services, and phone or video conference lines. In addition, MCOs should be directed to take all necessary measures to reassure MLTSS enrollees that their participation on any member advisory committee, including any feedback, criticism and personal information provided by the representative enrollee, will not lead to any retaliation or negative action from the plan. Medicaid beneficiaries that DREDF has spoken with in the past are very cognizant of the degree to which their independence in the community and their quality of life depend on key provider relations and LTSS. Vulnerable MLTSS beneficiaries cannot be expected to blithely voice their frank opinions and thoughts about the capacities and shortcomings of their own MCO

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[11] Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

without at least some concrete and formal protection from the possible implications of such criticism.

(c) Proposed Institution for Mental Diseases' (IMD) Exception: § 438.3

DREDF strongly opposes the rule's proposed § 438.3(u) that would allow states to provide capitation payments to MCOs for enrollees aged 21-64 who spend a portion of the month for which the capitation payment is made in an institution for mental diseases (IMD) that is a psychiatric hospital, a substance use disorder inpatient facility, or a subacute facility providing psychiatric or SUD crisis residential services for 15 or fewer days in a month. Our colleagues at the Bazelon Center for Mental Health Law and at Access Living in Chicago have supplied abundant research in their comments to the rule to support our contention that relaxation of the IMD exception at this point ill-serves people with mental health and SUD disabilities by incentivizing institutionalization at the expense of needed investment in effective community mental health services and infrastructure.

The proposed "narrow" exemption appears to rely on the premise that increasing federal Medicaid payments to private psychiatric hospitals will lead to greater access to higher quality inpatient care. This premise, however, is beside the point. Paying more for something can sometimes increase its quality, but it cannot give it value in the first place. In light of the ADA's integration mandate under *Olmstead*, it is not a matter of choosing between poor inpatient care or better inpatient care, but a matter of reducing long-held overreliance on inappropriate psychiatric hospitalization in favor of building functional community health service systems that are capable of supporting individuals *before* the need for emergency hospitalizations arise. The IMD exception was intended to incentivize state development of *Olmstead* compliant, community-based mental health and SUD systems, and the need for incentivization on this front remains sharper than ever when MCOs administer Medicaid.

If CMS chooses to disregard our above arguments and attempt to regulate capitated payments to MCOs under § 438.3(u), we recommend the following additional safeguards on such a provision:

- Shorten the timeframe during which federal financial payments are permitted to a maximum of 8 days, which is the average length of stay in a psychiatric hospital according to national research on length of stays in psychiatric hospitals.[12] Moreover, the rule should expressly prohibit the adding together of 8 days at the end of one month to 8 days at the beginning of the next, thereby avoiding the intended maximum altogether.

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[12] *See, e.g.*, Elizabeth Stranges et al., Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, *State Variation in Inpatient Hospitalizations for Mental Health and Substance Abuse Conditions, 2002-2008*, at 2, http://www.hcup-us.ahrq.gov/reports/statbriefs/sb117.pdf (national average length of stay of 8 days for mental health conditions and 4.8 days for substance use disorders); Centers for Disease Control and Prevention*, FastStats*, http://www.cdc.gov/nchs/fastats/mental-health.htm (2010 data showing national average length of stay of 7 days in inpatient hospitals for mental conditions).

- Just as MCOs must bear the costs of *both* institutional LTSS and home-and community-based services under LTSS, MCOs must bear the costs of *both* psychiatric hospitalizations and the wrap around community-based services and supports that would enable people with mental health and SUD disabilities to avoid hospitalization. If this were not the case, an MCO would be financially incentivized to approve psychiatric hospitalizations that would be paid for by the state rather than itself paying for community based mental health infrastructure.
- Limit relaxation of the exception to psychiatric hospitals to avoid a proliferation of poorly regulated board and care homes that seek to provide short-term “crisis residential” services.
- Work with the Social Security Administration to amend regulations and policies as necessary to prevent a forfeiture of Supplemental Security Income (SSI) while recipients experience short-term IMD stays. A loss of SSI revenue exacerbates the difficulty of a recipient’s successful return to the community and independence, and greatly increases the likelihood of a cycle of increasing institutionalization.

DREDF appreciates the opportunity to comment on the proposed rule. We would be happy to answer any questions you may have on the above or any of our recommendations.

Yours truly,

Silvia

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