



**Comments to the Centers for Medicare & Medicaid Services
Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed
Care
Notice of Proposed Rulemaking
(CMS 2408-P)
Submitted by Community Catalyst
January 14, 2019**

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed changes released November 14, 2018 to the Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Final Rule, published in May 2016. Community Catalyst is a national, non-profit health care advocacy organization dedicated to quality, affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, along with policymakers and foundations, providing leadership and support to change the health care system so it serves everyone.

We have been working to improve Medicaid managed care for consumers for more than a decade, producing tools for consumer health advocates to use in state-based advocacy as well as tools for use by other stakeholders. These tools include "[Strengthening Long-Term Services and Supports](#)"¹ and "[Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities](#)."² We also conceptualized and produced key data, including sanctions against managed care organizations (MCOs), for the Kaiser Family Foundation’s [Medicaid Managed Care Market Tracker](#).³

We appreciate the opportunity to provide comments on the proposed changes. Our overall concern is that some of these proposals, in their attempt to provide states and MCOs with more flexibility or less administrative burden, reduce or remove certain important consumer protections, including transparency, access and quality standards established in the 2016 final rule. We therefore write to express our opposition to these changes and make recommendations for amending them prior to the publication of the final rule.

¹ Community Catalyst; *Strengthening Long-Term Services and Supports*, <http://www.communitycatalyst.org/resources/tools/mmltss>

² Community Catalyst; *Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities*, <https://www.healthinnovation.org/resources/toolkits/meaningful-consumer-engagement>

³ Kaiser Family Foundation; *Medicaid Managed Care Market Tracker*, <http://kff.org/data-collection/medicaid-managed-care-market-tracker/>

I. Medicaid Managed Care

2. Actuarial Soundness Standards – §438.4

b. Capitation Rate Development Practices that Increase Federal Costs and Vary with the Rate of Federal Financial Participation (FFP) – §438.4(b)(1)

We oppose the proposal to prohibit any differences in capitation rates that vary with the rate of Federal financial participation (FFP) associated with covered populations in a manner that increases federal costs. Overall, we support the policy that capitation rates must be developed in accordance with generally accepted actuarial principles and based on valid rate development standards representing the actual cost differences in providing covered services to covered populations. However, there may be instances in which a capitation rate related to the FFP associated with a covered population is based on actuarially sound standards and valid rate development standards, but, as a result, also increases federal costs. Therefore, we believe CMS must be sure to safeguard variations that coincidentally correlate to higher FFP when there is a higher needs population with an actual cost difference. Otherwise, CMS risks punishing plans that take on more complex enrollees, and potentially encouraging cherry-picking of lower-needs populations. Overall, we think it is unreasonable for CMS to propose a blanket prohibition on any capitation rate that increases federal costs and urge CMS to only require capitation rates to be developed in accordance with actuarial principles and valid rate development standards representing actual cost differences in providing services to covered populations.

4. Special Contract Provisions Related to Payment –

c. Pass-Through Payments Under Managed Care Contracts - § 438.6(d)

Overall, we support the addition of a three-year transition period for states to make pass-through payments to safety-net providers as a way to protect these providers from losing funding when states are transitioning away from fee-for-service (FFS) supplemental payments. We support the overall goal of phasing out pass-through payments over the long-term, though, because we agree with CMS that pass-through payments are not consistent with federal standards for actuarially sound rates since they do not tie provider payments with the provision of services. We also believe this funding would be better spent increasing provider rates rather than used as quasi-supplemental payments that can be distributed in ways that lack transparency. However, we recognize that in the short-term, CMS must ensure that safety-net providers do not lose funding during transitions to managed care, and therefore support the three-year transition period.

d. Payments to Managed Care Plans for Enrollees that are Patients in an Institution of Mental Disease - §438.6(e)

Overall, we support allowing FFP for capitation payments for IMD stays longer than 15 days, but do not support lifting the IMD exclusion in all cases. CMS reiterates in this proposed rule that states can receive FFP for capitation payments for longer stays by applying for a Medicaid Section 1115 waiver that lifts the IMD exclusion, and therefore declines to amend the 2016 final rule restricting reimbursement to stays no longer than 15 days. We support lifting the IMD exclusion for the purpose of expanding access to care for consumers with substance use disorders. The IMD exclusion can create a barrier to consumers with substance use disorders

receiving needed treatment because it contributes to a shortage of allowable inpatient and residential treatment facilities in which they may receive care. The exclusion also runs contrary to the stated aim of federal parity laws, which are intended to ensure that behavioral health conditions are treated equally to other types of health conditions in health plans.

