Community Health Councils

January 7, 2019

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8013

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

Dear Administrator Verma,

Community Health Councils (CHC) submits the following comments to the Center for Medicare and Medicaid Services (CMS) Department of Health and Human Services' in opposition to the proposed changes to the Medicaid and CHIP Managed Care Regulations that were published in the Federal Register on November 14, 2018.

CHC is a non-profit, community-based health education and policy/systems change organization committed to promoting social justice and achieving equity in community and environmental resources for underserved populations. For over 26 years, CHC has been at the forefront of policy work to eliminate health disparities by promoting social justice and achieving equity in community and environmental resources to improve the health and well-being of underserved populations. Our network of coalitions is comprised of over 100 neighborhood leaders, consumer advocates, healthcare and social service providers, academic institutions, and faith-based organizations serving communities in South Los Angeles, across Los Angeles County, throughout California and the nation. Our healthcare work is built on the following values:

- Healthcare coverage must be available for all and reduces the number of uninsured;
- Healthcare systems need to provide individuals with access to quality and comprehensive services that are affordable and provided in a timely manner;
- Healthcare systems must engage in coordinating efforts to reduce disparities in health outcomes, improve the quality of healthcare delivery, and preserve the healthcare safety-net; and,
- Consumers must be provided with the appropriate information and resources to be able to understand and navigate their healthcare coverage and the healthcare system either on their own or with the help of others.

Based on current evidence, CHC firmly believes having the right care, at the right time, in a language that can be understood, without having to travel far in many cases can mean the difference between life and death. The proposed rule is seeking to make several significant changes to the comprehensive Medicaid and CHIP Managed Care Regulations that were finalized in 2016, based on considerable stakeholder feedback and engagement. While these proposed changes are supposed to streamline and strengthen the Medicaid system, they will

instead **limit and threaten access to healthcare systems and health resources across the nation.**

It is based on this concern and misalignment with CHC's values that we do not support the proposed changes. Below we offer specifics on the proposed changes we are most concerned about.

Network Adequacy Standards

Network adequacy standards ensure that consumers are able to access healthcare providers in a timely manner, taking into account geographic and other sociocultural barriers, such as language access. These standards are especially crucial for vulnerable populations, such as communities of color, who largely make up the Medicaid Managed Care population.[i] Communities of color largely face disproportionate barriers to accessing their healthcare, such as an insufficient distribution of providers, transportation barriers, language barriers and lack of flexible hours. [ii] *Network adequacy standards ensure that despite all these barriers, timely, culturally competent care is accessible.*

CMS is seeking to undo the 2016 Medicaid and CHIP Managed Care Final Rule so that states are no longer required to develop time and distance standards. Instead, states will be allowed to develop any "quantitative standards," as defined by each state. Additionally, the proposed rule explicitly clarifies that states will define what specialists are subject to the quantitative standards. While each state would have the opportunity to make its own network adequacy standards, there is a concern that in some states patients will receive inadequate care, especially for those individuals with higher-cost conditions.[iii] *There is a fear that some states will become lenient in determining its time and distance standards merely because they would be afforded the right to do so, which offers a focus on provider needs rather that patient needs.*

California's network adequacy standards exceed the federal government's requirements and can be taken as a model at the Federal Level to assure adequate access to high quality care. The California Department of Health Care Services (DHCS) is responsible for the oversight and monitoring of health plans to ensure that the state meets and maintains its network adequacy standards. The state takes a vigorous approach and takes into consideration additional factors when setting time and distance standards, similar to those required in the 2016 final rule: [iv]

- Anticipated Medicaid enrollment;
- Expected utilization of services;
- Characteristics and healthcare needs of specific Medicaid populations covered by plans;
- Number and types of network providers (regarding specialization, training and experience);
- Number of network providers who are not accepting new patients, the geographic location of network providers;
- Ability of network providers to communicate in non-English languages;
- Ability of network providers to ensure access;
- Availability of culturally competent care to those with disabilities; and,
- Use of telemedicine or similar technologies.

California also considers beneficiary demographics, geographic differences, and provider availability to name a few.[v] When looking at California's Final Network Standards for Adult and Pediatric Primary Care Services, it is stipulated that such services must be 10 miles or 30 minutes from the beneficiary's residence. However, this is not true for other states. CMS conducted a study in 2014 and found that three states had their maximum distance to PCP to be 60 miles.[vi] Having a hospital within 10 miles compared to 60 miles away from a person's place of residence can be the difference between life and death. In the United States nearly 16%of America's mainland is 30 miles or more away from a hospital with emergency care and 30 million do not live within an hour of trauma care. [vii] Without specific network adequacy standards individual's lives are put in jeopardy, as they will not be able to get proper care in a timely manner.

CHC firmly opposes the proposed change to the Network Adequacy Standard because without proper oversight of the state's network adequacy, healthcare consumers may be put in life-threatening situations because they do not have adequate access to the services in a timely manner.

