July 27th, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule for Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098

Dear Acting Director Slavitt,

AAPCHO thanks CMS for the opportunity to comment on the Medicaid Managed Care rule. Medicaid provides a critical health insurance lifeline for millions of vulnerable Asian Americans, Native Hawaiians, and Other Pacific Islanders (AA & NHOPIs). It is critical that Medicaid be modernized and strengthened. This will ensure that beneficiaries are able to access the high quality of linguistically and culturally competent care to which they are entitled.

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, 29 of which are Federally Qualified Health Centers (FQHCs). AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and care access of medically underserved AA&NHOPIs in the U.S., its territories, and its freely associated states.

AAPCHO members focus on providing services that are uniquely appropriate to their patient populations including: comprehensive primary medical care, culturally and linguistically appropriate health care services, and non-clinical enabling services such as interpretation and case management. On average, AAPCHO's health centers have a higher percentage of patients age 65+ than other health centers (10% vs. 7%). Our members also have a much higher rate of patients who are Limited English Proficient (LEP) (50% vs. 23%), with some health centers serving as many as 99% LEP individuals. AAPCHO members also provide a higher average number of enabling service encounters (9274 vs. 4953) than other health centers in response to the needs of our patients (HRSA Uniform Data System, 2013).

Given the unique patient population served by AAPCHO's members, we recommend that:

- Plans should provide vital information in non-English languages to enrollees, potential enrollees, and the public;
- CMS should strengthen and modernize the definition of "prevalent" languages;
- CMS should require materials to include a specific minimum number of in-language taglines to reflect all prevalent languages in the region;
- Providers' language competencies should be included in provider directories;
- FQHCs should be eligible to become choice counselors for beneficiaries enrolling in plans;
- CMS should collect data on provider language competence to examine network adequacy for LEP individuals;
- AA&NHOPI stakeholders and others who specialize in language access should be included in all stakeholder engagement strategies;

- Plans should cover an initial care coordination review that includes an assessment of the key social determinants of health (SDOH), being aware of the SDOH that impacts different communities;
- Networks must be adequate and payments appropriately set and risk adjusted such that beneficiaries have timely access to culturally and linguistically appropriate services.

AAPCHO's comments on the proposed rule are below:

§438.10 Information Standards

The proposed rule requires states to ensure that a robust set of plan information and materials, including provider directories, handbooks and notices, are readily available and accessible to beneficiaries, in prevalent non-English languages. CMS defines "prevalent" non-English languages as those spoken by a significant number or percentage of potential enrollees and enrollees in the state who are LEP, consistent with the standards used by the Health and Human Services' Office of Civil Rights in enforcing anti-discrimination provisions related to LEP individuals. **AAPCHO recommends that the standards for determining prevalent languages be based on the plan's service area and not based on the state or county. AAPCHO recommends "prevalent" be strengthened and defined as 1,000 or 5% of potential enrollees or enrollees in the plan's service area.**

Plan materials must include taglines in prevalent non-English languages explaining what languages written materials are available in, as well as availability of oral interpretation in-language (and at no charge to the consumer). **AAPCHO recommends that CMS require materials to include a specific minimum number of taglines to reflect all "prevalent" languages in the region. AAPCHO recommends that taglines be available in a minimum of 15 languages.**

Materials must be "readily accessible" to consumers, at an appropriate health literacy level, in English and/or in-language. Information provided electronically will have to be compliant with all language, formatting and accessibility standards and be printable. All information must be made available to enrollees in paper format upon request at no cost and within 5 calendar days. **AAPCHO recommends that the "vital" documents available to consumers in prevalent non-English languages, at a minimum, include: provider directories, member handbooks, appeal and grievance notices, denial and termination notices, enrollment and health access materials and other notices that are critical to obtaining services.**

Many plans have found it useful to develop specific marketing materials for specific populations, ethnicities and cultures. **AAPCHO recommends that CMS adopt a standard set of documents on secondary language access that would require plans specifically marketing to any population to provide materials in the language corresponding to that population.** This is in addition to the requirements listed above. The secondary standard would ensure that plans that directly market to and enroll LEP populations would also be required to provide vital materials in-language.