We strongly urge the Administration to approve only state 1115 waivers that propose limited, well-defined IMD services for residential and inpatient substance use disorder treatment across the continuum of care in conjunction with well-defined outcome measures. We oppose broad waivers of IMD – including waivers that lift the exclusion for consumers with mental health conditions – which could create a financial incentive for treatment providers to keep consumers in residential care even when community-based care is the more appropriate choice for the consumer.

8. Information Requirements - §438.10

a. Language and Format - § 438.10(d)

We strongly oppose the proposed rollbacks to access standards for individuals with visual impairments and limited English proficiency. CMS proposes to amend the requirement that “all written materials” include taglines in the prevalent non-English languages in a state, and instead only require materials that are “critical to obtaining services” to include taglines, including those that explain the availability of written translation or oral interpretation, how to request auxiliary aids and services for individuals who have limited English proficiency or a disability, and the toll-free phone number of the entity providing choice counseling services. CMS also fails to specify who decides whether and what information is “critical to obtaining services.” We therefore strongly oppose this change as it will likely limit the ability of individuals with limited English proficiency to access and understand their health information.

CMS also proposes to change the requirement that taglines be printed in 18-point font, noting that “since the publication of the final rule, states and plans have found that requiring taglines in 18-point font size sometimes increases overall document length, thereby decreasing the ease of use by enrollees and eliminating the use of certain effective formats such as postcards and trifold brochures.” We disagree with CMS that removing the print document guidelines from the American Printing House for the Blind – that documents be printed in no-smaller than 18-point font - would make documents easier to read for enrollees with visual impairments. We strongly oppose CMS’ proposal to replace the “no smaller than 18-point” standard with the standard of “conspicuously visible.” Both the “conspicuously visible” and “critical to obtaining services” standards are much lower and more vague than the current standards. Furthermore, they run the risk of impairing the ability of individuals with visual impairments and limited English proficiency to access the information they need to obtain necessary services. Additionally, this proposal opens the door to adverse selection whereby plans discourage enrollment by persons with significant health needs. Overall, we feel that limiting information access for enrollees and potential enrollees will have harmful consequences and therefore urge CMS to keep the current standards in place.

b. Information to All Managed Care Enrollees – General Requirements § 438.10(f)

We strongly oppose CMS’ proposal to reduce the amount of time that plans must inform enrollees that a provider is leaving their network. CMS proposes to change the length of time from within 15 days of when the provider submits notice of termination to within 30 days of the provider actually leaving the network. CMS justifies this change by explaining that sometimes, providers and plans resolve the issue that gave rise to the provider’s decision to leave the network, which requires the plan to then have to rescind the notice. The dissemination and rescinding of the notices “can cause alarm and confusion for enrollees who believe that they need to locate a new provider,” and therefore CMS proposes that notifying enrollees within 30 days of when the provider is actually leaving the network is more fair. However, based on the example CMS provides in the proposed regulation, enrollees will inevitably have less time to find a new provider if their provider is indeed leaving their network. The issue of needing to find a new provider is substantially more important to, and has a substantially greater impact on, enrollees than the issue of receiving a notice that proves to be unnecessary. In addition, shortening the notice window to consumers may increase the risk to their health, especially if the services are essential to their lives – for example, treatment for a substance use disorder or personal attendant services to help someone with a physical disability get out of bed or eat. Therefore, we urge CMS to keep the current policy in place. To address potential enrollee confusion over rescinded notices, we suggest that CMS require states and/or plans to maintain a hotline that enrollees can call to ask questions about and better understand the rescinded notices.

d. Provider Directories - § 438.10(h)

We strongly oppose the proposal to remove the requirement that provider directories indicate whether a provider has completed cultural competency training. While we support the proposal for provider directories to include providers’ cultural and linguistic capabilities, including the languages spoken by the provider or skilled medical interpreter providing interpretation services at the provider’s office, we believe it is also important for enrollees to be informed of whether their provider has completed cultural competency training due to the cultural and linguistic diversity of Medicaid enrollees. We therefore recommend that CMS require managed care plans to include both whether providers have completed cultural competency training along with the specific cultural and linguistic capabilities of providers in their directories.

