

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 14, 2019

By electronic delivery to www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2408-P
7500 Security Boulevard
Baltimore, Maryland 21244

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

Justice in Aging appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the above-referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have extensive experience with Medicare, Medicaid, and the Affordable Care Act (ACA), with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

We have decades of experience with Medicaid, with a particular focus on long-term services and supports. Our recent work is heavily focused on managed care, both in Medicaid managed care programs and in the dual eligible financial alignment demonstrations. Please find our comments below.

1. Standard Contract Requirements (§438.3)

The NPRM proposes to revise Section 438(t) to remove the requirement that, in states where the state Medicaid agency has delegated to MCOs the responsibility for coordinating benefits for dual eligibles, the MCO must enter into a Coordination of Benefits Agreement (COBA) with the Medicare program. As proposed, CMS would give states the option of, instead, specifying an alternate methodology by which the state would ensure that MCOs receive all appropriate crossover claims.

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A crossover claims system that runs smoothly and efficiently is important for enrollees for two related reasons. First, Medicare providers are more likely to be willing to serve Qualified Medicare Beneficiaries (QMBs) and other dual eligibles if they know that, whatever remittance they are due, the payment will arrive promptly and will not place any additional burden on the provider's administrative and billing systems. Second, providers who are promptly and accurately paid are less likely to engage in improper billing of QMBs and other dual eligible patients.

Justice in Aging had been pleased with the adoption of Section 438(t) because we saw these problems arise for enrollees, particularly in the California Coordinated Care Initiative (CCI) when the state required most dual eligible in CCI counties to enroll in MCOs. Several MCOs did not have COBA agreements and each had its own requirements for submitting claims after a Medicare provider remittance. The process—some MCOs wanting paper claims, others electronic—was a nightmare for providers and a strong disincentive to serve QMB patients. A [chart on the CalDuals website](#) attempting to assist providers through the maze shows how complex the system had been.¹

The modification to the regulation that is now proposed raises questions for us about how states are coordinating benefits and the complexity of those arrangements. If some flexibility is needed to support procedures that are working well, we would not object, but we do question how the procedures described in the NPRM actually work and whether they are, in fact, efficiently serving provider and enrollee needs.

We note that states with dual eligibles in MCOs have the option of retaining payment of crossover claims in-house within the Medicaid agency or of delegating payment to MCOs. It seems to us that states should be required to adopt one option or the other. If a state decides to delegate crossover payment responsibility to an MCO, that delegation should cover all claims for all Medicare covered services. That delegated responsibility could be handled as part of the negotiated capitated payment or as a direct pass through. Having the Medicaid agency pay some crossover claims and the MCO pay others seems to us to be duplicative and overly cumbersome.

Payment of crossover claims is purely an accounting function that does not require any determination of medical necessity or any specialized expertise. If Medicare covers a service, the remittance responsibility for crossover claims is simply to pay the provider according to a payment schedule set by the state. If a state has chosen to carve out behavioral health for Medicaid services, as in the example in the NPRM, there is no necessity to carve out payment of Medicare crossover claims for Medicare services that happen to relate to behavioral health.

Looking at the example in the NPRM, it appears that the state in the example operates a system where all crossover claims are funneled through the state. The state then processes those

¹ http://calduals.org/wp-content/uploads/2016/08/PhysToolkit_crossover_all-R7.pdf.

claims related to behavioral health, but passes on to the MCO claims for other services and, in those rare instances where a service involves oral health, passes on those claims to the PAHP responsible for Medicaid dental services.² As a result, though the overwhelming majority of Medicare crossover claims would be in the purview of the MCO, all claims are subject to this two-step process. This inevitably slows down payment. CMS has proposed to require states in those instances to send notice to the provider that the claim is being forwarded to the MCO. While that is useful information, it does not address the core concern of complexity and delays.

The NPRM also notes that states have asked for the change because there can be issues when individuals change plans. We agree that data lags for MCO membership changes can cause many problems for enrollees and providers, including problems that more directly affect enrollee access to services. Lags in recording changes in plan membership are best addressed directly through more frequent and accurate data exchange,³ rather than through slowing down and complicating the crossover claim process.

