American Cancer Society
Cancer Action Network
555 11th Street, NW
Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

January 9, 2019

Seema Verma
Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-2408-P: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Proposed Rule
83 FR 57264 (November 14, 2018)

Dear Secretary Verma:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed rule concerning changes to the Medicaid and Children's Health Insurance Plan (CHIP) Managed Care rule. ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.

The stated intent of the proposed rule purports to streamline the Medicaid and CHIP managed care regulatory framework; relieve regulatory burdens; and promote transparency, flexibility, and innovation in the delivery of care. Although the majority of the proposed changes in the proposed rule are technical corrections to the 2016 Medicaid and CHIP Managed Care Final Rule ("final rule"), there are several proposed changes – which we have highlighted in this letter - that concern ACS CAN.

Information Requirements (§438.10)

Information for all enrollees of MCOs, PIHPs. PAHPs, and PCCM entities: General requirements (§438.10(f))

In previous federal regulations, the Center for Medicare and Medicaid Services (CMS) required notice to enrollees of a provider's termination from a Medicaid managed care plan within 15 days of a covered plan's receipt or issuance of a termination notice (67 FR 41015). This was put in place to ensure that enrollees received advance notice of a provider's termination from the managed care network, as providers often give little notice of their plans to terminate from a network. Section 438.10(f)(1) requires managed care plans to make a good-faith effort to provide notice of the termination of a contracted in-network provider to all affected enrollees within 15 days of receipt or issuance of the termination notice. The proposed rule would change the requirement to the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the

notice, so that enrollees did not receive "unnecessary notices" if a contract was amicably resolved and the termination is rescinded.

While we commend CMS for their attempts to decrease confusion for enrollees who may incorrectly believe they need to locate a new provider, we urge CMS to ensure that patients are given as much notice as possible for provider terminations, particularly for specialists in managed care networks. It can be difficult to find another specialized provider within a short period of time, and 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the notice may not be enough time to find and secure an appointment with a specialist. This could cause continuity of care issues, particularly for individuals managing complex chronic conditions like cancer.

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Additionally, recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,[1] and suffer from multiple comorbidities linked to their cancer treatments.[2] When cancer treatment is delayed or disrupted, the effectiveness of the treatment could be jeopardized, and the individual's chance of survival can be significantly reduced.[3] Ensuring both cancer patients and recent survivors receive the care they need is critical to positive health outcomes. Therefore, we urge CMS to consider continuity of care issues before making any changes to the 2016 final rule.

Information for all enrollees of MCOs, PIHPs. PAHPs and PCCM entities: Enrollee Handbooks (§438.10(g))

The 2016 final rule requires that paper provider directories be updated at least monthly and that electronic provider directories be updated no later than 30 calendar days after receiving updated provider information. CMS asserts that states and managed care plans have raised concerns about the cost of reprinting paper directories, and therefore propose to modify the requirements for updating paper provider directories quarterly, as long as the managed care plan offers an updated mobile-enabled electronic directory.

ACS CAN supports provisions that require plans to provide accurate and current provider directories. This ensures that individuals are able to choose a plan and/or provider based on accurate information. Outdated provider directories often cause confusion for enrollees and can lead to delay in care. We also note that the National Association of Insurance Commissioners (NAIC) recently updated their network

---

[1] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed July 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[2] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[3] Graboyes EM, Kompelli AR, Neskey DM, et al. Association of treatment delays with survival for patients with head and neck cancer: A systematic review. *JAMA Otolaryngol Head Neck Surg*. 2018; doi: 10.1001/jamaoto.2018.2716.

adequacy model act and included provisions requiring plans to update their provider directory at least monthly.[4]

While we support the provider directory being available to enrollees via the mobile-enable electronic means, this vehicle of administration is not a sufficient proxy for a paper provider directory. Medicaid beneficiaries have limited means and may not have continuous access to mobile devices from which to access provider directories. We also note that broadband internet service can be challenging in rural areas and thus Medicaid beneficiaries in rural areas may be hampered in their ability to access on-line resources.

