Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

January 14, 2019

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2408-P
Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Sir or Madam:

Thank you for the opportunity to comment on proposed rule CMS-2408-P, "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care."

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act.

Summary

Medicaid is the health insurer for 37 million children—some 40% of our Nation's children, who account for half of all Medicaid beneficiaries.[1] As a health insurer, Medicaid's job is to make sure that children enrolled in the program have access to the early and periodic screening, diagnostic, and treatment (EPSDT) services they need. [2] Over two-thirds of the children enrolled in Medicaid are enrolled in managed care organizations (MCOs).[3] State Medicaid agencies have contracted with these MCOs to organize provider networks to furnish covered services to their enrollees. If these networks are inadequate—if providers qualified to deliver the services children need do not participate in the network or are located too far from the

enrollees—then access to covered services by children and families will be compromised.

In May of 2016, after a 7-month rulemaking process, your agency issued a final managed care rule that modernized the Medicaid and CHIP managed care regulations, 81 FR 27498 (May 6, 2016). As noted you acknowledge in the preamble to this proposed rule, the 2016 final rule "strengthened efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries," 83 FR 57265 (November 14, 2018). One of the key reform provisions was the requirement for network adequacy standards at 42 CFR §438.68. As part of a phased-in implementation strategy, this requirement took effect for rating periods for contracts beginning on or after July 1, 2018.[4]

In this proposed rule, issued less than 6 months after that implementation date, your agency is proposing to unwind these reforms by eviscerating the network adequacy standards. We strongly object, for the reasons set forth below.

We have additional comments on other provisions, some of which we support because they will promote better transparency. With respect to Medicaid managed care, we also address proposed revisions relating to enrollee encounter data (§438.242(c)); quality rating system (QRS) (§438.334); State quality strategy (§438.340); external quality review (EQR)(§438.362); and grievance and appeal system (§438.402 and §438.406). We also comment on proposed revisions relating to CHIP managed care.

Our comments include citations to supporting research, including links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

Medicaid Managed Care

Network adequacy standards (§438.68)

Network adequacy is foundational to a Medicaid MCO's ability to ensure access to covered services by its enrollees, especially children and families. We believe that the current rules, which require state Medicaid agencies to develop and enforce, at a minimum, time and distance standards for at least 7 provider types, fall short by not

specifying a federal minimum or floor. We reiterate now our comments on the 2015 proposed rule in which we urged CMS to establish minimum, multi-faceted, quantitative standards for network adequacy, such as appointment wait times, provider-patient ratios for adult and pediatric primary and specialty care, along with the time and distance standards already required.[5] The proposed rule would further dilute this already inadequate network adequacy standard.

Specifically, the proposed change would strike the current minimum requirement for time and distance standards for at least 7 provider types and simply require states to develop and enforce a "quantitative network adequacy standard" for each of the 7 provider types. In addition, the proposal would allow states to pick and choose which types of specialists (adult and pediatric) would be subject to a "quantitative network adequacy standard" of any kind. We strongly object.

MCOs generally will not pay for services received by enrollees from providers who are not part of the MCO's provider network. Thus, in order for enrollees to have access to needed services, MCOs must have participating in their networks enough providers who accept their enrollees as patients and whose practice locations are within a reasonable travel time from the enrollees. Time and distance standards are the basic measure of whether enrollees have this access. They are not a perfect measure—such a measure has not yet been identified—but as your agency recognized in the preamble to the 2016 final rule, when adjusted for provider type and for geographic area, they are the minimum test for access:

"We thank commenters for their support of proposed §438.68(b)(1). We decline to add additional network adequacy standards in addition to time and distance. We believe that the regulation strikes the appropriate balance among the goals of avoiding overly prescriptive federal requirements, ensuring standards that ensure access to care, and permitting state flexibility. States will have the authority to add additional network adequacy standards, such as provider to enrollee ratios, and timely access standards such as appointment and office wait times. This proposed provision will still allow states to establish those network adequacy standards in their managed care contracts. *It is for these same reasons that we decline to remove time and distance standards as a requirement in §438.68(b)(1), or allow states to only adopt a 'reasonable access' standard similar to the state and federal Marketplaces. While we understand the need for states to have adequate flexibility, we also believe that the flexibility must be subject to some national requirements; requiring that states establish and use time and distance standards is a minimal way for us to ensure access to care for Medicaid managed care beneficiaries."* 81 FR 27661 (emphasis added).

