



January 14, 2019

Administrator Seema Verma  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: RIN 0938-AT40 - Medicaid Program: Medicaid and Children's Health Insurance Plan (CHIP) Managed Care CMS-2408-P**

**Submitted electronically via regulations.gov**

Dear Administrator Verma:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation - improvements that make a real difference in people's lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

Families USA appreciates the opportunity to provide comment on the proposed rule, *Medicaid Program: Medicaid and Children's Health Insurance Plan (CHIP) Managed Care* (Medicaid Managed Care Proposed Rule).

Our comments focus on proposed changes to sections related to information requirements, network adequacy, Medicaid managed care quality rating system/quality review, and appeals and grievance processes.

## **Overarching Comments**

The objective of the Medicaid program, set forth in section 1901 of the Social Security Act, is to furnish medical services to low-income individuals.<sup>1</sup> As the agency overseeing that program, CMS must fully assess the impact of proposed regulatory changes not only on

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<sup>1</sup> Social Security Act Sec. 1901. [42 U.S.C. 1396], Appropriations.

states and providers (in this case managed care entities) but also on the individuals the program is designed to serve.

Many of the proposed rule changes have at their core a goal of reducing administrative burden on states or managed care entities. For many of the proposed changes, CMS does not provide an adequate assessment of the impact on beneficiaries. While we support efforts to improve efficiency and reduce costs to states and plans, those efforts must be balanced with a full assessment of the impact that removing or altering requirements will have on Medicaid beneficiaries, the individuals the program is intended to serve.

In the preamble to the proposed rule, CMS notes that many of the proposed changes are in response to comments of added burden received from states or managed care plans. It is not surprising that many states or plans would comment on added burdens when confronted with regulatory changes. That is a common response to new or altered requirements. However, that alone is insufficient to justify some of the changes that CMS is proposing, particularly when CMS fails to balance state or plan concerns related to their operational inconvenience with a full assessment of the impact of proposed changes on Medicaid beneficiaries.

The vast majority of Medicaid beneficiaries receive some or all of their health care through some form of managed care.<sup>2</sup> The proposed changes will, therefore, affect most Medicaid beneficiaries. The need for a full analysis of enrollee impact is exceedingly important.

Finally, there has not been sufficient time since the revised rules were finalized in April 2016 to adequately assess their impact, either on states, plans or on Medicaid beneficiaries. Many of the proposed changes are premature. That is a particular concern given that many, if implemented, have the potential to negatively impact Medicaid beneficiaries' access to care.

Our comments on specific sections are set forth below.

### **§438.10 Information requirements**

Several changes are proposed to this section, many of which would make it more challenging for beneficiaries to obtain information critical for their provider selection, or that would increase the risk of gaps in health care services.

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<sup>2</sup> Kaiser State Health Facts, "Share of Medicaid Population Covered Under Different Delivery Systems," as of July 1, 2018, online at <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Navigating managed care systems can be difficult for any consumer. For Medicaid beneficiaries, all low-income by definition and many dealing with serious health conditions, those challenges can be even greater. We do not support proposals to relax several of the information requirement standards established in the 2016 regulations.

Furthermore, the changes proposed do not have improving enrollee communications at their core. They are designed to reduce plan or state requirements. However, no extreme burden has been quantified sufficient to justify proposals that will reduce availability of timely or accessible information for consumers.

**§438.10(d)(2) and (d)(3) Language and format.**

The current rule requires states and managed care plans to include taglines in prevalent non-English languages and use large print, defined as font size of 18 points or greater, for all written materials for potential and current beneficiaries. The proposed rule would relax those standards with regard to font size, non-English languages and taglines. All of these three protections have importance for a significant subset of Medicaid beneficiaries. Taglines are an important mechanism for communicating information to individuals with low English proficiency (LEP) and disabilities. Materials that are critical to obtaining services must, in their entirety, be available in the prevalent non-English language in the state.

**The proposal to limit tagline requirements on language accessibility and large print to "critical" materials.**

***The standard should not be changed.*** The proposal to limit the requirement from "all written materials" to "critical" materials appears to be designed to reduce plan requirements and printing costs. However, all plan written materials presumably provide some information of value to potential or current beneficiaries. Given the importance of plan selection to enrollee care and satisfaction, and the importance that beneficiaries understand all plan requirements, the current standard applying to "all written materials" should not be changed.

