AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Mail Stop 314G
Washington, DC 20201

Re: Medicaid Program; Medicaid and Children's Health Insurance Plan Managed Care; Proposed Rule

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on managed care under the Medicaid and Children's Health Insurance Programs (CHIP). While we appreciate that CMS' purpose with this proposal is to better align the 2016 managed care rule with states' actual experience, and to reduce state administrative burdens while enhancing states' ability to effectively manage their Medicaid and CHIP programs, key provisions of the 2016 rule became effective only for plan years beginning July 1, 2018, so there actually has been very limited evidence to date from states' actual experience. And, while we are pleased that CMS is proposing to leave much of the managed care rule intact, the AMA is concerned that several significant provisions in the proposed rule could result in inadequate payments to physicians and other providers, weaken access protections for beneficiaries, especially through changes to network adequacy, and decrease information transparency. Our comments, therefore, focus on these key provisions.

Coordination of Benefits (Sec. 438.3)

Managed care enrollees may have several sources of coverage in addition to their Medicaid plan. As a result, managing coordination of benefits without imposing burdens on physicians and other providers is critical. The current rule requires that contracts with a managed care organization (MCO) that cover Medicare-Medicaid dually eligible enrollees provide that the MCO enter into a Coordination of Benefits Agreement and participate in crossover Medicare's automated claims process. This policy enables physicians to submit a single bill, rather having to send separate bills. CMS now proposes that rather than using Medicare's methodology for crossover claims, states could develop their own systems for managing crossover claims. The AMA is concerned that this could result in physicians receiving numerous payment denials and having to submit multiple claims, and urge CMS to reconsider this proposal.

Actuarial Soundness, Rate Certification, and Special Contract Payment Provisions (Secs. 438.4-438.6)

The AMA supports several key principles that should inform how states determine whether the capitation rates paid by states to MCOs are actuarially sound. Policymakers have an obligation to fully fund Medicaid programs and develop realistic capitation rates that support enrollment and provision of necessary services to all enrollees and promote access to quality care. Requiring states to provide CMS with enough data for the agency to understand the assumptions and methodologies underlying the rates will help ensure MCOs meet their obligation to provide timely access to quality care for all Medicaid beneficiaries. In addition, physician payment rates paid by MCOs should be based on realistic costs of care and are an essential element of the capitation rate-setting. Adherence to these important safeguards will help to improve the Medicaid program for all stakeholders.

The 2016 rule clarified that any proposed differences among capitation rates for specific covered populations must be based on valid rate development standards and not based on the rate of federal match, i.e., the federal financial participation (FFP), associated with the covered populations. Now, CMS proposes to prohibit states from setting different actuarial rates for different populations that are tied to the level of the federal match. Rates could differ only by beneficiary or service characteristics, not by the FFP rate or in a way that increases federal costs. The AMA supports CMS' effort to ensure capitation rates are "based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations," rather than linked to the FFP rate. We are concerned, however, that the proposed rule would explicitly prohibit certain state rate development practices that CMS would consider evidence of higher costs based on FFP. Such practices would include "the additional cost of contractually required provider fee schedules or minimum levels of provider reimbursement, above the cost of similar provider fee schedules, or minimum levels of provider reimbursement, used to develop capitation rates for the covered population, or contract, with the lowest average rate of FFP." This could inadvertently sweep in differences that only coincidentally relate to higher FFP when there is an actual cost differential due to a higher needs population. This could result in inadequate payments to physicians, especially those who see higher need, more complex patients with higher costs, and provide a disincentive to such physicians to continue to treat such patients or even participate in the Medicaid program. It could also discourage plans from taking on more complex patients and potentially encourage cherry-picking of enrollees with less complex needs and lower costs. The AMA opposes the inclusion of this proposal [Sec. 438.4(d)(ii)] and urges CMS not to adopt it.