We also strongly oppose CMS’ proposal to waive the requirement that managed care plans update the paper version of their provider directories on a monthly basis if they make a mobile-enabled, electronic version of their directory available. CMS justifies this proposal by noting that “states and managed care plans have raised concerns about the cost of reprinting the entire directory monthly,” as well as the fact that “64 percent of U.S. adults living in households with incomes less than \$30,000 a year owned smartphones in 2016.” Therefore, “providing mobile-enabled access to online provider directories may provide additional value to enrollees by allowing them to access the information anytime, anywhere which is not feasible with a paper directory.” This explanation blatantly ignores the rights of the remaining 36 percent of low-income households that do not own a smartphone to be able to access critical information about the providers in their network. We strongly believe that waiving the monthly update requirements for paper directories if plans offer a mobile-enabled, electronic version will not provide all Medicaid enrollees with sufficient access to provider directory information and therefore urge CMS not to change the current requirements.

Overall, the burden or adverse impacts on consumers is a more important issue to consider and address than any burden that states or managed care plans might experience when trying to meet the language and format requirements, notice regarding provider termination requirements and provider directory requirements. Since all of the proposed changes to these requirements have the potential to adversely affect enrollees, we urge CMS to keep the current policies in place.

10. Network Adequacy - §438.68(b)(1)

We strongly oppose the elimination of time and distance standards for network adequacy as well as the proposal to make time/distance standards optional for specialists. We recommend that CMS continue to keep these standards in place as well as include standards for appointment wait times. In the 2016 final rule, CMS required that states impose time and distance standards on managed care plan networks but allowed states the flexibility to set their own exact standards. With this proposed rule, CMS provides even greater flexibility by allowing states to set alternative “quantitative minimum access standards,” including but not limited to minimum provider-patient ratios, maximum travel time or distance standards, a minimum percentage of contracted providers that are accepting new patients, maximum wait times for an appointment and hours of operation requirements, as well as a combination of any of these.

We urge CMS to set national network adequacy standards for Medicaid managed care, in the way they exist for Medicare Advantage, so that no state is able to set a standard that is more beneficial to plans and providers than it is to consumers. Additionally, setting a national minimum standard for network adequacy in Medicaid managed care will provide consistency and continuity for enrollees, and will ensure that enrollees in all states are held to the same basic standards of access. Medicaid enrollees, by virtue of having low incomes and resources, are more likely to face transportation and access challenges than those who are privately insured, which necessitates a robust network adequacy standard, particularly for rural areas.

In our comments to the 2015 proposed rule, we recommended that CMS impose national quantitative access standards that follow from the time/distance standards many states already have in place.⁴ We offered specific time and distance standards that would guarantee access to covered benefits and services and be reasonable for plans and providers to meet. We reiterate our previously recommended standards below:

- Services that provide primary care (adults and pediatrics), mental health and substance use disorders treatment (adult and pediatric), pediatric dental, women’s health care, hospitals and pharmacies – 30 minutes or 15 miles
- Specialty services (adults and pediatrics) as defined in § 438.14(a) – 60 minutes or 30 miles

If a managed care plan is unable to meet these standards, we recommend that CMS require plans to arrange alternative options for enrollees to receive care in a timely manner. These options should not result in additional out-of-pocket costs to enrollees. These options might include:

- Arranging for enrollees to see out-of-network providers;

⁴ Department of Health and Human Services Office of the Inspector General, *State Standards For Access To Care In Medicaid Managed Care*, September 2014, <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>

- Arranging for a provider to travel to the enrollee or a designated location that is within the state's standard for travel time and distance.