We are concerned that the proposed rule differentiates between the information needs of potential enrollees – that is, individuals who are eligible for Medicaid coverage but have not yet chosen a managed care plan – and plan enrollees. For example, plans are required to make formulary information and provider directories available to plan enrollees, but not potential enrollees. In many instances, however, potential enrollees would find this information useful as they search for a managed care entity that can meet their health care needs. Other individuals, such as family members, consumer assisters or case managers, may also find this information useful as they help

enrollees access services within the plan. CMS should therefore require states to make all of the information required in this section available to potential enrollees, plan enrollees, and the public, and in all prevalent languages.

§438.10(h): Plan Provider Directories
This rule would expand the information required to be included in provider directories. While the required elements are different than the provider directory elements in commercial and Medicare plans, they are critical for Medicaid beneficiaries. **AAPCHO strongly supports the requirement that the provider directory list each provider's cultural and linguistic capabilities. However, AAPCHO recommends that CMS clarify this provision to require that a provider be sufficiently proficient in a non-English language in order to list language proficiency in the Provider Directory. In addition, AAPCHO would like to see provider directories note if a provider's health facility has qualified certified translators on-site (e.g. Community Health Workers, Case Managers, etc.).**

§438.71: Beneficiary Support System
AAPCHO supports the provisions that require States to provide independent "choice counseling" to all individuals who are enrolling in an MCO. Plans can vary dramatically in the amount, scope and duration of their benefits. Thus, clarity on this range of plan support services is critical for enrollees to make informed choices. FQHCs are experienced at providing non-biased choice counseling for a wide range of beneficiaries and consistent with their experiences as navigators in the Marketplace. They provide high-quality, independent services to beneficiaries; this is particularly true for AAPCHO members who provide counseling in-language. **CMS must ensure that community-based providers are eligible to be choice counselors even if they have contracts with MCOs, and clarify that nothing in this rule would prohibit an FQHC from becoming a choice counselor under this proposal.**

§438.207(b)(1) Assurances of adequate capacity and services
We encourage CMS to retain the provision that MCOs submit regular documentation to the State to demonstrate that they have the capacity to provide services that are adequate for the anticipated number of enrollees and the geography the plan covers. **AAPCHO recommends that CMS encourages MCOs to report data on how many providers they have in-network who can provide services in prevalent non-English languages—and if that network is sufficient for the anticipated number of enrollees in the geography who need this service. If a region has a high concentration of LEP enrollees—but has only one provider who can provide in-language services, whether in one language or many—CMS should use these data to encourage the plan to improve the provider network to reflect the languages spoken within a region.**

Stakeholder Engagement when LTSS is Delivered Through Managed Care
The rule would require States to create and maintain a stakeholder advisory group that consists of beneficiaries, providers and other stakeholders to discuss the design and implementation of the Managed Long Term Supports and Services (MLTSS) program. **AAPCHO recommends that CMS explicitly state that these stakeholder advisory groups must include representatives from AA & NHOPI organizations, as well as include stakeholders who have expertise in language access.**

§438.214 Provider discrimination prohibited

Plans are neither required to contract with all providers nor with more providers necessary to meet the needs of its enrollees. **AAPCHO reiterates its concern that plans must contract with an appropriate number of providers who can serve LEP populations within a facility's coverage area.** It is critical that plans are prohibited from discriminating against providers who serve LEP populations, who may cost more due to having to also mitigate the social determinants of health that their population faces (e.g. language proficiency, environment, cultural biases).