As noted above, the current time and distance standards only became effective—at the earliest—less than 6 months prior to publication of this proposed rule. The preamble to the proposal presents absolutely no data on operational experience with the current requirement, or for that matter any other empirical data, that would support a reversal of your agency's view that "requiring that states establish and use time and distance standards is a minimal way for us to ensure access to care for Medicaid managed care beneficiaries." You assert—but present no evidence from the implementation of the current regulation now underway—that states have insufficient flexibility. In the absence of such evidence, this assertion sounds like an ideological imperative rather than a reasoned policy analysis.

In attempting to justify the proposed changes, the text at 83 FR 57278 describes one challenge with the current rules: time and distance analyses may not accurately reflect provider availability, specifically the use of telemedicine. This justification ignores the current regulatory text at §§438.68(c) and (d), outlining the elements states must consider when developing network adequacy standards and the exceptions process. For example, at §§438.68(c)(1)(v) and (vi), states are instructed to consider the number of providers not accepting new patients and the geographic location of network providers when setting their time and distance standards. In the preamble to the 2016 final rule, your agency explained that the regulations, "would permit states to vary those standards in different geographic areas to account for the number of providers practicing in a particular area," 81 FR 27659. Further, at §438.68(c)(1)(ix), the current regulations instruct states to consider the availability of telemedicine, e-visits, and other technological solutions. And at §438.68(d)(1)(ii) the current regulations expressly permit exceptions to the time and distance standards based on, at a minimum, the number of providers in a specialty practicing in the service area. In short, the current regulations give states the needed flexibility to accommodate any state- or region-specific time and distance standard challenge.

We strongly oppose removing the provision at §438.68(b)(1)(viii), which allows CMS to include additional provider types in the network adequacy standards as needed to promote the objectives of the Medicaid program. This provision was included in order to address future provider workforce shortages and would only be used after soliciting public input, 81 FR 27660. In attempting to justify the removal of this provision, CMS writes that states are concerned that these changes may be made without allowing managed care plans sufficient time to adjust their networks, 83 FR 57279. If this is a real concern, CMS should specify the timeline for compliance rather than removing the provision altogether.

Finally, we would like to draw your attention to current §438.68(e), which requires states to publish network adequacy standards. This provision was effective for rating periods for contracts beginning on or after July 1, 2018, but a recent review by the Medicaid and CHIP Payment and Access Commission (MACPAC) indicates many states are out of compliance.[6] MACPAC staff searched for information on 20 states of the 42 with comprehensive managed care delivery systems and found related documents for only 70 percent of states searched. Even among states with some information posted, staff noted that few states have standalone network standards as required and very few states included metrics or standards to measure access or network adequacy. Though this review did not include all states, it is clear that more oversight of the existing network adequacy standards is needed in order to ensure that Medicaid beneficiaries have access to care.

To allow state Medicaid agencies to replace time and distance standards with any "qualitative" standard whatsoever, as proposed, would undermine access to care by Medicaid beneficiaries enrolled in MCOs, especially children and families. It would invite state Medicaid agencies that are under fiscal pressure to develop standards that do not, as a practical matter, require MCOs to demonstrate networks with sufficient providers who are actually accessible to enrollees and deliver needed services to them. This fiscal incentive to hide the access ball will become even more compelling when the next recession arrives. Rather than undoing the already weak network adequacy standard, we urge that CMS set a national floor for time and distance standards, accounting for public transportation limitations, as well as quantitative standards regarding provider hours and availability, maximum appointment wait time standards, and primary care provider-to-patient ratios.