We also believe that time and distance standards alone are insufficient to guarantee timely access to care. We recommend that CMS require states to account for foreseeable road closures due to weather conditions in certain regions. In addition, we strongly urge CMS to set additional standards in § 438.68(c)(1) regarding wait times, such as:

- Primary care and specialty care, including routine pediatric dental care – 15 business days
- Urgent care for medical and dental services – within 48 hours
- Urgent care for mental illness and substance use disorders – 24 hours
- Non-urgent mental and behavioral health services – 10 business days
- Accessing providers by phone – 24 hours a day and seven days a week
- Immediate access to life-threatening emergency care, including care for substance use and mental health emergencies, and emergency access to child-specific emergency services and specialists
- Separate behavioral health standards for children. Given that wait times to see behavioral health providers can be high for both adults and children and that the behavioral health needs of children are, in some ways, distinct from those of adults, it would be prudent to establish a standard that distinguishes between adult and pediatric behavioral health providers, to ensure children's access is not compromised

We feel strongly that time/access standards, coupled together with wait-time standards where appropriate, are overall better measures of whether enrollees can meaningfully access a health care provider than some of the alternative standards CMS mentions above. For example, minimum provider-patient ratios and a minimum percentage of providers who are accepting new patients alone won't be helpful standards for enrollees if there are simply no providers in their area. However, we also understand the need for state flexibility regarding time and distance, as states and regions vary widely with respect to population density, geography and numbers of providers. Therefore, we recommend that if a state wants to use a different quantitative minimum access standard, that it be required to apply to CMS for an exemption. In its exemption request application, the state should be required to comprehensively explain why the current time/distance standard is an insufficient measure of network adequacy, along with what standard it feels would be a better measure and why. We also agree with CMS that states should solicit stakeholder input when determining its alternative quantitative minimum access standard, and therefore recommend that CMS require states to solicit that input from stakeholders, including consumers and consumer advocates, and to disclose and explain this stakeholder input process in its exemption request. Lastly, we recommend CMS require states to explain and confirm in its exemption request that the alternative minimum access standard would benefit consumers more than it would reduce administrative burdens to plans and providers.

For LTSS services provided in the home and in the community (HCBS), we urge CMS to require states to solicit stakeholder input in devising required network adequacy standards, and ensure those standards support consumer choice of providers and community living. We recommend CMS define a separate menu of network adequacy standards for HCBS that states can choose from, and reference the need for different standards for agency employees versus independent personal care workers. For HCBS agencies, time and distance standards should be part of the menu, as should an access standard similar to that already adopted by many states – access to at least two providers of each type of HCBS per region.

However, for in-home services, especially those provided by individual workers, we urge CMS to recognize that additional standards are needed, because time, distance and access standards may not adequately match the number of providers to the demand. We urge CMS to recommend use of service gap standards. These measure the time between authorization of services and service delivery, as well as the gap over a year between authorized services and services received. In addition, for individual workers, we urge CMS to recommend use of ratios of direct care providers to service hours needed in a particular service area.⁵

13. Medicaid Managed Care Quality Rating System - § 438.334

We support the proposals to align the Medicaid managed care quality rating system (QRS) with the qualified health plan (QHP) QRS only where appropriate because we agree that the populations enrolled in QHPs vs. Medicaid are substantially different, and therefore may require different quality rating systems. We also support CMS’ decision to explicitly engage with states and other stakeholders in developing subregulatory guidance on an alternative QRS as well as the agency’s intent to identify a set of mandatory performance measures after allowing for a public notice and comment process. We strongly agree that identifying a uniform set of mandatory measures is key to high-quality Medicaid and CHIP programs in all states.

