CLASP

Policy solutions that work for low-income people

Medicaid and CHIP Managed Care Proposed Rule Comments (File Code CMS-2408-P)

The Center for Law and Social Policy (CLASP) appreciates the opportunity to comment on the proposed rule for 42 CFR Parts 438 and 457. CLASP is a national, nonpartisan, nonprofit organization advancing policy solutions for low-income people. CLASP works to develop and implement federal, state, and local policies (in legislation, regulation, and on the ground) that reduce poverty, improve low-income people's lives, and create pathways to economic security for everyone. That includes directly addressing the barriers people face because of race, ethnicity, and immigration status.

CLASP's comments on the proposed rule focus on four areas:

- **§438.10 Information Requirements**
- **§438.68 Network Adequacy Standards**
- **§438.406 Handling of Grievances and Appeals and §457.1260 Grievance System**
- **§457.1240 Quality Measurement and Improvement**

Information Requirements (§ 438.10)

CLASP opposes the proposed changes in this section and urges HHS to reconsider. Having access to timely and accurate information about providers, benefits, and other details of managed care plans is paramount for enrollees to successfully navigate the system and receive needed health care. Disability and language-related barriers to access may severely limit an individual's opportunity to access medical care, assess options, express choices, and ask questions or seek assistance. The proposed language weakens current standards and will ultimately lead to limiting access to health care for persons enrolled in managed care, particularly for persons with disabilities or those with Limited English Proficiency (LEP).

All of the entities governed by this provision receive federal funds, they are all subject to Section 1557 of the Affordable Care Act, the ACA's nondiscrimination requirements. Under the final regulations implemented by the HHS Office for Civil Rights, these "covered entities" must provide taglines on all "significant" documents. HHS now would create a competing standard, making it challenging for entities covered by both sets of regulations to ascertain how to comply – is a document significant yet not critical to obtaining services? Is it critical but not significant? We strongly oppose CMS's HHS' attempt to redefine the requirements under Section 1557 in a manner that directly conflicts with the final regulations issued by the Office for Civil Rights. The regulation issued by OCR were carefully considered with significant input from all stakeholders and HHS CMS should not create a less restrictive requirement solely for Medicaid managed care entities.

Provider Directories

Provider access begins with having accurate, up-to-date provider directories available to enrollees and potential enrollees. However, instead of strengthening federal standards, this proposal would weaken them. HHS seeks to change requirements for provider directories by allowing Managed Care Organizations (MCOs), Prepaid Inpatient

Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) entities to update printed directories quarterly, instead of monthly, if the MCO, PIHP, PAHP, and PCCM also provides a mobile-enabled electronic directory.

HHS cites data on cell phone use by low-income persons to justify this change but provides no information on enrollee use of printed directories. U.S. Census data shows that low-income persons are less likely to have access to broadband and internet services. For example, more than one in five Virginian households (21.4%) lack broadband internet access.[1] Nationwide, half of households with incomes under $25,000 have either no computer or no broadband at home.[2]

In the absence of additional research on enrollee preferences for print versus mobile/electronic formats and accessibility, it would be premature to ease current requirements for updating provider directories.

The HHS Office of the Inspector General (OIG) identified significant shortcomings in provider access in its 2014 report, Access to Care: Provider Availability in Medicaid Managed Care.[3] However, issues and deficiencies regarding provider access remain.

Instead of "encourag[ing] managed care plans to perform direct outreach to providers on a regular basis to improve the accuracy of their provider data," HHS should maintain current standards and engage in active compliance monitoring and enforcement actions when plans fail to meet those minimum standards.

CLASP urges HHS to retain the existing regulation.

Tagline Requirements

Taglines are an effective and cost-efficient manner of informing persons with disabilities and LEP individuals and will help assist plans in determining in which languages additional materials should be provided. HHS proposes to limit use of taglines to written materials that "are critical to obtaining services." This standard is not only vague, but HHS fails to specify who decides whether information is critical to obtaining services. The vagueness of this language will likely lead to plans omitting taglines from materials that currently contain taglines, meaning that persons with disabilities (particularly visual disabilities) and LEP individuals will not receive information they may currently receive. CLASP strongly urges HHS to retain the language in the existing regulation, following language set by Section 1557 of the ACA.

