



January 14, 2019

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Washington, DC

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

Dear Administrator Verma:

The American College of Physicians (ACP) appreciates the opportunity to comment on the Medicaid and Children's Health Insurance Program Managed Care proposed rule. ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Standard Contract Requirements (438.3)

According to the 2015 proposed rule the intent of 438.3(t) is to prevent providers from having to submit separate claims to different payers in electronic or paper formats and to encourage providers to care for more dual-eligible enrollees. ACP is concerned that this revised proposal could result in additional administrative burdens, claims denials, and confusion for physicians and other health care professionals. States should only be permitted to maintain an existing crossover claims process if it does not lead to additional administrative hassles, delayed payments and other problems for physicians. We request the agency to reconsider this proposal.

Delivery System and Provider Payment Initiatives Under MCO, PIHP, or PAHP contracts (438.6 (a) and (c))

The College believes Medicaid value-based purchasing arrangements should result in improved quality, care, and physician participation. The proposal to expand the types of payment

arrangements to include Medicare-equivalent rates may help to incentivize physician participation in Medicaid and enable participating physicians to serve more Medicaid enrollees.

ACP continues to support the Patient-Centered Medical Home (PCMH) model, a team-based model that emphasizes care coordination, a strong physician-patient relationship, and preventive care. According to the Kaiser Family Foundation, 29 states report that at least some beneficiaries are served by a PCMH in their Medicaid programs (1).

Wider implementation of the PCMH model through MCO and other contracts may encourage delivery of care based on value rather than volume and improved patient experience as well as achieve other important goals such as the integration of behavioral health into the primary care setting.

#### Information to Plan Enrollees (438.10)

Medicaid has become more complex for patients over the last decade as more programs have transitioned from fee-for-service to managed care and introduced concepts typical of private insurance plans such as narrow networks, cost-sharing, and wellness programs. The College believes Medicaid plan materials should be made available to meet the needs of the Medicaid population, including those with disabilities and/or limited English proficiency and literacy. Multilingual Medicaid informational materials and language interpretation services should be made available since more than half of people with limited English proficiency have incomes that would make them eligible for Medicaid.

ACP is concerned about the changes to 438.10(f) that propose to change the requirement that MCOs notify enrollees within 15 days of a covered plan's receipt or issuance of a provider termination notice. Changing the requirement to up to 30 days before the effective date of termination may not give enrollees sufficient time to find and transition to a new physician or other health care professional. We urge the agency to reconsider this change.

Health literacy among racial and ethnic minorities must be strengthened in a culturally and linguistically sensitive manner. ACP has recommended that cultural competency training be incorporated into medical school curricula to improve cultural awareness and sensitivity (2). We request that MCO provider directories continue to be required to disclose whether a physician or other health care professional has completed cultural competence training so that enrollee are matched to the provider that best suits their needs.

We are also concerned about the proposed changes to provider directory requirements. Evidence from the Arkansas Works waiver work requirement implementation effort shows that the Medicaid population may not have ready access to online information sources or may experience confusion navigating web-based information (3). We believe that paper provider

directories must be updated on a regular basis and that online resources and mobile phone-based applications should supplement, not replace, accurate paper directories.

#### Network Adequacy Standards (438.68)

We strongly oppose the elimination of requirement that states develop and enforce time and distance standards for primary care and specialist physicians. In general, MCOs and other entities must have a sufficient number of providers to assure that all appropriate services are available and accessible to each enrollee with reasonable promptness and immediately available when medically necessary. ACP supported the 2015 proposal to require states to apply travel time and distance standards for primary care providers and other provider categories (4). Time and distance standards are used by Medicare Advantage and private insurance plans to determine network adequacy and provide a more accurate reflection of enrollee access than other standards such as provider-to-enrollee ratios. Medicaid managed care has a history of provider access problems (5) and strong adequacy standards are necessary to prevent MCOs from developing narrow, insufficient provider networks, where primary care physician turnover (and the disruption of the patient-physician relationship) is common (6). We agree that other quantitative standards should be used to obtain a full understanding of the various facets of access but these should be used in addition to and not in place of time and distance standards.

Additional steps are needed to ensure network adequacy standards are transparent and enforced. A recent MACPAC review of network adequacy standards for Medicaid managed care found that state documents were difficult to locate and that “most states do not provide specific enforcement mechanisms for failure to meet access standards or report network data” (7). We urge the agency to work with states to ensure that network adequacy standards are enforced so that Medicaid enrollees have true access to their preferred physician or health care professional.

#### Resolution and Notification: Grievance and Appeals (438.408)

The agency should reconsider the proposal to reduce the number of days an enrollee has to request a state fair hearing for an adverse benefit determination. Capitated managed care is economically encouraged to “underserve” enrollees and plans may be particularly incentivized to deny services (8). As a result, enrollees should be allowed a sufficient amount of time to prepare necessary materials, evidence, and expert advice to substantiate their case. We request that the 120 day timeframe remain.

Thank you for considering our comments. If you have any questions please contact Ryan Crowley, Senior Associate for Health Policy at [rcrowley@acponline.org](mailto:rcrowley@acponline.org).

Sincerely,

Ana María López, MD, MPH, MACP  
President  
American College of Physicians

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<sup>1</sup> Kaiser Family Foundation. States that Reported Patient Centered Medical Homes in Place. Accessed at <https://www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>2</sup> American College of Physicians. Racial and Ethnic Disparities in Health Care, Updated 2010. Philadelphia: American College of Physicians;2010:Policy Paper. Accessed at [https://www.acponline.org/acp\\_policy/policies/racial\\_ethnic\\_disparities\\_2010.pdf](https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf)

<sup>3</sup> Musumeci M, Rudowitz R, Lyons B. Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. December 19, 2018. Accessed at <https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/>

<sup>4</sup> Riley W. Letter to U.S. Department of Health and Human Services. July 27, 2015. Accessed at [https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_proposed\\_rule\\_cms\\_2390\\_p\\_2015.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_proposed_rule_cms_2390_p_2015.pdf)

<sup>5</sup> Levinson DR. Access to Care: Provider Availability in Medicaid Managed Care. Department of Health and Human Services Office of Inspector General. December 2014. Accessed at <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>

<sup>6</sup> Ndumele CD, Staiger B, Ross JS, Schlesinger MJ. Network Optimization and the Continuity of Physicians in Medicaid Managed Care. Health Aff. 2018;37(6): <https://doi.org/10.1377/hlthaff.2017.1410> Accessed at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1410>

<sup>7</sup> Medicaid and CHIP Payment and Access Commission. Network Adequacy in Managed Care. December 2018. Accessed at <https://www.macpac.gov/publication/network-adequacy-in-managed-care/>

<sup>8</sup> Musumeci M. A Guide to the Medicaid Appeals Process. Kaiser Commission on Medicaid and the Uninsured. March 2012. Accessed at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>