However, we oppose the proposal to change the requirement that a state-based alternative be “substantially comparable” to the federally developed Medicaid quality rating system by adding the clause “to the extent feasible.” We are concerned this change will allow states to implement insufficient, incomplete rating systems under the guise that doing more would not be feasible. CMS proposes to temper this significant rollback by proposing a limited set of mandatory measures that would apply across states and be modeled after the measures selected for its Scorecard initiative. We oppose using the Scorecard initiative as a model for several reasons. First, the Scorecard only consists of voluntary state-reported data on 16 performance measures that leaves huge measurement gaps relevant to key Medicaid populations, including people with disabilities.⁶ Further, it has no actual measures for LTSS, only a single measure related to pregnancy and postpartum care, and a measure that is at best only tangentially related to care affordability. Therefore, using the Scorecard would not provide the QRS with an adequate base to measure the quality of managed care systems that cover adults, children with disabilities, pregnant women and aging populations. We recommend instead that CMS create a more uniform

⁵ Ari Ne’eman; *Managed Long-Term Services and Supports: Assessing Provider Network Adequacy*, Community Living Policy Center, University of California San Francisco. December 2018, <https://clpc.ucsf.edu/publications/managed-long-term-services-and-supports-assessing-provider-network-adequacy>

⁶ Centers for Medicare & Medicaid Services, *State Health System Performance*, Medicaid.gov, <https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/index.html>

quality accountability system by designing a robust federal QRS that provides a broad, shared base upon which individual states can expand as needed.

We also oppose the proposed changes in this section related to the alignment of the Medicare Advantage 5-Star quality ratings system where appropriate. We believe that using the Medicare Advantage 5-Star quality rating system should be disallowed for plans serving only dually-eligible consumers because this system does not include any information about LTSS performance. We are concerned that using the 5-Star QRS will not capture plan performance on LTSS and therefore recommend that CMS prohibit use of this QRS for plans serving dually-eligible consumers. Instead, we recommend that the Medicaid managed care QRS include independent and adequate LTSS measures, such as requiring that it address at least the domains listed in § 438.330(c)(1)(ii) on quality of life, rebalancing, and community integration.

Lastly, we oppose removing the requirement that states obtain prior approval from CMS before using an alternative quality rating system. We are concerned that waiving the prior approval requirement would allow a state to implement a problematic or inadequate alternative QRS. CMS states that it intends to waive the prior approval requirement to “reduce the upfront administrative burden on states and speed time for implementation.” The agency also states that it will still review a state’s alternative QRS and “work with states to identify any deficiencies.” We don’t think that allowing a state to implement a deficient alternative QRS while CMS and the state work on addressing the deficiencies is beneficial or worthwhile, and therefore urge CMS to continue to require prior approval for alternative QRS’s to ensure they meet federal standards before being implemented.

14. Managed Care Quality Strategy - § 438.340

We support the technical correction CMS proposes to add PCCMs to the list of entities subject to the expanded quality strategy requirements added in the 2016 final rule so that these requirements can apply to all types of managed care entities. We further support the proposed change to allow for states, when developing strategies to reduce disparities based on demographic factors including age, sex, race, ethnicity, primary language and “disability status,” to examine and review different sources of information other than whether an individual qualifies for Medicaid on the basis of a disability, to determine whether an individual has a disability. We agree with CMS that this definition of “disability status” is too narrow, since many individuals may not be eligible for Medicaid on the basis of a disability, but may be considered an individual with a disability under other federal laws such as the Americans with Disabilities Act. We further support the encouragement to states to send updated demographic information to an enrollee’s managed care plan whenever it is made available to the state. We want to note, however, that encouraging state flexibility in defining “disability” may make it harder to evaluate disparities across states. Therefore, we recommend that states be required to publicly disclose in their quality strategy how they define disability in this context and what additional sources of information they used when selecting a definition.

16. Exemption from External Quality Review - § 438.362

We support the proposed requirement that states annually identify on their website the names of the managed care plans they have exempted from their external quality review process, and when the current exemption period began. The 2016 final rule only encouraged, rather than

required, states to make these data available. We believe making these data available would be beneficial and useful to both potential and current managed care enrollees, providers and stakeholders alike. We further agree with CMS that posting this information on the state's website, in the same location where EQR technical reports are made available, would not present a burden to states since states are already required to make this exemption determination, inform their external quality review organization of which plans are exempted from EQR and maintain EQR information on their website. We further support adding this information to the EQR technical report in addition to posting the information on their website. Overall, the benefits of making this information public substantially outweigh any potential negative consequences or administrative burden, and therefore we recommend this change be finalized as proposed.