In light of these concerns, we ask that, instead of changing the regulation, CMS work with states to simplify and streamline their procedures so that all crossover claims can be handled promptly by one entity, either the state Medicaid agency or the MCO, without intermediate steps. We note that when CMS adopted Section 438.3(t), it allowed states time to get COBA agreements in place. If more time is needed to help some states to rationalize their procedures, we believe the better course would be extend the time for enforcement rather than to modify the regulation.

2. Information requirements (§ 438.10(d)(2))

We strongly oppose the proposed changes to language access requirements. Clear enforceable language access standards act to ensure people with disabilities and individuals with Limited English Proficiency (LEP) have genuine access to health care and decrease the significant disparities in access to care these populations experience.

Access for persons who are visually impaired

Current regulations require taglines in large print no smaller than 18-point font (42 C.F.R. § 438.109d)(2)). In 2016, HHS explained that it based this standard on guidance from the American Printing House (APH) for the Blind (81 Fed. Reg. 27724). The APH's 18-point font standard was based on research conducted on the "impact of print characteristics on readers." HHS is now proposing to replace this evidence-based standard with a vague and subjective requirement that taglines be "conspicuously visible." We oppose this change.

² Because Medicare coverage of dental procedures is currently very limited, and thus the volume of crossover claims would be quite small, we question whether a dental PAHP would actually have procedures in place to properly process the very rare crossover claims that might be submitted.

³ See, e.g., SMDL #18-012, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicare and Medicaid (Dec. 19, 2018), available at www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf.

Limiting information access through taglines

HHS is proposing to limit the use of taglines to materials deemed “critical to obtaining services.” This is a vague standard that also fails to make clear who makes a determination of whether information is critical to obtaining services. Furthermore, the entities governed by this rule are also subject to Section 1557 of the Affordable Care Act that requires taglines on all “significant” documents. The proposed rule would create a different standard subjecting plans to increased administrative burden in order to comply with competing standards. Taglines have proven to be a low-cost and effective means of communicating information to LEP individuals and people with disabilities, and, accordingly, the current requirement should be maintained.

3. Provider directories (§ 438.10(h))

We believe that at this time it is premature to decrease the frequency health plans must update printed provider directories from a monthly basis to a quarterly basis when health plans also offer mobile-enabled electronic directories. While we recognize the burden of updating written provider directories on plans, access to accurate provider directories is critical to ensuring enrollees or potential enrollees are able to make informed choices and access care.

Low-income Medicaid enrollees may have cell phones, but use of smart phones and access to data packages that permit online use remain limited. U.S. Census data shows that low-income persons are less likely to have access to broadband and internet services. For example, more than one in five Virginian households (21.4%) lack broadband internet access.⁴ Nationwide, half of households with incomes under \$25,000 have either no computer or no broadband at home.⁵

In the absence of additional research on enrollee preferences for print versus mobile/electronic formats and accessibility, we encourage HHS to maintain the current standard.

4. Network adequacy standards (§ 438.68)

We oppose the proposed changes to the network adequacy standards, and strongly urge HHS to go further and promulgate prescriptive federal standards. Strong network adequacy requirements are critical in ensuring that managed care enrollees have access to their covered services. Inadequate or narrow networks also lead to surprise billing or improper billing of Medicaid recipients.

⁴ Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015* 8 (2017), <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>.

⁵ *Id.* at 9; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>.

Time and distance standards, which are currently required under the rule for many provider types, including LTSS where the enrollee travels to the provider, are crucial in ensuring provider access. Without providers close enough to travel to, enrollees have no meaningful access. Time and distance metrics are, therefore, an important first step in establishing network adequacy. Accordingly, we urge HHS to continue to maintain the time and distance standards in their current form.⁶

Moreover, we strongly encourage HHS to adopt additional national quantitative standards and minimum requirements. Consistent standards across states provide a baseline and allows regulators to make apples to apples comparisons over time, hold health plans accountable, and guarantee that all Medicaid enrollees, regardless of where they live, have equal access to care. Medicare Advantage rules, for example, include minimum standards for regional and geographic access based on population and density, provider to patient ratios, and time and distance standards. These prescriptive standards are equally appropriate for Medicaid managed care given the low-income and high need population served by the program.