Under this proposal, plans are also prohibited from discriminating against providers who serve high-risk patients or patients who require expensive treatments. AAPCHO centers, for example, see disproportionate rates of hepatitis B, because of the high prevalence among Asian Americans and Pacific Islanders. Treating hepatitis B and resulting complications can be very costly, but addressing the problems early, among providers that are trusted within a community, is incredibly important to reduce the health disparities that exist. Providers who are trusted among AAPI communities, who are knowledgeable about the complex disease should not be discriminated against, because of the high-risk populations that they treat for hepatitis B. We strongly urge CMS to modify the current protection to prohibit MCOs from employing provider exclusion measures to control costs.

438.208(b) Care Coordination Activities

In addition to formally recognizing the role of community-based organizations, this rule proses that MCOs make their best effort to complete an initial health risk assessment of every patient within 90 days of enrollment for all new enrollees. AAPCHO strongly recommends that this initial health risk assessment be mandatory for the MCO. What is more, we recommend that this assessment include a home visit and that it be explicitly possible for existing home visitation programs to include an initial health risk assessment. It is a perfect opportunity to assess the social and economic challenges that a patient may face.

§ 483.3 Covered Outpatient Drugs and Formularies

The proposed regulatory text does not sufficiently protect meaningful pharmaceutical access for Managed Care enrollees. First, we believe that a benchmark or a floor that ensures the MCO formulary is not more restrictive than the FFS formulary is necessary. Otherwise, MCOs can and do move medications recommended for treating chronic and expensive conditions off-formulary. This practice requires individuals and their providers to pursue often burdensome, non-evidenced-based prior authorization processes. CMS must take steps to ensure that most medications do not get hidden behind a "prior authorization" firewall, which slows or denies access to treatments and discourages individuals from obtaining the care they need. We have seen increasing disparities in access to Fee for Service programs and Managed Care programs in the last several years. For example, in Massachusetts, people living with Hepatitis C (HCV) may access curative treatments with relatively few restrictions while their counterparts enrolled in MCOs must wait until their HCV progresses to significant liver damage, they can demonstrate medically irrelevant information such as sobriety for at least six months, and they can find a narrow range of specialists who are allowed

to prescribe such medications.[1] These restrictions not only undermine the ability of MCO enrollees to receive care but incentivize these individuals and their providers to find loopholes to move them back into the Fee for Service program. To avoid these issues, we believe that CMS should specify that a formulary may not be more restrictive than the comparable Fee for Service program to avoid access disparities for individuals enrolled in Fee for Service and Managed Care.

General Comments on Beneficiary Access

As discussed throughout our comments, Medicaid beneficiaries, who often face multiple social determinants of health, may present significantly different costs than patients in the commercial market. AAPCHO supports CMS' efforts to ensure that plan capitation rates are actuarially sound and are based on strong and current data that includes measures of SDOH. We underscore the need to base trend factors and risk adjustment on current data, and data that are based on the actual experience from the same or similar population cohorts. It is critical that provider reimbursement rates are appropriately set to ensure access; this is true regardless if the beneficiary receives services at an AAPCHO member, at an FQHC or at another provider.

The value-based purchasing models proposed in the rule may result in greater care coordination and higher quality for beneficiaries. AAPCHO centers have been on the vanguard of coordinated delivery systems—and the health center model provides a good example of coordinated patient-centered care. AAPCHO looks forward to working with CMS to share the health center experience. We caution that nothing in value-based purchasing should undermine the Medicaid relationship with health centers (including the prospective payment system—PPS). Participation in value-based purchasing should be voluntary and there must be limits to the amount of risk that a health center may shoulder. In particular, CMS should prohibit states or MCOs from requiring FQHCs to accept risk for services beyond primary and preventive care as a requirement of joining an MCO network.

