May 22, 2018

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:

Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to comment on the 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 (Proposed 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 accessible and equally effective healthcare for people with disabilities, and eliminating persistent health disparities that affect the length and quality of their lives.

We have grave concerns with exempting any state from its obligation to ensure that Medicaid reimbursement rates are sufficient to provide a full range of state Medicaid plan services for all Medicaid beneficiaries, including those enrolled in fee-for-service Medicaid. Low-income people with various disabilities rely on Medicaid not only for acute and preventive care, but for specialty services, chronic care therapies, rehabilitation and habilitation services and devices, mental health and behavioral health treatment, medical and non-medical transportation, support for special education, and long-term services and supports. This broad range of services, across a breadth of primary, specialist, and “ancillary” providers¹, is what enables people with disabilities across all ages to function as independently as possible in their own communities, living productive lives.

While managed care delivery of Medicaid services has become a growing trend across the country, people with disabilities, for good reason, are frequently either exempted or among the last population categories to be required to enroll in managed care. The limited provider networks of managed care can lack the specialty services, providers and specialty clinics needed by people with complex medical conditions and disabilities.

¹ In California, “ancillary” services is often used to refer to services from pharmacists, durable medical equipment providers, transportation service providers, and others who do not deliver primary or urgent care.
As such, people with disabilities are directly implicated by the proposed rule, and the most likely to be adversely affected by exemptions of fee-for-service access rules.\(^2\)

CMS itself has acknowledged that people with disabilities are disproportionately impacted by people with disabilities, and in 2015 advised states to take particular care to tailor their access monitoring review plans to capture access for people with disabilities who continue to receive services through fee-for-service systems.

“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 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.”\(^3\)

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.

Certainly this is the case in California, where managed care penetration does not yet reach these 85% threshold suggested in the proposed rule, but is approaching that number, and the proposed rule appears to contemplate a range of exemption between 75 and 95% penetration. Services such as dental, significant mental health, behavioral health, and long-terms services and supports are carved out of most managed care plan capitation rates. In addition, a Medi-Cal patient who would otherwise be required to join a managed care plan can file for a “Medical Exemption Request” (MER) on the basis of having a complex medical condition or ongoing treatment under current providers and he or she cannot safely be transferred to managed care plan physicians of the same specialty. In a single year, from October 2016 to September 2017, over 11,000 MERs from managed care were submitted.\(^4\) Of these, approximately 500 were approved. Individuals with MERs are usually individuals who have complex conditions that require management by a full team of providers and specialists. According to the latest Medi-Cal Performance Dashboard report, the highest rate of MER approvals was granted to children aged 0 to 18 (68%).


While the proposed rule speaks of reducing administrative burden, there is very little discussion of why medically frail persons with disabilities such as those who receive MERs and therefore rely on fee-for-services services and providers, should receive reduced state responsibility for ensuring their access to services, or why they should benefit from less federal oversight and monitoring. Nor is there any actual data that supports the theory that people with disabilities who rely on fee-for-service providers and services in California and other states already have such robust access to Medicaid services that CMS should now place first priority on reducing state administrative burdens.

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. Given these findings, CMS' unsupported statement appears arbitrary, and DREDF strongly opposes implementing such a threshold.

DREDF has several other concerns with the proposed rule which we share with advocacy organizations such as the Consortium for Citizens with Disabilities, NHeLP, Justice in Aging. We will not repeat the concerns with how the proposed rule proposes exempting certain rate reductions, or makes assumptions about state solicitation of stakeholder feedback, as they are ably expressed by comments submitted by our colleagues. Rather we will join them in calling for CMS to prioritize the development of common benchmark measures and rates that will truly ensure sufficient access to a range of Medicaid services, including home and community-based services, for people with disabilities. Federal leadership and guidance in this area will surely help to reduce administrative burden for states who may be unsure of how to achieve and monitor access within their own remaining fee-for-service delivery systems.

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,

Silvia Yee
Senior Staff Attorney

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5 Supra note 2, at 130-146.