18. Grievances and Appeals – Statutory Basis and Definition - § 438.400

We oppose the proposed change to no longer send notices to enrollees when claims for payments of services are denied because they do not meet the definition of a “clean claim.”

We believe these types of denials should continue to be treated as adverse benefit determinations that trigger notice requirements. CMS states that it believes this proposed modification would eliminate burdens on plans to send “unnecessary” notices as well as “avoid anxiety for enrollees receiving such notices.” We believe it is important to err on the side of providing more transparency and information to enrollees so they can be as fully engaged in their care as possible. Therefore, we recommend that CMS continue to send notices for these types of denials, but provide a process for enrollees to opt out of receiving the notices if they so choose. We further recommend that CMS require managed care plans to provide a hotline and personnel for enrollees who wish to gain a better understanding of these types of notices, so they can ask questions and be able to make an informed decision about whether they wish to continue receiving these types of notices.

19. Grievance and Appeal System – General Requirements - § 438.402 and § 438.406

We oppose the proposed change to no longer require oral requests for a fair hearing to be followed up with a written request. While we understand how CMS could view this change as making the appeal process easier for both enrollees and plans, we are concerned that no longer requiring a written request will harm enrollees by removing any evidence of an appeal request. We believe this type of change may inadvertently cause states to no longer be able to hold plans accountable for the overall grievance and appeal system, including following up on appeal requests in a timely manner, processing requests and initiating the appeals process. We also believe requiring a written request may make it easier for certain populations to file an appeal, such as individuals with disabilities, individuals who are incapacitated, individuals with limited English proficiency and individuals with health aids, health care proxies, powers of attorney and translators, because they would be able to request an appeal in a manner and at a time that is most convenient for them. Therefore, we urge CMS to keep the current policy in place.

20. Resolution and Notification: Grievances and Appeals – § 438.408

We oppose the proposed change to allow states to reduce the timeframe in which individuals can request a fair hearing from 120 days to no less than 90 days. CMS justifies this proposed amendment by noting that the Medicaid FFS delivery system only allows for a 90-day window to request a hearing, and so it seeks to reduce the timeframe for requests within managed care to better align the two delivery systems. CMS believes this change would “allow states that wish to

align managed care with the FFS filing timeframe to do so while not jeopardizing the enrollee's ability to gather information and prepare for a state hearing." We believe providing enrollees with as much time as possible to prepare for a hearing is substantially more important than providing states with the ability to align their managed care and FFS delivery system filing timeframes, and therefore recommend that the current 120-day timeframe remain in place.

II. Children's Health Insurance Program (CHIP) Managed Care – §457

Overall, we support the clarifications and technical corrections to the following sections: compliance dates for part 457, information requirements at §457.1207, structure and operations standards at §457.1233, quality measurement and improvement at §457.1240, sanctions at §457.1270, and program integrity safeguards at §457.1285. Specifically, we support the clarification to require submission of enrollee encounter data to CMS at §457.1233(d) and the application of the requirements to collect and submit quality performance measurement data to PCCM entities at §457.1240(b). Finally, we support the proposed changes to the CHIP grievance system in so far as they clarify the application of subpart F of part 438 to CHIP at §457.1260.

However, we disagree with CMS' policy to exclude the rules in Medicaid managed care regarding continuation of benefits while an appeal is pending and payment for such services (§§438.420 and 438.424(b), respectively) from being applied to CHIP. These exclusions permit states to allow managed care entities to terminate services for CHIP enrollees pending an appeal. Applying the prohibition on termination of services would ensure children have access to needed services during the appeals process. Additionally, we want to note that the language at §457.1260(e)(4) implies that these policies *do* apply to CHIP. Specifically, at §457.1260(e)(4)(ii), the proposed rule requires that the content of the notice of appeal resolution include notice of the right to request and receive benefits while the review is pending and how to make the request. We continue to believe that CHIP enrollees should have the right to receive benefits pending an appeal. But at the very least, CMS should clarify the regulatory text and only require inclusion of applicable CHIP enrollee rights in the notice.

Thank you for your consideration.

Respectfully submitted,

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