AAPCHO supports other key beneficiary protections as well, including:

- 14-day choice period for individuals being enrolled in Managed Care Organizations (MCOs);
- Shorter timeframes for MCOs to respond to prior authorization requests;
- A minimum of a choice of two language-accessible MCOs for all beneficiaries in non-rural areas;
- Requiring states to post their MCO contracts on-line;
- Stronger protections for patients who are being forced to change providers when they move into managed care;
- Requiring that care coordinators provide patients with info about community-based, non-medical supports;
- Adding a definition of preventive services as including but not limited to services with a grade of "A" and "B" from USPSTF in the general definitions of the proposed rule to harmonize it with the requirements of the ACA. We also believe that, in § 438.3, a standard contract requirement specifying that MCOs must provide for coverage of preventive services as required by the ACA and any applicable state requirements should be added to standardize the MCO offerings with Medicaid expansion and QHPs; and

[1] Harvard Law School Center for Health Law and Policy Innovation, Hepatitis C Virus Treatment Access: A Review of Select State Medicaid Fee-For-Service and Managed Care Programs. Online at http://www.chlpi.org/wp-content/uploads/2013/12/Examining_HCV_Treatment_Access_Report.pdf (accessed 07/09/2015).

- While we believe that the requirement that MCOs use service authorization standards that are "appropriate for and do not disadvantage those individuals that have ongoing chronic conditions or needing [long term services and supports]" is an important development, we also believe that CMS must not only urge state Medicaid programs to specifically review MCO service authorization decisions but that CMS itself should retain some oversight.

AAPCHO has formally recommended that HHS establish a permanent full-time position dedicated to coordinating language access services across all government health insurance programs nationally, as well as regional positions to coordinate with the national entity, to provide technical assistance to MCOs while they implement language access requirements. We reiterate that need here and encourage HHS to establish this position in order to appropriately implement the provisions of this rule once codified.

In addition to strengthening information and services for potential enrollees, it is critical that plans provide language access services to ***current*** enrollees. We strongly support the National Health Law Program's proposed recommendation to add a new section--**§438.72 Language access and disability access—**to ensure that all beneficiaries who are enrolled in the plan have access to all needed language access services. This clarifies that plans must provide LEP beneficiaries culturally and linguistically appropriate information and provide internal organizational support for such needs, including:

- Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;
- Collect and maintain updated information on the composition of the communities in the service area, including the primary languages spoken;
- In compliance with §438.10(c) and (f), provide enrollees and potential enrollees with information and assistance in the consumer's preferred language, at no cost to the enrollee or potential enrollee, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when necessary or when requested by the enrollee to ensure effective communication;
- Provide oral and written notice to enrollees with LEPs, in their preferred language, informing them of their right to receive language assistance services and how to obtain them;
- Provide staff with ongoing education and training on providing culturally and linguistically appropriate services; and
- Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

AAPCHO strongly supports the several key provisions in the comments of the National Association of Community Health Centers (NACHC). In particular, we support the provisions listed below:

- **Actuarial Soundness (§438.4) (also §438.60)**
    - NACHC strongly supports CMS' efforts to update the regulatory structure for MCO rate setting to ensure increased consistency and transparency, thereby strengthening beneficiary access. AAPCHO also supports efforts to ensure that capitation rates are set at levels that are actuarially sound, and include payment only for those costs that are appropriate for the MCO to pay. In this section, we ask

CMS to reinforce its long-standing policy specifying which FQHC-related costs are appropriate for inclusion in actuarially sound capitation rates.