***The proposed standard is inconsistent with the Affordable Care Act's nondiscrimination requirements.*** While we urge HHS to retain the requirement applying to "all written material," if that requirement is relaxed, CMS must, at the least, apply the tagline requirement to "significant" documents, consistent with ACA requirements. The ACA's nondiscrimination requirements apply to all of the entities covered by this regulation. Under the final regulations implemented by the HHS Office for Civil Rights, these "covered entities" must provide taglines on all "significant" documents. By limiting the current requirement to "critical," CMS is setting up a competing, and less stringent, requirement.

The regulations issued by the Office of Civil Rights were carefully considered with significant input from stakeholders. CMS should not create a second, less stringent standard, for managed care entities.

## The proposal to relax font size requirements.

***Replacing the 18-point font requirement with a "conspicuously visible" requirement does not ensure that materials will be accessible to the visually impaired.*** The American Council on the Blind guidelines for documents for low-vision individuals specifies 18-point font at a minimum, preferably 20-point.<sup>3</sup> Replacing an exact requirement that is already at the low end of the standard with "conspicuously visible" reduces the likelihood that documents will be accessible to the visually impaired.

Although "conspicuously visible" is the standard specified in regulations implementing the non-discrimination provisions of the Affordable Care Act, a more prescriptive standard is appropriate for documents intended for Medicaid beneficiaries. Visual impairment is more common among low-income individuals than the general population, therefore more likely to affect Medicaid beneficiaries.<sup>4</sup>

Furthermore, while we oppose limiting the requirement to "critical" documents (see above), if the requirement is limited to critical documents, the agency removes one of its central arguments for relaxing the font size requirement for materials for potential beneficiaries, i.e., the difficulty of producing tri-folds and post cards in 18-point font. The types of written materials that CMS specifies as "critical" in (d)(3) (provider directories, enrollee handbooks, grievance and appeal notices, denial and termination notices) are unlikely to be printed on a post card or tri-fold.

**Recommendation:** Retain the current requirements in §438.10 (d)(2) and (3).

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

The current rule requires that plans notify affected individuals that their physician is leaving (or has left) the network within 15 calendar days following the notice of provider termination. (Affected individuals are individuals who receive primary care from or are seen regularly by the terminating provider). CMS proposes relaxing the standard to within 30 days of actual termination.

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<sup>3</sup> American Council of the Blind, "Best Practices and Guidelines for Large Print Documents used by the Low Vision Community authored by the Council for Citizens with Low Vision International and Affiliate of the American Council for the Blind Arlington, VA," online at <http://www.acb.org/large-print-guidelines>.

<sup>4</sup> Nearly 30 percent of individuals with a visual disability have incomes at or below the poverty level, compared to 12.3 percent of the general population. See: National Federation of the Blind, "Statistical Facts about Blindness in the United States," updated June 2018, online at <https://nfb.org/blindness-statistics>; and, University of California Davis Center for Poverty Research, "What is the current poverty rate in the United States?" updated October 2018, online at <https://poverty.ucdavis.edu/faq/what-current-poverty-rate-united-states>.

The rationale given for the proposed change is that there “can be circumstances” where plan/provider negotiations are ongoing during the notice period and ultimately resolves, and individuals will be notified “unnecessarily,” thus causing enrollee confusion. While that might be the case in certain circumstances, CMS does not provide any analysis of the difficulty patients might experience with a shortened 30-day timeframe.

The possible risks and consequences of a patient being prematurely notified are significantly outweighed by the risk of patients undergoing active treatment not receiving adequate notice to find a new provider. Inadequate notice can result in gaps in care. This is a particular risk for patients living in rural areas where there are fewer providers.

In the best of circumstances, finding a new provider can be a difficult and fraught endeavor that takes time. Shortening the notification window will reduce the likelihood that patients will be able to make an orderly, satisfactory transition to a new provider. When patients do not have time to replace a terminating provider with one they trust and relate to, or even find one at all, disruptions in care are inevitable. Those disruptions can negatively affect health outcomes and increase costs of care.

