

CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS
ADDRESSING PUBLIC POLICY ISSUES IN CANCER

January 14, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Verma:

The undersigned organizations of the Cancer Leadership Council appreciate the opportunity to comment on the proposed rule changing certain standards for Medicaid and Children's Health Insurance Plan (CHIP) managed care. We understand that the proposal is intended to increase the flexibility of states in implementing Medicaid and CHIP managed care programs. However, we have concerns that certain of the changes proposed will adversely affect patient access to quality care.

We represent people with cancer of all ages, and many of them rely on Medicaid for access to care. At least one-third of children with cancer are Medicaid enrollees. For all of these people with cancer, a Medicaid program that ensures access to cancer care specialists, recommended drug therapies, and other elements of quality care is of critical importance. Our comments below reflect the needs of these patients.

In the preamble to the proposed rule, the Centers for Medicare & Medicaid Services (CMS) states that stakeholders have indicated that current regulations are "overly prescriptive and add costs and administrative burden to state Medicaid programs with little improvements in outcomes for beneficiaries." The agency states that it has undertaken a review of current regulations and now is proposing new standards to address burdens in the administration of Medicaid managed care programs.

The 2016 final rule that modernized the Medicaid and CHIP managed care regulations has been in effect for a limited amount of time, and as a result we question whether the concerns and complaints of state Medicaid officials relate to the impact of the 2016 final rule. We suggest that a revision of the 2016 final rule be withheld until its effects can be fully evaluated. This would seem to be a prudent course, in light of the significant time and effort dedicated to the modernization of Medicaid and CHIP managed care standards through the 2016 final rule.

Network Adequacy

During the regulatory process that resulted in the 2016 final rule, we acknowledged the limitations in time and distance standards, applied to specialists, for defining network adequacy. However, we have serious misgivings about the proposal from the agency, as it gives so much discretion to the states that there will be virtually no standards for access to specialists.

The agency proposes to permit states to set a quantitative minimum access standard for specified health care providers. The proposed rule would allow states to choose from a variety of quantitative standards (minimum provider-to-enrollee ratios, maximum travel time or distance from providers, maximum wait times for an appointment, among other standards) and would encourage the use of a combination of these quantitative measures. The proposed rule would also clarify that the states have the authority to define specialist in “whatever way they deem most appropriate for their programs.”

We are concerned that the significant grant of flexibility to the states – flexibility in setting quantitative standards for access to health care providers and discretion to the states in defining specialist – will have the effect of denying Medicaid enrollees of assurances of network adequacy in their managed care plans. We do not believe that the proposed rule achieves a balance of flexibility to the states and protections for patients. We recommend, as noted above, that the 2016 final rule remain in place and its effects on network adequacy be assessed.

Access to Provider Directories

The proposed rule would permit states to make less frequent than monthly updates to the provider directory if the state offers a mobile-enabled, electronic directory. In its justification for this change, the agency cites statistics about smartphone ownership and suggests that consumers can use their smartphones to gain access to provider directories.

Access to an up-to-date provider directory is of critical importance to cancer patients who need to identify a specialist with expertise to treat their kind of cancer.

We have no objection to a movement toward access to mobile-enabled electronic directories. However, we recommend that access to routinely updated provider directories be continued until the states can provide assurances about mobile access. Those assurances would require proof that mobile-enabled access is available and that the vast majority of Medicaid recipients in fact have smartphones for such access. We are expressing caution about this change because of the experience in some states with Medicaid work requirements where recipients are encountering great barriers to accomplishing online registration of their work. This is occurring because Medicaid recipients do not in fact have online access, although in advance of implementation of the requirement it was suggested that they did have such access. We caution against making a similar misstep in this situation, by assuming smartphone access and the ability to access mobile-enabled electronic directories, when in fact that capacity may not exist. We urge that care be taken in transitioning toward mobile access to provider directories, a process that may take some time and that may end with continued access to regularly updated hard copy provider directories.

The proposed rule would also change the timeframe for notices to enrollees regarding the termination of a provider. Currently, plans are required to provide notice of a provider's termination within 15 days of the issuance or receipt of the termination notice. The proposed rule would require that notice be given to enrollees the LATER of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the notice. This change has the potential to create disruptions in care for people with cancer, who may find it difficult to identify a new provider with appropriate expertise for their disease in 30 days or less. We urge that the current standard be retained.

Standards for Appeals

The 2016 final rule requires that an oral appeal be followed by a written, signed appeal. The proposed rule would eliminate the requirement that a written appeal be filed after an oral appeal. The agency argues that this will reduce the burden on enrollees and on states and plans.

Although we appreciate the effort to reduce burdens on enrollees, we do not support the elimination of the requirement for filing a written, signed appeal. We urge that oral appeals be permitted to proceed before the written appeal is filed, but we also recommend that the written appeal requirement be retained. The filing of the written appeal helps to ensure that data are available on appeals filed and processed, as well as data on the disposition of appeals. Finally, data on appeals can provide insights about the operation of plans and patient access to care.

We appreciate the opportunity to comment. We urge that, instead of finalizing the proposed rule, CMS leave the 2016 final rule in place until its effects are understood and only then make a decision about revising the rule's standards.

Sincerely,

Cancer Leadership Council

CancerCare
Cancer Support Community
The Children's Cause for Cancer Advocacy
International Myeloma Foundation
Leukemia & Lymphoma Society
LIVESTRONG
LUNgevity Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Alliance
Prevent Cancer Foundation
Susan G. Komen