Network Adequacy Standards (§ 438.68)

CLASP strongly opposes the proposed network adequacy changes and urges HHS not to adopt them. The proposed changes dilute the existing network adequacy standards to the point where plan enrollees may not have any reliable information on which to judge provider networks. Medicaid enrollees continue to experience more difficulty accessing services and providers than their privately insured counterparts.[4] This is often especially true for "specialty" providers, such as behavioral health care or dental care.

Strong network adequacy standards are necessary to ensure that Medicaid managed care enrollees can access covered services. The proposed rule further weakens network adequacy standards, taking a step in the wrong direction toward ensuring access to covered services.

Specifically, the proposed change from states defining their own time and distance standards to defining any network adequacy standard that is quantitative will have two primary effects. It will encourage states to develop network adequacy standards that provide the most favorable impression of their provider networks rather than provide the information enrollees need to best access health care.

The preamble to the proposed rule (preamble p.57278) says that the current time and distance requirement produces results that do not accurately reflect provider availability. CLASP does not disagree with this but asserts that the proposed changes do not solve this problem. For instance, measuring how soon someone can receive an appointment with a provider is useless if the provider is too far away for the enrollee to travel. Similarly, measuring the provider to patient/enrollee ratio does not provide Medicaid managed care enrollees with all the information they need when assessing a provider network, such as how soon they will be able to receive an appointment.

The bottom line is that while no one measurement of network adequacy may provide all the right information enrollees need to choose a managed care plan and then a provider in the plan's network, the proposed rule is a step in the wrong direction. CLASP urges HHS to, at a minimum, retain existing language, and further encourages HHS to consider alternatives that more accurately reflect the adequacy of provider networks.

Handling of Grievances and Appeals (§ 438.406) and Grievance System (§ 457.1260)

CLASP strongly supports CMS' decision to remove the requirement that enrollees must confirm oral hearing requests in writing. Requiring that oral inquiries be treated as appeals will improve meaningful access to the appeals process for persons with LEP and persons with disabilities who may have barriers to reporting grievances or challenging adverse decisions in writing.

CLASP opposes the proposal to eliminate continuation of CHIP benefits while an appeal is pending. CHIP managed care plans cover behavioral health care and other ongoing services vital for children with complex medical needs and long-term chronic conditions. In the preamble, HHS states that it did not intend the continuation of benefits provided under Medicaid to apply to CHIP (83 Fed. Reg. 57286) and proposes to eliminate informing requirements regarding the right to continued benefits. We believe that CHIP enrollees should have the right to continue to receive benefits pending an appeal and to be informed of this right.

Quality measurement and improvement (§ 457.1240)

Stakeholder engagement and input from the public is essential when developing and implementing quality measurement and improvement standards. Currently, HHS requires states to involve the public in the design of CHIP, as well as ongoing public involvement once the state plan has been implemented. HHS now proposes to eliminate references to Medical Care Advisory Committee (MCAC) consultation when developing CHIP quality measurement and improvement. The proposed rule offers no alternate means or opportunity for input from child health advocates, providers, consumers, and other key stakeholders to provide input on a state's CHIP quality assessment and performance improvement program. We disagree with this approach and believe that HHS should take a more active role in supporting MCACs and other advisory groups so that stakeholders have a meaningful opportunity to share their expertise and provide input.

Thank you for the consideration of these comments. If you have questions please contact Suzanne Wikle at swikle@clasp.org.

[1] Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015* 8 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf**.**
[2] Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say
[3] OIG, Access to Care: Provider Availability in Medicaid Managed Care, OEI-02-13-00670 (Dec. 2014), available at http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.
[4] *See, e.g.,* Medicaid & CHIP Payment & Access Comm'n, *Medicaid Access in Brief: Children's Difficulties in Obtaining Medical Care* 1 (2016) ("[C]hildren in Medicaid or CHIP are more likely than those with private coverage to report difficulties accessing medical care; these difficulties include finding a provider who will accept their insurance, obtaining a timely appointment, and obtaining a referral to a specialist."), https://www.macpac.gov/wp-content/uploads/2016/11/Adults-Experiences-in-Obtaining-Medical-Care.pdf**.**