Patient notification rules should be designed to promote continuity of care by giving patients as much notice as possible to find a new provider. This change would have the opposite effect.

**Recommendation:** Retain the current standards for patient notification regarding terminating providers.

**§438.10(h)(3)(1): Provider Directories, Information on cultural competency training.**

We are pleased that provider’s cultural and linguistic capabilities, as well as availability of interpretation services at offices, are and will continue to be required in directories. These are critical aspects of a providers’ services that have a huge bearing on whether patients relate to their providers and can fully understand and comply with treatment. That consequently affects outcomes.

Language alone, however, is often an insufficient measure of whether a physician, dentist, or other provider can adequately communicate with a patient. Information on cultural competency training is important not only to patients, but also to referring providers, helping them to make the most effective referral possible.

**Recommendation:** Retain the requirement regarding cultural competency training as a required item in provider directories.

**§438.10(h)(3) Updating Provider Paper Directories.**

The proposed rule would reduce the frequency with which paper directories must be updated from monthly to quarterly for plans that offer mobile-enabled electronic directories. This change is prompted by contractor complaints about printing costs and inconvenience associated with monthly updates.

To support this change, CMS notes that 64 percent of adults living in households with incomes less than \$30,000 a year owned smartphones in 2016 and that lower-income adults are more likely to rely on smartphones to access the internet because they are less likely to have an internet connection at home.

We object to this change. Adequate, up to date information on provider network participation is critical information for Medicaid beneficiaries. CMS acknowledges as much, listing provider directory information as "critical" in the proposed change to language and font size requirements in this same proposed rule.

For any managed care enrollee, but particularly low-income beneficiaries, inadvertently seeing a non-network provider can be financially devastating. Failing to provide beneficiaries who need or prefer a printed directory with up to date information puts those beneficiaries at a disadvantage.

***CMS does not adequately evaluate smartphone usage among Medicaid consumers.*** In citing statistics on smartphone use to justify this change, CMS ignores the fact that, under its own supporting statistic, 36 percent of individuals with incomes less than \$30,000 did *not* have a smartphone in 2016.

Furthermore, the "under \$30,000" measure used in the analysis would include many individuals who make too much for Medicaid eligibility. \$30,000 is roughly 250% of poverty for an individual and 200% of poverty for a family of two.<sup>5</sup> A more accurate measure of smartphone usage among Medicaid consumers would be individuals with incomes well below \$20,000.

Essentially, CMS is proposing a change that ignores the impact on at least a third, and likely significantly more, of potential plan enrollees. Ignoring the impact of a proposed rule on a third of the target population is a significant omission.

***CMS does not adequately evaluate how Medicaid consumers use their smartphones.*** As further justification, CMS notes that the majority of Americans use their smartphones to access health information. How the majority of Americans use their smartphones is not relevant to the question of how to best provider network participation information to low-income individuals enrolled in Medicaid.

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<sup>5</sup> HHS Federal Poverty Guidelines for 2018, online at <https://aspe.hhs.gov/poverty-guidelines>; and, Families USA Federal Poverty Guidelines 2018, online at <https://familiesusa.org/product/federal-poverty-guidelines>.

Even if one assumes that the majority of Medicaid beneficiaries who have smartphones use those phones to access health information, it is not a relevant statistic for this analysis. Simply because individuals obtain health information using smartphones is no indication that those same individuals will be able to obtain provider directory information via smartphones. It is far easier to do a Google search for a medical term on a smartphone than it is to log onto a health plan, find the provider directory, and search that directory.

This change is driven by plan convenience, without any systematic study of or effort to truly understand how Medicaid beneficiaries in various geographic areas, at different ages, at different income levels, and with varying disabilities and health conditions obtain information on their health plans and provider network participation.

The recent experience in Arkansas, where internet access was the method for beneficiaries to report work status and hours, vividly demonstrates that the internet (which includes smartphones) is not the best method for interacting with Medicaid beneficiaries.

In Arkansas, within a three month period, nearly 17,000 Medicaid beneficiaries were disenrolled for failure to report work hours via the online reporting system the state employed.<sup>6</sup> While by no means the only problem with the Arkansas program, use of the internet as primary means for beneficiaries to report information exacerbated communication and reporting problems. Relying on smartphones or other online technology to impart critical information to Medicaid beneficiaries will invariably leave a large number of beneficiaries without adequate information.