- **Appropriate costs for inclusion of actuarially sound capitation rates (§438.4)**
  - In the preamble discussion of which costs are appropriate to include when calculating actuarially sound capitation rates, CMS should clarify that the only FQHC-related costs that are appropriate for inclusion are those for payments made at the same rate as payments to similar providers.
- **Special Contract Provisions Related to Payment §438.6(c)(2); § 438.6(c)(1)**
  - In recognition of the unique requirements faced by FQHCs, states or MCOs should not be permitted to require FQHCs to accept risk for services beyond primary and preventive care as a condition of joining a MCO network; and
  - Clarify that States may impose additional requirements on MCO expenditures beyond those in this section, if those requirements are statutorily mandated.
- **Risk Adjustment (§438.5(g))**
  - NACHC supports CMS' decision to develop risk adjustment methodologies to account for the health status of enrollees when predicting costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs contracted with the state. Specifically worth noting, social determinants of health (SDOH) contribute to patient complexity and disease severity in ways that are not adequately captured by clinical measures. As SDOH contribute to the etiology and trajectory of disease outcomes, safety net providers in particular are disadvantaged when payment and public reporting are based on patient outcomes without regard to underlying, non-clinical risk factors. Current risk adjustment methodologies do not adequately capture these non-clinical risk factors, and research demonstrates that this can undervalue the providers who serve populations facing significant SDOH challenges.
- **Withholding payments in response to a "credible allegation of fraud" (§438.608(a)(8))**
  - Require a State's notification to the MCO of a pending investigation of a credible allegation of fraud to be in writing and to be certified by an appropriate State official;
  - Require the State to recertify to the MCO at regular intervals (for example, every ten days) that the fraud investigation is ongoing; and
  - Specify that the managed care contract must require the MCO to process suspended payments to a provider on a timely basis (for example, within three days following notification from the State that an investigation has been resolved in favor of a suspended provider).
- **Interaction of 340B and Medicaid Managed Care (438.3(s)(3)**
  - Clarify that neither states nor MCOs may prohibit 340B providers who are in MCO networks from using 340B drugs for their patients;
  - Clarify that neither states nor MCOs may require providers to agree not to use 340B drugs to their patients as a condition of participating in an MCO's network;
  - Prohibit MCOs from paying lower rates for drugs purchased by 340B-covered entities than for the same drugs when purchased by other MCO network providers. Similarly, states should be prohibited from requiring MCOs to pay lower rates for drugs purchased by 340B-covered entities than for the same drugs when purchased by other MCO network providers; and
  - Prohibit MCOs from requiring 340B providers to use a methodology for identifying 340B claims that makes it highly difficult or impossible for these providers and their contract pharmacies to use 340B for Medicaid MCO patients.

- **Network Adequacy Standards (438.68)**
  - Establishing minimum NA standards that explicitly address, at a minimum:
    - number and types of providers, including specific provider types such as primary care and Ob/Gyn
    - language and physical accessibility
    - travel time and distance
    - wait times for appointments
    - accessible hours for working populations
  - Ensure that the minimum standards are at least as – and ideally more – stringent than those current required under Medicare Advantage; and
  - Require states to "factor in" (as opposed to consider) the issues outlined in §438.68(c) when setting these standards.
  - Require MCOs to contract with Essential Community Providers (ECPs) according to same standards applied to Qualified Health Plans participating in Federally-Facilitated Marketplaces (i.e., contract with at least 30% of all ECPs in the service area, at least one from each category in each county, etc.), and allow states to establish different standards for ECP contracting as long as these standards are at least as stringent as the CMS-established minimum standards. AAPCHO recommends that HRSA work with CMS to develop these standards; and
  - Give states the flexibility to establish different standards as long as they are at least as stringent as the CMS-established minimum standards.

AAPCHO strongly supports the several key provisions in the comments of the HIV Health Care Access Working Group. In particular, we support the provisions listed below:

- **Covered Outpatient Drugs and Formularies (§ 483.3)**
  - Clarify that when an MCO provides prescription drug coverage, the coverage of such drugs must meet the standards of § 1927(k)(2) of the Medicaid Act and that when there is a medical need for a covered outpatient drug not included in the formulary enrollees must be given access under a prior authorization process;
  - CMS should specify that a formulary may not be more restrictive than the comparable Fee for Service program to avoid access disparities for individuals enrolled in Fee for Service and Managed Care.

Thank you again for the opportunity to provide comments on this important rule. If you need any clarifications on the above, please contact Isha Weerasinghe, AAPCHO's Senior Policy Analyst, at iweerasinghe@aapcho.org.