The AMA appreciates CMS' recognition in the final 2016 rule that state direction of provider payments through an MCO is a useful and effective tool to improve access to care. We support CMS' current proposal to expand states' ability to test certain value-based provider payment reforms. We also support CMS' proposal to add a provision authorizing states to direct MCOs "to adopt a Medicare-equivalent rate," but do not support the rest of the proposed provision that would allow a cost-based rate, a commercial rate, or other market-based rate for network providers that provide a particular service under the contract." We recommend that CMS add protections to this proposal to ensure the new methodology will increase payment rates to providers. In addition, as we had previously commented on the 2015 proposed Medicaid managed care rule, it is unclear in section 438.6(c)(iii) whether and how states are permitted to differentiate based on provider type. As written, the rule may be interpreted to allow states to direct certain payments only if the payment amount is uniform across all provider types, specialties, and settings. We urge CMS to clarify section 438.6(c) to allow states to direct payment amounts for certain services to providers of differing types, specialties, and settings.

Under the policies adopted in the 2016 final rule, CMS allowed FFP for a full monthly capitation payment to an MCO for an enrollee aged 21 to 64 who received inpatient treatment in an institution for mental disease (IMD) for part of the month, if the length of stay in the facility was no more than 15 days in the month for which the capitation payment is made. The AMA strongly supports this provision and agrees with states and other stakeholders that FFP should be provided for capitation payments made for months that include stays longer than 15 days, especially for Medicaid enrollees who may require substance use disorder (SUD) treatment. Given the ongoing opioid epidemic, there simply are not enough inpatient beds for treatment, especially for people in crisis, and without a bed many end up on the street or in jail. Moreover, beds in freestanding psychiatric facilities and psychiatric units in general hospitals have declined over the past decade, but investment in community-based treatment resources has not been adequately funded. Although the newly enacted SUPPORT for Patients and Communities Act (H.R. 6; Public Law No: 115-271) included provisions to lift restrictions on SUD treatment in IMDs, and the AMA supported these provisions, the authorization is time-limited. Accordingly, the regulatory provision is still needed. We applaud CMS for continuing to allow managed care plans the flexibility to cover SUD treatment in IMDs and urge that CMS reconsider expanding the provision as discussed earlier.

Information to Plan Enrollees (Sec. 438.10)

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. Providing full access for patients with disabilities, such as those who may be visually impaired and/or have Limited English Proficiency (LEP), is key to ensuring that a state's Medicaid program provides appropriate services to all participants, including managed care enrollees. It is particularly important for managed care plans to protect and promote access because they often have limitations, such as limited provider networks, which may mean that people with disabilities and LEP may face additional burdens accessing care or may not be able to obtain the care they need. It is essential for Medicaid managed care plans to provide accurate, timely, and accessible information to its covered members, especially those who are most vulnerable, e.g., individuals with disabilities and with LEP.

Therefore, it is particularly disturbing that only two years after providing additional protections for this population in the 2016 managed care rule, CMS is now proposing to weaken the 2016 standards for making information available to potential enrollees and enrollees, which could lead to limiting access to health services, especially for persons with disabilities and individuals with LEP.

The current rule requires that written materials must be accessible to members with visual disabilities or with LEP. All written materials must include taglines in the predominant non-English languages in the state, and written materials must use a font size of at least 18 points. This font size is based on guidance from the American Printing House for the Blind, which based its standards on research of the impact on readers of print characteristics, such as font size. CMS now proposes to replace this evidence-based standard with a vaguer requirement that taglines be "conspicuously visible." However, CMS does not provide any information or description of what constitutes a "conspicuously visible" tagline, nor does it provide any evidence on how persons with visual impairments would be able to access health information under this new standard. We urge CMS to retain the current standards.