**Recommendation:** Retain the requirement to update paper directories monthly.

### **§ 438.56 Disenrollment requirements and limitations**

We support the proposal to revise 438.56(d)(5) by deleting “PCCMs or PCCM entities,” as enrollees should not be required to exhaust a PCCM’s (or PCCM entity’s) internal grievance system before the state can make a determination on the enrollee's request to disenroll. As noted in the Preamble, the 2016 final rule inadvertently included PCCMs and PCCM entities in this section even though those entities are not required by § 438.228 to have such a grievance system. As noted in the preamble, this change makes the regulations internally consistent. Deleting this requirement eliminates a barrier that should not exist for beneficiaries to request disenrollment. We similarly support CHIP conforming changes made at § 457.1212.

### **§ 438.68 Network Adequacy Standards**

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<sup>6</sup> Robin Rudowitz, et al., *A Look at November State Data for Medicaid Work Requirements in Arkansas* (Washington, DC: Kaiser Family Foundation, December 18, 2018) online at <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>.

**§438.68 (b)(1) and (2). Replacing time and distance standards with a "quantitative network adequacy standard."**

The current time and distance requirements in 42 CFR 438.68 (b)(1) require that states, at a minimum, develop time and distance standards for specified provider types. 438.68(b)(2) requires time and distance standards for LTSS provider types to which beneficiaries must travel for services.

The current rule is not prescriptive as to what those time and distance standards must be.<sup>7</sup> This offers states a great deal of flexibility—we can and have said too much flexibility given the Supreme Court decision in *Armstrong* and consistent concerns about Medicaid networks over the program's history. The proposed rule makes this problematic situation even worse.

Current regulations give states flexibility to develop standards consistent with the conditions and beneficiary needs in each state. The regulations specify what states must consider in developing those standards in 438.68(c), and that includes but is not limited to: number of providers not accepting new patients; modes of travel Medicaid beneficiaries in a given area typically use; anticipated Medicaid enrollment; expected service utilization; and the use of telemedicine, e-visits or other evolving technological solutions. Current regulations specify that states should also factor in telemedicine availability. They also allow for states to seek exemptions [438.58(d)].

The current regulations are designed to balance state flexibility with sufficient guidance to states in how to develop standards to ensure that beneficiaries do, in fact, have physical access to care.

CMS proposes replacing the existing requirement that states develop time and distance standards for the provider types specified under 438.68(b)(1) with a "quantitative standard" to be developed by each state. CMS provides examples of standards states may elect to use: provider to enrollee ratios; minimum percentage of providers accepting new patients; maximum wait times for an appointment; maximum travel time or distance to providers; or hours of operation requirements. However, these standards—many of which current regulations require states to consider in developing time and distance standards—would only be suggestive. CMS notes that these are standards states may elect to use, but they are not limited to those standards.

In proposing this very significant change in network adequacy standards, the agency notes that states have reported that time and distance standards do not accurately reflect provider availability.

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<sup>7</sup> 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>

As an example, CMS notes that in areas where telehealth is prevalent, provider to enrollee ratio might be more indicative of access than travel time or distance. (CMS does not acknowledge that current regulations already require states to consider availability telemedicine in developing network adequacy standards using the time and distance requirement.)

Using telehealth as an excuse to jettison time and distance measures ignores the fact that the impact of telehealth on in-person visits is unclear.<sup>8</sup> Furthermore, most health care consumers prefer to receive telehealth services from a provider they have a relationship with, a relationship developed through in-person encounters.<sup>9</sup>

***It is inappropriate for CMS to eliminate time and distance requirements without any replacement standard that would ensure that beneficiaries have a provider within a reasonable physical distance.*** Technological advances notwithstanding, the ability to physically get to a provider within a reasonable time is a foundational measure of access. While it may be true that measures in addition to time and distance are also critical [and currently incorporated in 438.68(c)], travel time/distance to providers remains a basic and fundamentally sound measure of network adequacy. This remains the case even in areas where telemedicine is prevalent, because beneficiaries still need to receive some care on-site. (Furthermore, as noted above, the impact of telehealth on in-person service use is unclear and may be different for low-income populations than for the general population.)

