February 28, 2017 Via electronic delivery to hcsmcqmdnau@dhcs.ca.gov

Department of Health Care Services
State of California, Health and Human Services Agency

Re: Medicaid Managed Care Final Rule – Network Adequacy Policy Proposal

Dear Department of Health Care Services Representatives:

I write to you on behalf of the Disability Rights Education & Defense Fund (DREDF), a nonprofit national law and policy center dedicated to protecting and advancing disability and civil human rights. As an organization committed to promoting access to equally affective healthcare services for people with disabilities, DREDF thanks you for the opportunity to comment on the Network Adequacy Policy Proposal (Proposal) released by the department of Health Care Services (DHCS) on February 2, 2017.

Given the breadth of the Proposal, we are focusing our comments on the topics of disability accessibility, long-terms services and supports (LTSS), and monitoring and enforcement. Our overall interest encompasses many other areas of the proposal as many of the persons with disabilities who we represent are also beneficiaries of the Managed Care Organizations (MCOs) that must meet network adequacy standards. We have read and support the comments of the Health Consumer Alliance (HCA) on the proposal, particularly their observation that the California Administrative Procedures Act requires promulgation of the network adequacy standards, including physical accessibility and reasonable accommodation requirements, as actual regulations.[1]

The bulk of our comments follow.

Disability Accessibility

The Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) establishes that a state must develop network adequacy standards for MCOs, and in that development, it must consider "the ability of providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities."[2] Moreover, the state must ensure that its contract with each MCO complies with accessibility and access considerations such that the MCO "must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities," and delivers culturally competent services to all enrollees, including those with disabilities.[3] Finally, the general service provisions

[1] Cal. Gov. Code § 11340.5.
[2] § 438.68(c)(vii).
[3] § 438.206(c)(2) and (3).

of Medicaid were modified to require the state to have "methods to promote access and delivery of services in a culturally competent matter to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation of gender identity."[4] Even though this last provision does not directly affect MCOs, it emphasizes how the Final Rule renewed the federal directive toward cultural competence and non-discrimination for particular sub-populations within all aspects of Medicaid, including people with disabilities who remain in fee-for service Medi-Cal.

As the comment summary in the Final Rule points out, the emphasis on disability access makes sense in light of the population being served, many of whom are older and many of whom have disabilities. We also note that while the specificity of the accessibility requirements may be new to the federal managed care rule, they are not "new" in the sense that accessibility has long been required of both the state and MCOs in California. As recipients of federal financial assistance through Medicaid, they are subject to Section 504 of the Rehabilitation Act.[5] As either the state or recipients of state Medicaid funds, they are subject to California non-discrimination law.[6] The state itself is also subject to Title II of the Americans with Disabilities Act (ADA),[7] and MCOs are independently subject to Title III of the ADA[8] as public accommodations that provide healthcare services.

DREDF's evaluation of the Proposal's disability access provisions take place within the above context, which lays out a long history for the application of disability non-discrimination and equal access laws across the state's public and private healthcare delivery systems. Despite this long history, we do not know of *any* current disability-accessible standards used by DHCS or any MCO as a measure of provider network adequacy. DHCS does not appear to monitor or keep track of disability accessibility complaints brought against Medi-Cal providers, plans or itself. The department does not take any steps to evaluate whether or how an MCO's provider network provides physical accessibility, reasonable accommodations, or accessible equipment to its members with disabilities. The department is not engaged in a process – with or without stakeholder input – to determine the accessibility and accommodations that Medi-Cal beneficiaries with disabilities need, or how to evaluate whether beneficiaries get what they need.