We also strongly encourage HHS to improve both federal and state oversight of network adequacy. CMS oversight is needed to guarantee that states' development of network adequacy standards complies with federal rules and that states are adequately monitoring compliance of their contracted plans. For example, under the current rule, states are required to set time and distance standards for LTSS providers that enrollees must travel to. Yet, California in finalizing its network adequacy standards excluded nursing facilities and adult day health care centers despite enrollees having to travel to these providers.

California argues that time and distance standards do not apply to nursing facilities because the enrollee "resides at the facility of care."⁷ The final managed care rule, however, does not permit this exclusion. In fact, it is hard to imagine what the final rule was intending when it set time and distance standards with regard to LTSS if nursing facilities were somehow excluded because the enrollee "resides at the provider," and therefore, neither travels to the provider and the provider does not travel to the enrollee. Of the three LTSS benefits that California's managed care plans are responsible for delivering in which the enrollee travels to the provider, California has determined that no network adequacy standard applies. California's reasoning is entirely contrary to the rules set forth in the managed care final rule, and as implemented fails to improve access to these covered LTSS benefits. This example illustrates the need for CMS oversight of how states are implementing the network adequacy standards set forth in the managed care rule.

⁶ HHS notes that time and distance standards may not properly account for access to telehealth. Preamble at 57278. This does not mean, however, that time and distance standards should be discarded altogether. Rather, HHS could provide guidance to states on how to account for telehealth when devising time and distance standards.

⁷ California Department of Health Care Services, Medicaid Manage Care Final Rule: Network Adequacy Standards (2018), available at <https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf>.

LTSS

We strongly recommend that HHS retain time and distance standards for LTSS when enrollees are traveling to providers. As with medical services, time and distance standards for LTSS ensure that enrollees have meaningful access to these benefits. With regard to nursing facility and other institutional-type LTSS, time and distance standards also ensure that enrollees are able to maintain their relationships with their community and family during their time in a facility. If an enrollee has to enter a facility far way (either in time or distance) from their home and community, they are less likely to be able to maintain the support networks they will ultimately need to successfully transition back into the community.

With regard to network adequacy standards for LTSS providers who travel to the enrollee, we encourage HHS to provide states with increased guidance rather than less, including, for example, network adequacy metrics based on choice standards, service fulfillment standards, and provider ratios. Guidance should ensure that networks for LTSS services in which the provider travels to the enrollee are just as robust as those in which the enrollee travels to the provider.⁸

The final rule currently provides states with significant flexibility in setting network adequacy standards that has led to wide variation in standards across states. This proposal takes a step in the wrong direction in allowing even more flexibility rather than moving towards a national standard that ensures equal access to Medicaid-covered services for all enrollees. We therefore strongly oppose these proposed changes and urge HHS to maintain the current standards and improve upon them by setting more prescriptive national standards and increasing oversight of the rule's implementation in states.

5. Grievances and appeals— Statutory basis, definitions, and applicability (§ 438.400)

Adverse Benefit Determination. We do not object to CMS' decision to exclude denials of payment for failure to submit clean claims from this definition. We do, however, urge CMS to include in its guidance that states and plans must make it clear to providers that they are prohibited from billing Medicaid enrollees if they do not get paid for failure to submit a clean claim.

6. Handling of grievances and appeals (§ 438.406)

We support CMS' decision to remove the requirement that enrollees must confirm oral hearing requests in writing. This is an important change that will protect enrollees' due process rights.

⁸ Community Living Policy Institute, University of California San Francisco, Managed Long-Term Services and Supports: Assessing Provider Network Adequacy, available at <https://clpc.ucsf.edu/publications/managed-long-term-services-and-supports-assessing-provider-network-adequacy>.

Thank you for this opportunity to comment in response to this proposed rule on Medicaid Managed Cares. If you have any questions or concerns about our recommendations, please contact Amber Christ at achrist@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" being more prominent than the last name "Goldberg".

Jennifer Goldberg
Deputy Director