Beneficiary Information

The proposed rule seeks to change the way plan enrollees obtain information about their health plans. The first proposed rule change would extend the time in which a managed care plan must notify enrollees that their physician has left the network from 15 days to 30 days. *Given the complexity of an already complicated system, extending the notification period from 15 days to 30 days would extend and set back an enrollee's timeframe to be able to find a new provider in a timely manner.*

Second, the proposed rule would remove the requirement indicating whether a provider has received cultural competency training in the provider directories. Given how diverse our country is, it is essential to have this training indication. When health providers are sensitive to the beliefs, practices, and culture of their patients, it is conducive to a good patient-provider relationship and vice versa. Such relationships can lead to better care and health outcomes. *Removing this indication will limit a patient's confidence in choosing a provider that is best suited for them, preventing adequate access to healthcare services.*

Thirdly, the proposed rule would remove the requirement to update paper copies of provider directories monthly when the health plan has a mobile-enabled online directory. It is important for beneficiaries to know what providers are in their network. *The rule change will hinder some beneficiaries from obtaining this information.* In a recent study, CMS notes that 64% of low-income households own a smartphone, while 36% do not. And, of the 64% of low-income households that own a smartphone not everyone who has a smartphone knows how to navigate complex plan websites to get provider directory information or read such details in electronic format.[viii] *Additionally, technology often glitches; therefore, relying on the mobile-enabled online directory is not sufficient in providing beneficiary information.*

Finally, when it comes to individuals getting their healthcare needs met, taglines play an essential role in ensuring that individuals understand all important information that is related to their care. The proposed rule would eliminate the 18-point font standard for large print taglines

and instead states that fonts should be "conspicuously-visible," rather than defined at a set standard across the nation. With changes to the taglines it will impede access to care as conspicuously-visible font sizes are subjective and will prevent those with visual disabilities from being able to obtain important information regarding their healthcare plans and needs. Moreover, taglines would only be required for documents that are "critical to obtaining services." This may cause other critically important information to fall outside of the scope of what is considered significant, as it will be left up to the purview of each state.

Our healthcare system is vast and complex and Medicaid Managed Care is significantly more complicated to understand. Beneficiaries rely on timely access to information in a variety of mediums in order to navigate their care.

CHC opposes the proposed changes to how information will be presented because they would hinder beneficiaries' abilities to understand their care and play an active role in managing their health.

Notice and Appeals

The proposed rule seeks to make changes to the grievances and appeals process that are concerning:

- For Adverse Benefit Determinations, CMS is proposing to remove the notice requirement when the sole reason for denial is administrative, and there is no financial liability for the enrollee. Documentation is vital in every step of the process; a written notification serves as confirmation or evidence and can answer important questions regarding next steps or contact information for a beneficiary. Written confirmations, especially regarding a denial to an adverse benefit determination, provides proof that the consumer has done nothing wrong on their part. This is especially crucial given that system glitches can and do occur from time to time. The implementation of the Affordable Care Act (ACA) saw numerous administrative glitches: health plans were supposed to get a report when a consumer used HealthCare.gov to buy their health insurance policy, however reports contained inaccurate data. [ix] Errors and glitches will occur regardless of the regulations and systems in place; written notices help to prevent errors and provide clarification for both consumers and administrators.

- Additionally, the timeframe for enrollees to request a state fair hearing would change from 120 days and would allow states to set a range between 90 to 120 days. The regulations are absent any criteria on how decisions will be made in determining the timeframe including ensuring there is no harm to the consumer. Furthermore, we affirm that 120 days is reasonable and should not be shortened as it takes time to pull evidence together, gather proper documentation, and seek out legal help, among other tasks that might be required for this process. It is essential that the beneficiary has every opportunity to make their case and this includes there being a sufficient amount of time for the appeals process.

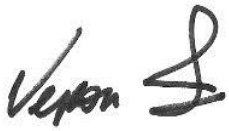
- Lastly, CMS also proposes to eliminate the required written confirmation of oral appeals. Having a written confirmation will help to streamline and reduce any confusion and be able to provide evidence to the beneficiary of their oral request.

CHC opposes the proposed notice and appeals changes as it would prevent beneficiaries from having written proof regarding motions that have positively or adversely affected their case. The proposed rule limits the opportunity for beneficiaries to effectively review and make an appeal request if they so choose, in addition to other circumstances that they may be facing.

In summary, the proposed changes will undo the work of ensuring that all individuals have access to quality healthcare. Even though California has its own strong regulations, values health care, and is not likely be impacted by the proposed changes, we are concerned that putting Network Adequacy Standards in the hands of states that do not value similar standards, or the variety of factors to take into consideration when setting their standards would be detrimental for the consumers of those states. These rule changes do not take into consideration those with disabilities, cultural differences, and low-income households with limited resources. **Contrary to what is stated, these rule changes eliminate transparency and fairness while putting up barriers that limit the rights of individuals to access health services. For these reasons, Community Health Councils urges CMS to withdraw this proposal.**

If you have any questions, please feel free to contact Chief Program Officer, Sonya Vasquez, at svasquez@chc-inc.org.

Sincerely,



Veronica Flores
Chief Executive Officer

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[ii] Families USA. 2014. Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color. Accessed at: https://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_082214_web.pdf

[iii] Hall, Mark, Brandt, Caitlin. 2017. Network Adequacy Under The Trump Administration. Health Affairs. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full/

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[v] Ibid.

[vi] Department of Health and Human Services Office of Inspector General. 2014. State Standards for Access to Care in Medicaid Managed Care. Accessed at: https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

[vii] Ostroff, Caitlin, Frisbie, Ciara Bri'd. 2017. Millions of Americans Live No Where Near A Hospital, Jeopardizing Their Lives. CNN. Accessed at: https://www.cnn.com/2017/08/03/health/hospital-deserts/index.html

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