CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

January 14, 2019

Submitted on regulations.gov.

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8013

Re: Proposed Rule for Medicaid and Children's Health Insurance Program (CHIP) Programs; Managed Care, 83 Fed. Reg. 57264

Dear Administrator Verma:

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on CMS' Proposed Rule on Managed Care in Medicaid and CHIP. CHCANYS is New York State's Primary Care Association for federally-qualified health centers (FQHCs). CHCANYS operates as an advocate and voice for health centers across New York State, with over 800 sites serving 2.3 million patients annually. FQHCs are non-profit, community run health centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking it, regardless of their insurance status or ability to pay. About 59% of our patients are covered by Medicaid or CHIP. CHCANYS supports comments submitted by the National Association of Community Health Centers (NACHC) and has restated some of those comments below.

Section 438.4 – Actuarial Soundness

In Section 438.4(a) CMS defines actuarially sound capitation as rates that are "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract…" and in Section 438.6(c) CMS allows states to require managed care organizations (MCOs) to implement value-based purchasing models for provider reimbursements. In this NPRM, the Agency proposes rule changes that, among other things, provide states with additional flexibility to set rate ranges, and allows states to become more involved in directing contractors to test certain value-based provider payment reforms tied to the state's quality improvement strategy.

CHCANYS hopes that CMS will revise these rules to enforce Medicaid statutory provisions requiring MCOs to reimburse FQHCs no less than what the MCO would pay other providers for comparable services and that, unless otherwise provided for in a State and FQHC agreed-upon Alternative Payment Methodology (APM), the **State** is responsible for paying the FQHC the difference between what it was paid by the MCO and the amount the FQHC would be paid under the FQHC Prospective Payment System (PPS).[1]

[1] Sections 1903(m)(2)(A)(ix) and 1902(bb)(5)and (6)of the SSA.

Section 438.10—Information to Plan Enrollees

It is critical that Medicaid managed plan enrollees are provided with timely and adequate information regarding provider choices and availability. We are concerned that several of CMS' proposals in this NPRM will undercut the ability of enrollees to make knowledgeable and timely provider choices. For example:

- CMS proposes to lengthen the time period governing when a managed care plan must notify enrollees that their physician is leaving the network. Currently, the rule requires that an enrollee be notified of a provider termination in 15 calendar days **following notice** of the provider termination, but CMS is proposing to lengthen that period to **within 30 days of actual termination.**[2] This change could result in a patient being notified of his provider leaving a network 30 days before the provider leaves even though the provider may have notified the plan of the date he is leaving long before that 30 day period. This change will obviously make it more difficult for the enrollee to find a new provider in the plan or request enrollment in another plan.

- Another proposed rule change would lessen the frequency with which paper provider directories would have to be updated if contactors offer mobile-enabled directories.[3] However, as CMS acknowledges in its preamble, more than a third of low-income households do not own a smart phone. This relaxation of the paper directory requirement is likely to make it more difficult for a number of enrollees to have accurate and timely information as to who is in their network.

- Current CMS policy requires that all written materials must include taglines in the prevalent non-English languages used in the state, and materials must use a font size no smaller than 18-point. The NPRM would amend the written materials provision to specify that only written materials that are "critical to obtaining services for potential enrollees" must meet access standards; would replace the 18-point font requirement with "conspicuously visible" as that term is used in regulations implementing the civil rights provision of the ACA (Patient Protection and Affordable Care Act, Section 1557) and would include as "critical" materials: directories, enrollee handbooks, appeal and grievance notices and denial and termination notices.[4]

Because of the potential harm that these proposals might create for Medicaid managed care enrollees making a knowledgeable and timely choice of providers, **CHCANYS asks CMS to eliminate the above rule proposals.**

[2] Proposed rule 438.10(f)(1), at 83 Fed Reg. 57295
[3] Proposed rule 438.10(h)(3), at 83 Fed. Reg., 57295
[4] Proposed rule 438.10(d)(2)and (3), at 83 Fed. Reg. 57295

Section 438.60 - Exceptions to the regulatory prohibition on duplicate payments

Section 438.60, as published in 2002, sought to avoid duplicate payments for the same service by prohibiting state agencies from making payments directly to managed care network providers for services covered under a managed care contract. However, the regulations contain an exception allowing direct payments by the State agency to network providers where those payments are explicitly required by federal law.

In the preamble to the 2002 Final Rule, CMS explained that this exception was intended to apply "to two types of providers—disproportionate share hospitals (DSH) and Federally qualified health centers (FQHCs)." CMS noted that the Social Security Act" specifically requires direct payments to these providers when they are part of an MCO provider network."[5] CHCANYS asks CMS to repeat this clarification in the portion of the preamble discussing Section 438.60, and that CMS notes: **"as stated in the 2002 rule, supplemental payments to FQHCs are one of the two types of payments to which this exception applies."**

Section 438.68 - Network Adequacy Standards

In its NPRM, CMS proposes to revise the managed care network adequacy standards it promulgated in 2016. CHCANYS is concerned that any loosening of these rules can result in inadequate availability of providers to Medicaid managed care enrollees. Thus, **we are opposed to the Agency's proposal to eliminate the current requirement that states set time and distance standards.**

Part 457—CHIP regulations

In the NPRM, CMS states that since the publication of its 2016 final rules, it has concluded that there is a "need for additional minor technical and clarifying changes to the CHIP managed care provisions, primarily to clarify that certain Medicaid requirements do not apply to CHIP." 83 Fed Reg, at 57284. However, certain provisions in the Medicaid statute relating to payment to FQHCs in managed care arrangements are specifically incorporated into the CHIP statute and they do apply to payments to FQHCs in CHIP.[6] CHCANYS believes it is important to reference these FQHC CHIP payment requirements in the preamble to this rule.

[5] In the preamble to the 2002 Final Rule, CMS referred to the supplemental payments to FQHCs as being required by SSA § 1902(a)(13). 67 Fed. Reg. 40989. This appears to be an error, as the Consolidated Appropriations Act, 2001, Pub. L. No. 106-554, App. F, § 702, amended the Social Security Act effective January 1, 2001 to delete the provision of § 1902(a)(13) addressing FQHC reimbursement and to add a new § 1902(bb), introducing the FQHC prospective payment system (PPS). The supplemental payment requirement dated from the Balanced Budget Act of 1997, Pub. L. No. 105-33, and the 2001 amendments made only minor changes to the supplemental payment provision.

[6] Section 503 of CHIPRA of 2009 amended section 2107(e)(1)(G) of the Act to require that separate CHIP programs use the Medicaid payment methodologies set forth in section 1902(bb) of the Act for all FQHC and RHC services provided on or after October 1, 2009.

CMS's SHO #16-006, issued by CMS a short time after CMS finalized its managed care rule in 2016, provides a clear explanation by CMS as to the requirement of PPS payment to FQHCs serving CHIP patients.

Thank you for the opportunity to comment on these proposed Medicaid managed care rules. If there are any follow up questions, please contact Marie Mongeon at mmongeon@chcanys.org.