The findings of the Office of Inspector General's (OIG) 2014 report, *State Standards for Access to Care in Medicaid Managed Care* remain relevant.<sup>10</sup> In that report, the OIG found that state access standards varied widely. The OIG recommended that CMS: strengthen its oversight of state access standards; strengthen its oversight of states' methods to assess plan compliance; improve states' efforts to identify and address violations of access standards; and, provide technical assistance to states and share effective practices.

By requiring states to develop time and distance standards, current regulations go a long way towards ensuring that across states, beneficiaries will have some assurance that plan providers will be physically accessible. While, as we noted above, there are other elements that go into a comprehensive measure of network adequacy, physical proximity/physical accessibility of providers remains critical. If beneficiaries cannot access providers within a reasonable time, the fact that other measures are met (such a low wait times for appointments) is irrelevant.

Furthermore, replacing the existing requirement with a vague requirement of "quantitative measures," is far from addressing the OIG's recommendation that CMS strengthen its oversight.

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<sup>8</sup> Sachin Shah, "Virtual Partially Replaced In-Person Visits in an ACO-based Medical Practice," *Health Affairs*: Vol 37, number 12, December 2018, online at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05105>.

<sup>9</sup> Brandon Welch, et al., "Patient preferences for direct-to-consumer telemedicine services: a nationwide survey," *BMC Health Services Research*, 2017; 17: 784, published online 2017 Nov 28 at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704580/>.

<sup>10</sup> Suzanne Murran, et al., *State Standards for Access to Care in Medicaid Managed Care*, (Washington, DC: Department of Health and Human Services, Office of Inspector General, September 2014) online at <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

The change proposed will only exacerbate the issue of widely varied access standards that the OIG noted in 2014.

In its oversight role, CMS must provide states with greater guidance, and set access parameters that will ensure that beneficiaries can physically access care. This role is now the only source of federal oversight and accountability, with the Armstrong decision reducing judicial oversight. The change proposed here is nothing short of CMS abdicating that responsibility. Current regulations give states significant flexibility and allow states to seek exemptions. Replacing the current measures with a vague directive for states to develop “quantitative measures” essentially removes real requirements that states ensure access.

***CMS should not delete §438.68(b)(1)(viii), but should retain the ability to apply time and distance standards to additional provider types when doing so would further the objectives of the Medicaid program.*** Current regulations allow CMS to apply time and distance standards to provider types in addition to those specified in §438.68(b)(1) without going through the regulatory process, when doing so would promote Medicaid’s objectives [438.68(b)(1)(viii)]. The proposed rule would delete §438.68(b)(1)(viii) and eliminate that flexibility.

In the preamble, the rationale given for deleting that section is that plans expressed concern about needing to quickly add providers without adequate notice.

The current rule allows CMS to work with states and respond to emerging access issues, workforce shortages, and changes in medical and dental practice without going through the rulemaking process, when doing so would be in the interest of furnishing medical assistance to Medicaid beneficiaries. Rather than eliminating current flexibility, the section could be amended to require advance notice of one year before adding a provider type to network adequacy standards.

**Recommendation:** At the least, retain time and distance standards. Amend, rather than eliminate, the option to specify additional provider types without needing to go through the regulatory process.

## **§ 438.242(c) - Enrollee encounter data**

Accurate encounter data is vital to effective oversight of Medicaid managed care plans, and is used for everything from rate setting to measuring network adequacy and quality. As the Government Accountability Office (GAO) noted in its recent October 2018 report, *Additional CMS Actions Needed to Help Ensure Data Reliability*, “the importance of reliable encounter data is paramount to ensuring that rates are appropriate and beneficiaries in Medicaid managed care are receiving covered service.”<sup>11</sup>

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<sup>11</sup> Government Accountability Office, *Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability*, (Washington, DC: GAO, October 2018), online at <https://www.gao.gov/assets/700/695069.pdf>.

Yet as noted in the title of the recent GAO report, additional CMS actions are needed to help ensure data reliability.

In the preamble, CMS notes that some states and managed care organizations are balking at providing both the allowed and paid amounts of their claims to HHS, claiming this information is a vital trade secret. CMS rightly rejects this assertion. We support the proposed change to clarify the reporting requirements that managed care organizations must include both the amount paid and the allowed amount in their reported encounter data.