Enrollee Encounter Data (§438.242(c))

Accurate and complete enrollee encounter data is fundamental to the accountability of MCOs and the state Medicaid agencies with which they contract for the accessibility of covered services for enrolled children and families. Without such data, it is impossible for state or federal officials, much less the public, to know whether covered services have actually been provided to beneficiaries who need them. The current regulation at §438.242(c) requires that contracts between state agencies and MCOs provide for the submission of all enrollee encounter data that the state is required to submit to CMS under §438.818. The proposed rule would clarify that this data include the "allowed amount and the paid amount" with respect to each encounter. *We strongly support this clarification,* which will strengthen the ability of state and federal officials to monitor MCO payments to network providers for their effect on access to care (e.g., is the spread between "allowed" and "paid" too

great to incent providers to participate?) as well as to identify potential fraud, waste, and abuse.

Quality Rating System (QRS) (§438.334)

The current regulations require states to operate a Medicaid managed care Quality Rating System (QRS). States have the option of using a QRS framework developed by CMS or, subject to CMS approval, an alternative state-specific QRS that produces "substantially comparable" information about MCO performance. This requirement is effective no later than 3 years from the date CMS publishes a final notice of its QRS framework in the Federal Register. CMS has not yet published this final notice, so states are not required to implement a QRS until January 2022 at the earliest. (The preamble at 83 FR 57280 indicates that CMS "expects" a notice of a proposed QRS framework to be published but does not indicate when).

With implementation of the current rule hardly off the ground, the proposed rule would revise the standard for the alternative state-specific QRS to require only that it produce information about MCO performance that is "substantially comparable [to the CMS-developed QRS framework] to the extent feasible … to enable meaningful comparison of performance across States." The proposal would also eliminate the current requirement for prior CMS approval of the alternative state-specific QRS. In the absence of any operational experience with the "substantially comparable" standard under the current regulation or prior CMS review, we oppose this change. We do not think it is realistic to expect that, under this revision, it will be possible for your agency or the public to meaningfully compare the performance of individual MCOs across states. Instead, it is likely that 50 different QRS flowers will bloom. As a result, another potential mechanism for holding MCOs accountable for the accessibility of the services they have contracted to provide to children and families will be seriously compromised.

Exemption from External Quality Review (§438.362)

As the statute and the current regulations recognize, vigorous, independent External Quality Review (EQR) is essential to holding MCOs accountable for the reliability of the encounter data they submit to state Medicaid agencies. As noted above, those data are fundamental to the ability of state and federal officials to monitor the accessibility and quality of services that Medicaid enrollees receive and to hold MCOs accountable for their performance. Under current regulations, states have the authority to exempt an MCO from undergoing an EQR if the MCO has a current contract with Medicare and has at least a 2-year track record of satisfactory performance under its Medicaid contract.

The proposed rule would require that states annually post on their websites, in the same location where the EQR technical reports are posted, the names of the MCOs, if any, that the state has exempted from EQR, as well as the date on which the exemption began. *We strongly support this proposed change.* It will provide needed transparency to beneficiaries and the public about state agency decisions to exempt specific MCOs, thereby increasing state agency accountability for those decisions.

Grievance and Appeal System: Statutory Basis and Definitions (§438.400)

A well-functioning grievance and appeal system is not just a good source of information about the accessibility of services in an MCO; it is also a critical consumer protection from arbitrary or erroneous denial of covered services. As recent reporting by Kaiser Health News indicates, wrongful denials of covered services are not an abstract problem in Medicaid managed care.[7]

The current regulation at (§438.404(a)) requires MCOs to give enrollees timely and adequate written notice of an “adverse benefit determination” so that the enrollee can challenge arbitrary or erroneous denials of care through the appeal process. An “adverse benefit determination” includes the “denial, in whole or in part, of payment for a service.” The proposed rule would revise this definition to exclude denials when the claim does not meet the definition of a clean claim at §447.45(b).