And yet California, more than most other states, already has an infrastructure in place that would allow it to take the crucial first step of evaluating MCOs' **current** capacity to provide physical and equipment accessibility. DHCS has required MCOs in California to review their primary care provider (PCP) office sites using common site review and medical record tools since at least 1996. The site review tool included a few structural accessibility questions. In 2002, DHCS developed an expanded "Facility Site Review" (FSR) tool with standardized criteria and guidelines for administration. Certain FSR violations would lead to corrective action plans, and the FSR was administered to PCP

[4] § 440.262.
[5] 29 U.S.C. § 701 et seq.
[6] Cal. Gov't Code § 11135 et seq.
[7] 42 U.S.C. § 12131 et seq.
[8] 42 U.S.C. § 12181 et seq.

sites every three years and as a new provider enters the network. This mandatory FSR became the framework for a partnership between disability advocates and a few plans, who together developed and piloted a "Physical Accessibility Review Survey" (PARS), a questionnaire that determined key aspects of a site's physical and equipment accessibility. A number of health plans voluntarily administered PARS and also agreed to publish the results in their provider directories using a three-tier categorization of a PCP site's accessibility. In 2011, DHCS took the key step of adopting and mandating MCO use of PARS, which by now had grown to 86 questions, as a component of its own FSR.[9] In 2012-13, the mandatory use of PARS was expanded to specialist providers who served a "high volume" of people with disabilities, as well as to ancillary service providers and Community Based Adult Services (CBAS) providers. Most recently, advocates and plans worked to adopt the PARS tool for effective use with non-physician entities such as ancillary and community based providers, as well as other key service providers such as hospitals. By now, administration of the PARS was conducted by individuals who underwent a stadardized multi-hour training on how to use the PARS tools.

If DHCS required MCOs to submit the PARS data in a uniform and searchable data format, it could establish current levels of physical and equipment inaccessibility. The statistical research that we have available stems from older PARS reviews conducted from 2006-10 of over 2400 PCP facilities in 5 MCOs. It found that only 8.4% of the sites surveyed had height-adjustable exam tables, and 3.6% had accessible weight scales.[10] These highly limited numbers unambiguously indicate a need for standards that will help MCOs to incentivize and build disability accessibility into their provider networks. While standards for medical equipment accessibility can involve technical considerations, a great deal of the actual work of standard setting has already been done by the Architectural and Transportation Barriers Compliance Board under the mandate of Section 510 of the Rehabilitation Act. The Board released the *Standards for Accessible Medical Diagnostic Equipment* in January 2017 as a rule, published in Part 1195 of title 36 of the Federal Code of Regulations. There is now an answer to the question "how do we know when a piece of medical equipment is accessible?"

With stakeholder input and review, the department would be able to develop standards that look at how physical and equipment accessibility intersect with applicable time and distance standards, as well as other considerations that MCOs must consider under the Final Rule. The standards could be structured so as to require increasing accessibility over time as older inaccessible medical equipment is replaced with accessible equipment and MCOs find innovative ways to help network providers deliver healthcare in physically accessible settings. An ongoing stakeholder workgroup could also work on developing ways to determine the availability of reasonable accommodations and

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[9] For more detail on the PARS, *see* DHCS Medi-Cal Managed Care All-Plan Policy Letter 12-006, available at: http://www.dhcs.ca.gov/formsandpubs/documents/mmcdaplsandpolicyletters/pl2012/pl%2012-006.pdf. For more detail on the entire FSR tool and process, see DHCS Policy Letter 14-004, available at:: http://www.dhcs.ca.gov/formsandpubs/pages/policyletters.aspx .

[10] N.R. Mudrick, M.L. Breslin, M. Liang, and S. Yee, *Physical Accessibility in Primary Health Care Settings*, Disability and Health Journal 5 (2012) 159-167.

effective communication within provider networks, and consider the standards that should apply to the availability of reasonable accommodations.

DHCS has the capacity to provide ground-breaking leadership on incorporating disability accessibility requirements within network provider standards. At the very least, the department would be able to achieve compliance with the Final Rule if it takes the opportunity to work with disability advocates and other key stakeholders to genuinely address the accessibility considerations mandated under the federal rule. DREDF strongly recommends that DHCS convene a workgroup to garner stakeholder input and establish clear standards for accessibility as a component of network adequacy, find effective and efficient ways *in addition* to plan sell-reporting to monitor for compliance with those standards, **and** develop ways to enforce compliance with those standards so as to achieve growing levels of accessibility over time.

