



January 14, 2019

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

Submitted via www.regulations.gov

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

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed rule, **Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care** published in the *Federal Register* on November 14, 2018.

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that deliver affordable, high-quality coverage and care. ACHP members are non-profit, provider-aligned health plans that provide coverage in all lines of business for more than 21 million Americans across 34 states and the District of Columbia. The community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, patient-centered medical homes, accountable health care delivery, information technology use, and other innovations to improve affordability and the quality of care that patients receive.

We applaud CMS' effort in reducing unnecessary and duplicative administrative burden and ensuring that states are able to design, develop and implement Medicaid managed care programs that best meet their local populations' needs. The rule reflects several ACHP recommendations and facilitates the ability of plan sponsors to strengthen benefits that reflect the needs of their enrollees and administer coverage efficiently. We highlight the following:

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Information Requirements

Language and Format

CMS is proposing to change current requirements for written materials so that these requirements are only applicable to written materials that are critical to obtaining services, and would eliminate requirements that written material be in large print, and instead require that material critical to obtaining services be printed in a conspicuously-visible font size. ACHP supports this proposed change and believes that it will give plans increased flexibility to provide beneficiaries with written communication that is most appropriate for their particular needs.

Information for all Enrollees of MCOs PIHPs, PAHPs, and PCCM Entities: General Requirements

CMS is proposing to extend the notification period regarding a provider's termination from the current 15 days to 30.

ACHP supports this modification and believes that extending the notice period will reduce the occurrence of unnecessary termination notices, and will provide beneficiaries with more accurate information on their provider networks.

Information for all Enrollees of MCOs, PIHPs, PAHPs and PCCM Entities: Provider Directories

Currently, paper provider directories must be updated at least monthly. CMS is proposing to extend the period to quarterly updates if the plan has a mobile-enabled electronic provider directory.

ACHP supports this modification and we appreciate CMS recognizing that current technology offers advances that can provide beneficiaries with improved access to plan information. Many beneficiaries utilize electronic communications to access healthcare information, so requiring monthly updates to paper provider directories is unnecessarily burdensome and does not provide additional beneficiary protections.

Network Adequacy Standards

CMS is proposing to make substantial changes to current Medicaid managed care network adequacy standards. Currently, states are required to have in place time and distance standards to enforce network adequacy standards. CMS is proposing to eliminate state time and distance standards and add a more flexible quantitative minimum access standard for specified health care providers and LTSS providers.

ACHP supports CMS' move away from time and distance standards in Medicaid managed care. States are in the best position to determine adequate safeguards of network adequacy that also reflect the unique provider availability of each state.

ACHP agrees with CMS that time and distance may no longer be the most effective standard for determining network adequacy and that time and distance analysis produces results that do not accurately reflect provider availability. ACHP supports abolishment of these outdated standards. Time and distance standards are based on a fragmented fee-for-service system and a “bricks and mortar” approach that assumes access can be provided only by geographic proximity. These standards may require health plans to contract with providers that may not share the plan’s goals for quality and value or be willing or able to participate in a more coordinated or integrated approach to care. Those providers also may not be willing or able to participate in a value-based model of payment.

ACHP member plans are able to provide high quality care by carefully choosing providers and continuously working with them to manage care and assure patient satisfaction. The emphasis on the physical location of a provider can impede the ability of these high value networks to continue to provide high quality, coordinated care.

In addition, advancements in telehealth have significantly enhanced access to care and further illustrates that evaluating time and distance is an outmoded approach to determining network adequacy. Telehealth has made it possible for a provider to treat a patient well beyond the scope of current time and distance standards and ACHP believes that it is appropriate to take this into account when states develop their own network adequacy standards.

Medicaid Managed Care Quality Rating System

CMS is proposing several changes to the Medicaid Managed Care Quality Rating System (QRS). Under existing guidelines, states are required to either adopt the managed care quality rating system that is being developed by CMS or develop their own system. A state’s system must be approved in advance by CMS and must produce performance data which are substantially comparable to that yielded by the CMS system. The proposed rule would allow state developed QRS frameworks to align with CMS framework *where appropriate* instead of requiring that the data be substantially comparable. States would also be able to implement an alternative QRS without obtaining prior approval by CMS.

ACHP supports the continued development of the Medicaid QRS system. A well-structured QRS could be instrumental in promoting high quality managed care for Medicaid recipients. ACHP believes that an effective QRS will reward high performing managed care plans with incentives that recognize the exemplary quality these plans bring to their beneficiaries. Some incentives that could be offered include driving enrollment into higher rated plans, bonuses, and offering higher capitation rates for the highest performing plans. CMS should incorporate incentives for high performing plans as it continues to finalize the federal QRS program.

ACHP also supports including mandatory performance measures in the federal QRS and requiring states to incorporate those mandatory measures in their alternative QRS system. As the QRS system continues to be developed, we ask CMS to have a robust public notice and

comment process for stakeholders to provide feedback during the development of the standardized set of measures that states' quality rating systems will have to measure and report on.

ACHP supports states being granted flexibility to develop their own QRS that reflects the needs of individual beneficiaries. However, ACHP is concerned that by eliminating the requirement that state QRS's must be substantially comparable with CMS framework, CMS is losing an opportunity to create a standardized QRS that is able to identify and reward the highest performing managed care plans.

In the final rule, we ask CMS to define and provide examples of what constitutes an appropriate alternative QRS. We also ask that CMS continue to require states to seek prior approval from CMS before they implement their own alternative QRS. This requirement will not be overly burdensome on states and will ensure that the alternative QRS meets basic suitability standards and promotes high-quality managed care.

ACHP appreciates CMS' response to recommendations that we and others have made for regulatory relief and administrative flexibility. Thank you for considering our views on the proposed rule. If there are questions or a need for additional information, please contact Kyle Levin, Manager of Public Policy, at klevin@achp.org.

Sincerely,



President and CEO
Alliance of Community Health Plans