We understand the logic of not triggering a written notice in the case of a denial of a claim that is not a clean claim, and we appreciate your representation that “this proposed change is not expected to expose enrollees to financial liability without notice, or to jeopardize their access to care or rights to an appeal.” 83 FR 57263. However, we believe that the regulatory text should make this intent crystal clear so that enrollees have the opportunity to protect themselves against financial liability. We therefore urge that the proposed revision to §438.400(b)(3) at 83 FR 57297 should read as follows (suggested additional text in italics):

(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service because the claim does not meet the definition of a “clean claim” at §447.45(b) of this chapter is not an adverse benefit determination, *but only if the denial of the claim for this reason will not result in any financial liability for the enrollee.*

Grievance and Appeal System: General Requirements (§438.402 and §438.406)

The current regulation requires that if a beneficiary appeals a denial of service verbally, the beneficiary must follow up on that oral appeal by filing a written,

signed appeal. The proposed rule would eliminate the requirement that enrollees submit a written, signed appeal after submitting an oral appeal in order to trigger their appeal rights. This has the potential to reduce administrative burden on enrollees without undermining their appeal rights. Crucially, the proposed rule would retain the current requirement at §438.406(b)(3) that specifies that MCOs must treat oral inquiries seeking to appeal an adverse benefit as an appeal. In the preamble to the proposed rule at 83 FR 57283 you represent that "as we noted in the 2016 final rule, we continue to expect managed care plans to treat oral appeals in the same manner as written appeals (81 FR 27511)." On this understanding, we support this proposed revision.

Children's Health Insurance Program (CHIP) Managed Care

We support the proposed clarifications and technical corrections to the following regulatory sections related to the Children's Health Insurance Program (CHIP): 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).

We also support the proposed changes to the CHIP grievance system insofar as they are intended to clarify the application of subpart F of part 438 to CHIP at §457.1260. However, we find the language at §457.1260(e)(4) confusing. The description of the policy regarding continuation of benefits while an appeal is pending and payment for such services at 83 FR 57286 is clear—CMS does not wish to apply either of these Medicaid rules (§§438.420 and 438.424(b)) to CHIP. But at §457.1260(e)(4)(ii), the proposed rule specifically 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 believe that CHIP beneficiaries should have the right to continue to receive benefits pending an appeal. At the very least, CMS should clarify the regulatory text and only require inclusion of applicable beneficiary rights in the notice. We also note that the language at §457.1260(e)(3) and (e)(6) appears to be duplicative.

We would also like to reiterate our recommendation from 2015 that the state monitoring requirements at §438.66 also apply to CHIP because strong state management and oversight is critical to program integrity. Finally, as noted above, all of our recommendations to revise provisions in part 438 that are applicable to

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

CHIP at part 457 should apply to CHIP as well in order to maintain alignment between Medicaid and CHIP requirements.

Thank you for the opportunity to submit these comments. Please contact Andy Schneider (email: andy.schneider@georgetown.edu) or Kelly Whitener (email: kdw29@georgetown.edu) if you have questions.

Respectfully submitted,

Georgetown University Center for Children and Families

---

[1] The number of children enrolled in Medicaid was retrieved from https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf; the percent of children covered through Medicaid (and other public health insurance) was retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2704&prodType=table; and the share of Medicaid enrollees that is children was retrieved from https://www.medicaid.gov/medicaid/program-information/downloads/february-2018-enrollment-data.zip.
[2] T. Brooks and K. Whitener, "At Risk: Medicaid's Child-Focused Benefit Structure Known as EPSDT," (Washington: Georgetown University Center for Children and Families, June 2017), available at: https://ccf.georgetown.edu/wp-content/uploads/2017/06/EPSDT-At-Risk-Final.pdf.
[3] MACSTATS, "Exhibit 30a. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2013," (Washington: Medicaid and CHIP Access and Payment Commission, December 2018), available at https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/.
[4] CMS, "Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) Implementation Dates (April 25, 2016)," https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf.
[5] Center for Children and Families, Comments on CMS-2390-P (July 27, 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2016/03/20150727-Comments-CMS-2390-P.pdf.
[6] Medicaid and CHIP Payment and Access Commission (MACPAC), "Network Adequacy in Managed Care," December 2018, available at https://www.macpac.gov/publication/network-adequacy-in-managed-care/.
[7] Chad Terhune, "Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit" (January 3, 2019), available at https://khn.org/news/coverage-denied-medicaid-patients-suffer-as-layers-of-private-companies-profit/.