As a final point, we would like to clarify that the reference at p. 24 of the proposal to the state's obligation to provide the network adequacy standards in alternative formats to people with disabilities extend to the provision of a fully accessible website that complies with WCAG 2.0 standards. That is, applicants and beneficiaries with disabilities should be able to read the standards on the DHCS website as readily as those without disabilities.

LTSS Standards

LTSS services are foundational to the capacity of many people with disabilities to live and function as independently as possible in their communities. We supported the Federal Rule's recognition that states needed to provide network adequacy standards that included LTSS providers as a component of MCO networks. We disagree with the statement at p. 20 of the Proposal that network adequacy standards "must only be required if the beneficiary is traveling to the provider to receive services."

While the Final Rule indicates that time and distance standards are only required for LTSS provider types in which the enrollee travels to the provider to receive services, *the state is still responsible for developing network adequacy standards other than time and distance for LTSS provider types that travel to the enrollee to deliver services.*[11] We recognize that California has led the way among states by incorporating legislative time and distance requirements for network adequacy many years ago. It will be challenging to develop, test, implement and monitor network adequacy standards that are not necessarily tied to time, and distance requirements, but that is exactly what the Federal Rule requires of states. We are confident that with a supported process for soliciting and incorporating thoughtful input, assistance, and innovative ideas from advocates and stakeholders, DHCS will be able to develop effective standards for critical LTSS providers that travel to the beneficiary such as MSSP providers.

In-Home Supportive Services (IHSS) providers are an example of a critical service provider that travels to a beneficiary's home, and could also benefit from having network

[11] § 438.68(b)(2)(i) and (ii).

or county adequacy standards applied in addition to timely access. Even though IHSS is no longer a managed care benefit, MCOs still bear some measure of responsibility for appropriately referring members who have unmet LTSS needs to IHSS authorities, and DHCS continues to bear ultimate responsibility for methods to promote access and delivery of covered services to persons with disabilities under the Final Rule.[12] The degree to which available IHSS service hours meet or exceed average per member service hours in a given catchment area, or a standard that addresses the need for emergency replacement IHSS services in the event of a provider's unexpected unavailability, are ideas for relevant standards in this important area.

We also disagree with the assertion at p. 21 of the Proposal that timely access requirements and network adequacy standards are not relevant where LTSS services such as MSSP are limited by waiver slots or service requirements. The fact that waiver requirements or applicable special terms and conditions may limit service capacity from falling below a statewide aggregate does not at all ensure the actual availability of that service for any given member who needs that service. Plan level network adequacy standards are about ensuring that any given plan, within the counties that it serves, has sufficient capacity to meet the care needs of its members. Even if the state maintains statewide CBAS levels at April 2012 levels, it must *also* establish standards that will allow beneficiaries in a rural Northern California county, for example, to have actual access to in-network CBAS services without having to travel great distances over great time periods.

And finally, DREDF strongly disagrees with the Proposal's statement at p. 20 that time and distance standards need not be established for Skilled Nursing Facilities (SNFs) or Intermediate Care Facilities (ICFs) where the beneficiary resides at the provider. Very few, if any SNF or ICF residents have lived their entire lives within a given SNF or ICF. Residents usually come from a community context when they reach a point that requires potentially moving to a SNF or ICF. The maintenance of existing ties with family members, friends, and community-based organizations and activities such as churches or a local choir is critical to any given individual's social, mental and physical health. Any assessment of a given MCO's LTSS network adequacy must begin with the assumption that SNF and ICF placement should preserve such ties to the greatest degree possible, not the assumption that time and distance standards are irrelevant because the beneficiary receives everything she or he needs within his residence. Moreover, we believe that the proposal should also consider adopting requirements on the degree to which a MCO's SNF and ICF network incorporates residences that meet the federal rule on the Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, published January 16, 2014 at 79 Federal Register 2947.

<u>Monitoring, Enforcement and Implementation</u>

[12] § 440.262.