Network Adequacy Standards (§438.68)

The 2016 final rule requires that state Medicaid agencies that contract with managed care organizations (MCOs) ensure that MCO provider networks are adequate to meet the needs of their enrollees. Specifically, the rule requires that states develop and enforce time and distance standards for eight different types of providers, including primary care (adult and pediatric) and specialist (adult and pediatric). The rule does not specify a national or specific benchmark for time and distance and instead gives states the flexibility to build their own standards appropriate for their programs and populations (81 FR 27661). The final rule allowed the standards to vary by provider type and by geographic area. The proposed rule would allow network adequacy standards to instead be based on other quantitative network adequacy standards.

Although we appreciate CMS encouraging states to solicit stakeholder input in the development of quantitative network adequacy standards, we are concerned that the text of the proposed rule fails to provide information regarding the types of quantitative network adequacy standards that could be adopted by a state. The preamble suggests a number of possible quantitative standards that could be implemented – including, but not limited to, minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (for example, extended evening or weekend hours); and combinations of these quantitative measures.[5]

We also note that the preamble references the use of telehealth services.[6] While we support the use of telehealth services, we also note that this technology should not be the only means by which a beneficiary is able to access a specific covered service.

Definition of "specialist" (§438.68(b)(1)(iv))
Current regulations specify the type of provider for which states are required to establish network adequacy standards, including "specialist, adult and pediatric." Under the proposed rule, CMS would give states the authority to define what qualifies as a "specialist" in determining network adequacy standards "in whatever way they deem most appropriate for their programs."

---

[4] National Association of Insurance Commissioners. Health Benefit Plan Network Access and Adequacy Model Act. MDL-74. 2015. Available at https://www.naic.org/store/free/MDL-074.pdf?72.
[5] 83 Fed. Reg. 57264 at 57279.
[6] 83 Fed. Reg. 57264 at 57278.

We appreciate CMS' recognition of the need to include specialists as part of a determination on the adequacy of a plan's network. We urge CMS to specifically define the term "specialist" to include providers who focus on a specific area of health, such as cancer, as well as sub-specialists who have additional training beyond specialist training. In cancer care, for example, depending on the type of cancer, a patient may need the services of an oncologist (specialist) or a pediatric oncologist (subspecialist). These specialties and subspecialties are not necessarily interchangeable. We urge CMS to look to the definition of the term included in the NAIC's network adequacy model act.[7]

Additional provider types (§438.68(b)(1)(viii))
The 2016 final rule requires states to establish time and distance standards for additional provider types to help address future national provider workforce shortages and network adequacy standards. The proposed rule proposes to remove section 438.68(b)(1)(viii) to eliminate any uncertainty states may have regarding this requirement.

ACS CAN urges CMS to keep these requirements in order to address future national provider workforce shortages and network adequacy standards, as was initially intended. For example, if CMS determines the need for a certain provider type in the Medicaid program, such as a palliative care specialist or patient navigator, CMS would need a way to establish these additional provider types as part of the network adequacy standards so that Medicaid enrollees have access to these providers without barriers.

Medicaid Managed Care Quality Rating System (QRS) (§438.334)

The 2016 final rule established the authority to require states to operate a Medicaid managed care quality rating system (QRS) to hold states and plans accountable for the care provided to Medicaid and CHIP beneficiaries. States were given the option to use a CMS-developed framework or establish an alternative system, which would require CMS approval. Under the proposed rule CMS would identify a set of mandatory performance measures that states would be required to use - regardless of the type of quality framework - to allow for greater comparability ratings across states. Because states would be required to use the mandatory performance measures, CMS also proposes to eliminate the requirement that states obtain prior approval from CMS before implementing an alternative QRS. Additionally, this section of the proposed rule proposes to revise §438.334(b) to provide that the CMS-developed QRS would align with the qualified health plan (QHP) QRS and "other CMS approaches to rating managed care plans," where appropriate.