Additionally, we encourage CMS to increase its efforts to increase accuracy, transparency and accountability of encounter data. The October GAO report recommended that the Administrator of CMS should provide states information on (1) scope and methodology of requirement for encounter data audits; (2) required content of the annual assessments; and, (3) circumstances for deferring or disallowing matching funds in response to noncompliant T-MSIS data submissions.<sup>12</sup>

**Recommendation:** We urge CMS to implement the GAO recommendation and provide states with the guidance needed as promptly as possible.

### **§ 438.334 - Medicaid Managed Care Quality Rating System (QRS)**

Medicare Advantage plans and Marketplace plans both have national quality ratings that inform consumer choice, allow for performance-based incentives on plans, and in general create a platform for quality improvement at both the plan and provider level. In the 2016 Medicaid managed care final rule, HHS committed to creating a quality rating system (QRS) for MMC plans to place Medicaid in alignment with these other types of insurance. HHS seeks to water down the requirement that a state-based alternative be “substantially comparable” to the federally developed Medicaid quality rating system by adding the clause “to the extent feasible.” This introduces an enormous exception states can exploit to implement bare-bones, incomplete rating systems.

CMS is trying to balance to goals recently stated by CMS leadership—“state flexibility” and accountability for outcomes. But the result will be a much smaller set of measures by which to evaluate plan and state quality. The proposal changes “an alternative state QRS produce substantially comparable information to that yielded by the CMS-developed QRS” to “the information yielded be substantially comparable to the extent feasible to enable meaningful comparison across states”. The proposal then--trying to salvage a national Medicaid quality rating framework--adds “a uniform set of mandatory measures”.

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<sup>12</sup> *Ibid.*

The April 2016 rule envisioned a uniform set of mandatory measures, and it was called a national quality rating system.

This will lead to a CMS quality rating that is a lot less than national and a set of mandatory measures that tells CMS or consumers much less than what they should know. CMS leadership's emphasis on state accountability and emphasis on state flexibility are in conflict on this issue.

Second, HHS further undermines the QRS process by proposing to eliminate a pre-approval requirement for states pursuing an alternative QRS. HHS suggests that pre-approval may cause implementation delays for states developing an alternative QRS. This provision involves two key changes. First, HHS would shift the timing of the public stakeholder process from "prior to submitting a proposal" to "prior to implementing and alternative quality rating system." This change could allow states to develop a proposal behind closed doors and treat the public comment process as a last minute formality after plans for implementation are well under way. Second, the proposed rule would eliminate the pre-approval requirement, instead asking states provide HHS the alternative QRS framework and associated materials for review upon request, and that HHS would identify potential deficiencies and work with states to correct them. (83 Fed. Reg. 57281). This passive approach to overseeing alternative QRS encourages states to pursue their own alternative systems and increases the chance that those alternatives will be inadequate, particularly given the large loophole proposed in § 438.334(c)(1)(ii) (see above).

**Recommendation:** HHS should not change the current regulations.

## **§438.400 -408, Grievance Systems**

### **§438.400, Statutory basis and definitions.**

CMS proposes redefining adverse benefit determinations for which enrollees must receive written notification. Specifically, CMS proposes changing (b)(3) in this section, "denial of service" to exclude notification of claims denied for administrative reasons. An example given is a missing provider number. The rationale provided is that notification is an unnecessary burden for managed care plans and that notifying enrollees when denials are for purely administrative reasons can create confusion and anxiety among enrollees. CMS noted that this change is "not expected" to expose enrollees to financial liability or jeopardize access to care.

As with many of the proposed changes, CMS fails to support its contention that the current system creates enrollee confusion or fully assess the potential impact on beneficiaries. This information may protect Medicaid beneficiaries if providers attempt to bill them, in a case where Medicaid payment is delayed or denied for administrative reasons.

While we recommend retaining the current requirement, if this proposed change is implemented, at the least CMS should provide guidance that states and managed care entities must make it clear to provider that they are prohibited from billing Medicaid beneficiaries if they are not paid.