In the Executive Summary of the Proposal, DHCS states that it "will be responsible for monitoring compliance with the standards as proposed in this document." While we certainly agree with that statement, DREDF would like to remind the department that the Final Rule also requires the state to "develop and **enforce** network adequacy standards."[13] The general rule in §438.68 unequivocally indicates any "State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and **enforce** network adequacy standards consistent with this section."[14]

The Proposal's only reference to enforcement occurs at p. 25 in a section titled "Medi-Cal Managed Care Health Plan Monitoring" where the department rightly claims that network adequacy standards will only be meaningful if it plans to "hold plans to the standards and enforce corrective action plan action if they fail to meet them." Unfortunately the Proposal provides very few details about how enforcement will be pragmatically achieved.

Monitoring is only half the story, and in the area of monitoring, the Proposal illustrates that DHCS relies heavily on plan self-reporting. The deficiencies of self-reporting, even where an objective third party vendor is hired to collect and prepare plan data, were highlighted recently in California when the Department of Managed Health Care (DMHC) audited annual reports for plan compliance with timely-access standards. We understand that DHCS works closely with DMHC to regulate MCOs that are licensed under the state's Knox-Keene Act. The audits revealed very substantial errors of up to 45% between self-reported plan data concerning the numbers of providers in a MCO's network and actual year-end tallies of network providers.[15] Obviously, if outdated and inaccurate provider counts are used as the basis of network adequacy assessments, the assessment itself will be skewed.

In the case of disability accessibility and access to LTSS, DREDF is not aware of any mandated MCO reporting to DHCS except for FSR and PARS information. The PARS information itself should be relatively accurate, given that the survey is administered by surveyors who are consistently trained by a relatively small cadre of master trainers. Unfortunately, the state does not appear to collect the PARS information or monitor it in any meaningful fashion. MCOs are inconsistent in their reporting of accessibility information in their provider directories and the information is not kept current. Even if the PARS reports themselves are accurate, and were maintained in a DHCS database that allowed for comparison and measurement of increased or decreased accessibility according to a pre-determined formula of some sort, using the PARS to determine overall accessibility would still be problematic if a MCO's provider lists are inaccurate For example, if 50% or even 10% of a MCO's providers who have accessible equipment leave the network in a given year, this would deeply impact the accessibility of the MCO's provider network given the small numbers of providers who have accessible equipment in the first place. If this decrease is not known or is inaccurately reported in a given year or from year to year, then the MCO and DHCS obviously cannot "ensure

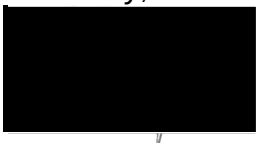
[13] §438.3.
[14] §438.68(a).
[15] *See* C. Terhune, "California Regulator Slams Insurers Over Faulty Doctor Lists," *California Healthline* (February 10, 2017), available at: http://californiahealthline.org/news/california-regulator-slams-health-insurers-over-faulty-doctor-lists/

that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities." Beneficiaries and prospective plan members with disabilities also will be unable to ascertain whether a given MCO will be able meet their accommodation and accessibility needs.

Even if DHCS were to receive and monitor accurate information, enforcement issues remain unanswered in the proposal. Will physical inaccessibility, lack of reasonable accommodation, or a dearth of accessible equipment within an MCO's provider network lead to a corrective action plan? When will accessibility and LTSS network problems trigger technical assistance or corrective actions from DHCS? How will DHCS track progress on corrective actions or check the progress that an MCO claims? In essence, the monitoring and enforcement issues are particularly acute because **accessibility has never been historically incorporated as an aspect of network adequacy**, and because MCOs' LTSS network have not been historically assessed on a practical working basis for network adequacy. DHCS therefore needs to pay **more** attention to these two areas of MCO network adequacy in the Proposal and not less. At the very least, DREDF calls upon DHCS to make a clear commitment to addressing these open questions through defined and open stakeholder and workgroup processes over a defined timeline.

Thank you again for the opportunity to comment on the Proposal. If you have any questions or concerns concerning the above, please contact me via email at syee@dredf.org or phone at 510-644-2555.

Sincerely,



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