---

[7] The NAIC network adequacy model act includes the following definition of the term "specialist":

(1) "Specialist" means a physician or non-physician health care professional who:
   a. Focuses on a specific area of physical, mental or behavioral health or a group of patients; and
   b. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.
(2) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

NAIC Network Adequacy Model Act. Section 3(X).

We agree with CMS that it would be beneficial to have mandatory performance measures that all states must include in their Medicaid managed care QRS to ensure greater quality of care and standardization across state Medicaid managed care programs. We look forward to CMS opening the CMS-developed QRS framework and mandatory performance measures for public comment, as ACS CAN would like to ensure cancer screenings and preventive care are included in those mandatory performance measures. However, we strongly urge against CMS eliminating the requirement that states obtain prior approval before implementing an alternative QRS. CMS should maintain prior approval to ensure that the states are enforcing CMS' mandatory performance measures and that any state alternative QRS' do not undermine the mandatory performance measures required by CMS.

We caution CMS on their proposal to align the CMS-developed QRS, where appropriate, "to other CMS approaches to rating managed care plans," such as the Medicare-Medicaid Plan (MMP) Financial Alignment Initiative or the Medicare Advantage 5-Star Rating System. While we appreciate the need for decreased administrative burden on states and enrollees, not all patient populations are the same. It may be improper to align the CMS-developed QRS, which would cover Medicaid and CHIP enrollees, with the MMP, which is designed for older adults on Medicare. It is critical to ensure that any performance measures are designed for the Medicaid and CHIP populations they serve.

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

The 2016 final rule adopted the requirement that an oral appeal must be followed by a written, signed appeal with the managed care plan to ensure appropriate and accurate documentation of enrollees' appeals. The proposed rule would eliminate the requirement for enrollees to submit a written, signed appeal after an oral appeal has been submitted, to "reduce barriers for enrollees who would have to write, sign, and submit the appeal, decrease the economic and administration burden on plans, and would expediate the appeals process."

In concept, we agree that this is a positive step for enrollees and removes barriers to the appeals process. However, we are concerned that the lack of a written record could create a "he said, she said" situation between the appealing enrollee and the managed care plan. We urge CMS to create a way to incorporate a written record that is less burdensome on the enrollee, perhaps assigning a confirmation number to the oral transaction, to ensure that the appeal is received and documented for the appeals process.

Resolution and Notification: Grievances and Appeals (§438.408)

The 2016 final rule revised the timeframe for enrollees to request a state fair hearing to 120 calendar days. To align state fair hearing timeframes with Medicaid fee-for-service (FFS) timeframes and prevent confusion for enrollees, the proposed rule would revise section 438.408(f)(2) to stipulate that the timeframe for enrollees to request a state fair hearing would be no less than 90 calendar days and no greater than 120 calendar days from the date the MCO's, prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) notice of resolution.

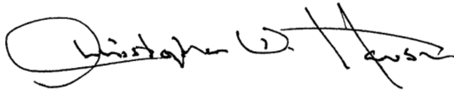
We urge CMS to keep the 2016 final rule timeframe of 120 days to ensure that enrollees are given the most amount of time possible to request a state fair hearing. Often, enrollees may not understand they

have the right to appeal, so it may take them time to reach the proper channels for the appeals process. Therefore, if CMS would like to ensure the managed care timeframes are consistent with FFS state fair hearing timeframes, we recommend that CMS change the FFS state fair hearing timeframe to 120 days, rather than 90, to align with the managed care timeframes. This will allow both FFS and managed care enrollees to get through the, often times, lengthy appeals process.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact me or have your staff contact Michelle DelFavero, Senior Policy Analyst, Policy and Legislative Support at michelle.delfavero@cancer.org or 202-585-3266.

Sincerely,



Christopher W. Hansen
President