**Recommendation:** Retain the current notification requirement.

**§438,402 and 406, General Requirement and Handling of Grievances and Appeals.**

CMS proposes removing the requirement that oral appeal requests be followed with written requests signed by the enrollee, unless the enrollee requests expedited appeal. In proposing to remove this requirement, CMS notes that they have received comments that the requirement for a written appeal poses a barrier to enrollee appeals submissions and creates problems for managed care plans who must invest resources to encourage enrollees to submit written appeals.

CMS notes that it considered retaining the written appeal requirement, but permitting managed care plans to proceed on the basis of the oral appeal if the plan could show that a good faith effort was made to obtain a written appeal. However, the agency notes that approach was abandoned because demonstrating a good faith effort would create too much of a burden on plans.

We fully support changes that would expedite and ease the appeals process for enrollees. However, changes must be weighed against other factors. This change will likely result in a decline in written appeals documentation. That could have negative consequences for enrollees, both in terms of individual appeal resolution and overall plan quality monitoring.

We urge CMS to adopt the approach that it considered but rejected, i.e., allow plans to accept an oral request alone after a specified, documented good faith effort (e.g., three attempts over a one month period) to obtain a written request.

**Recommendation:** Accept oral appeal request after good faith effort on part of the plan to obtain a written request.

**§438.408: Resolution and Notification Grievance and Appeals.**

CMS proposes reducing the time frame for enrollee's to request a state fair hearing from 120 days to a range of 90 to 120 days.

The rationale given for this proposed change is to give states the option to make the appeals time frame consistent with the 90-day time frame required for fee-for-service claims. CMS notes that states have commented on the cost and confusion of adhering to two different filing time frames. States that are overly burdened by the cost of adhering to two different filing time frames have the option to extend the time frame for fee-for-service fair hearing requests to 120 days. That would resolve the issue of costs associated with two time frames.

Yet CMS opts to give states the option to adhere to a lower standard, rather than pointing out that states could resolve the discontinuity problem by applying the higher 120 standard across the board, again opting for the position that favors plans or states over beneficiaries.

**Recommendation:** We recommend retaining the 120 day standard.

## **Additional issues in CHIP not addressed by the proposed rule**

### ***Reporting and Monitoring***

HHS currently requires states with separate CHIP programs, Medicaid expansion, and hybrid programs to submit an annual report describing enrollment, eligibility, and other features (42 C.F.R. § 457.750). However, the information provided is too limited to provide effective program evaluation and oversight. Strong state management and oversight is critical to program integrity.

**Recommendation:** Extend the state monitoring, oversight, and transparency requirements at 42 C.F.R. § 438.66 to CHIP.

### ***Beneficiary Support System***

The proposed rule does not require a beneficiary support system (BSS) in CHIP like the one in Medicaid authorized under 42 C.F.R. § 438.71. It should.

Managed care can be difficult for any consumer to navigate. Those difficulties can be compounded for lower income consumers. Therefore, we strongly support the creation of a mandatory beneficiary support system to help enrollees choose the most appropriate managed care plan to meet their needs; provide assistance and education in understanding managed care, including enrollee rights and mechanisms for advocacy; and provide assistance in navigating the grievance and appeal process. These services must be provided by knowledgeable professionals in a conflict-free manner that is accessible for enrollees and their caregivers. While choice counseling may not always be relevant to CHIP because there may only be one enrollment option, other aspects of the beneficiary support system are applicable. We recommend adding a new section to subpart L of part 457 requiring a beneficiary support system to meet the needs of CHIP enrollees and their caregivers.

**Recommendation:** Require a beneficiary support system to meet the needs of CHIP enrollees.

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In conclusion, we want to reiterate that it is premature to make many of the changes proposed. While CMS gives great deference to convenience for states and plans throughout much of the proposed changes, in many cases, the agency has not adequately (or at all) assessed the impact of the proposed changes on Medicaid beneficiaries. Such an assessment is critical for CMS to fulfill its role overseeing the Medicaid program.

Thank you for your consideration of our comments. If you have any questions, please feel free to contact Dee Mahan at (202) 628-3030 or by email at [dmahan@familiesusa.org](mailto:dmahan@familiesusa.org).

Sincerely,

Dee Mahan  
Director, Medicaid Initiatives