In a similar vein, CMS proposes to limit information access through taglines to written materials that "are critical to obtaining services." Taglines can be an effective and cost-efficient manner of informing persons with disabilities and LEP individuals and can help assist plans in determining in which languages

additional materials should be provided. This proposed standard is vague, and CMS fails to specify who decides whether information is critical to obtaining services. Further, MCOs must provide potential enrollees with information about Medicaid benefits not covered by the MCO. If potential enrollees know that a specific plan does not cover certain services, such as family planning services and supplies and abortion services, and obtaining these services is important to them, they can choose a plan that does cover the services. It is unclear whether information "critical to obtaining services" would include services that a plan does not provide. Moreover, this proposed change appears to conflict with the final rule implemented by the Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS), which requires "covered entities" pursuant to the non-discrimination provision (section 1557) of the Affordable Care Act (ACA) to provide taglines on all "significant" documents. The AMA is opposed to CMS' attempt to redefine the section 1557 requirements. We urge CMS to maintain the current standard instead of this proposed change.

We also do not support proposed changes to the requirements for plans to notify enrollees on physician terminations from the network. Under the current regulation, plans must provide notification to enrollees 15 calendar days following notice of physician termination, if the physician saw the patient on a regular basis. CMS now proposes to allow notification to each enrollee who received his or her primary care from, or was seen on a regular basis by the provider, by the later of 30 calendar days prior to the effective day of termination, or 15 calendar days after receipt or issuance of the termination notice. This means that even though a managed care plan may receive notice that a physician will be leaving the network in six months, the plan could wait to notify the physician's patients until 30 days prior to their physician's actual departure from the network. We do not believe that 15 days is an enough time for the affected patients to find another network physician or to request enrollment in a new plan. In addition, as we commented on the proposed managed care proposed rule, we remain concerned that notice is only required for enrollees that were seen regularly by the provider. Regular is undefined, and many Medicaid patients may have important relationships with providers that they visit infrequently. For example, a patient may visit her obstetrician-gynecologist once a year, but have a patient-physician relationship that is nevertheless important to preserve. We recommend that CMS require MCOs to notify enrollees of the termination of any provider the enrollee has visited.

Finally, the AMA is concerned about the proposed changes to provider directories. Medicaid enrollees need comprehensive, accurate, and up-to-date information to make informed choices about their health care and their health plans. Instead of strengthening federal standards, CMS now proposes to weaken them by allowing MCOs and other managed care entities to update printed directories quarterly instead of monthly, if the information is accessible through smartphone-friendly websites. While we understand that updating paper directories can be time-consuming, and that 64 percent of low-income households own a smart phone (i.e., according to CMS), having access to a cell phone does not necessarily mean that an individual understands how to navigate through complicated plan websites or can read provider directory information in electronic format. Since such information is critical for accessing necessary and appropriate care, we urge CMS to maintain the current requirements.

Network Adequacy Standards (Sec. 438.56)

Strong network adequacy requirements are critical to ensuring that Medicaid managed care enrollees can access covered services. AMA strongly supported the addition of new requirements in the 2016 final managed care rule that states develop time and distance standards to measure access. For the first time, all states with managed care programs are required to develop and implement time and distance standards for

primary care services (adult and pediatric), specialty care services (adult and pediatric), behavioral health services (adult and pediatric), obstetrical and gynecology services, hospital services, pharmacies, and pediatric dental services. While we supported these changes, we believe that time and distance standards alone cannot create as complete a picture of a network as needed to determine true adequacy. The AMA supports additional standards that would require provider-to-patient ratio standards, wait time minimums and access to alternative office hours (e.g., evening/weekends).

We therefore strongly oppose the proposed changes to the rule that would remove the time and distance requirement. Instead, noting that time and distance standards may not properly account for access to telehealth, CMS proposes a more general requirement that states set "quantitative" network adequacy standards. However, access to telehealth does not mean that time and distance standards are irrelevant and should be eliminated. As an alternative, CMS could provide guidance to states on how to account for telehealth in measuring network adequacy. Access to telehealth is not a substitute access to onsite services and ensuring an adequate network. We urge CMS not to adopt these proposed changes.

In conclusion, the AMA appreciates the opportunity to provide comments and thanks you for considering our views. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD