July 27, 2015

Centers for Medicare & Medicaid Services
Department of Health and Humans Services
P.O. Box 816
Baltimore, MD 21244-8016
Via email to: http://www.regulations.gov

ATTENTION: CMS-2390-P

PROPOSED RULE: 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

Dear CMS:

Thank you for the opportunity to comment on CMS-2390-P. We believe all Missourians should have access to the health care they need. We strongly support HHS’s proposed rules to update and revise the federal standards for Medicaid Managed Care.

This issue takes on added urgency in Missouri as we prepare for an expansion of Medicaid managed care to our rural communities in 2016. This geographic expansion of Medicaid will expand capitated managed care in Missouri by approximately 50%.

We support the proposed regulations, and suggest that they be further strengthened, in order to guarantee that:

- Consumer advocates, safety net providers, and the public can access information on managed care plans, including provider directories, drug formularies, and quality data.
- Patients who have a Medicaid card can actually see a provider when they need one.
- Patients enrolled in Medicaid managed care plans receive quality care.
- Medicaid managed care plans are accountable for how they spend taxpayer dollars.

Our detailed comments on the proposed regulations, including suggestions for further strengthening them, are included in the following pages.

Thank you for considering these comments and suggestions.

Sincerely,

Jen Bersdale
Executive Director
Missouri Health Care for All
Organizational Co-Signers:

- Central Reform Congregation
- CHIPS Health and Wellness Center
- Mariposa Men’s Wellness Institute
- Mental Health America of Eastern Missouri
- Missouri Budget Project
- Missouri Health Advocacy Alliance
- Missouri Jobs with Justice
- Missouri Rural Crisis Center
- Mother & Child Health Coalition
- NAMI Missouri
- NAMI St. Louis
- Paraquad
- REACH Healthcare Foundation
- St. Cronan Church
- St. Paul AME Church
- Whole Health Outreach
- Women's Voices Raised for Social Justice
With the expansion of Medicaid managed care in this state and others, it is important that federal standards provide transparency, protect consumers’ access to providers, quality of care, and assure that state taxpayers get good value from managed care entities. The proposed federal regulations are a significant step forward. The following comments provide information on why these regulations are important in Missouri, as well as suggestions on further strengthening the proposed regulations.

I. Transparency and Access to Information


We commend CMS for making transparency a priority in these proposed managed care standards. States will be required to post online or provide links to important consumer information, including enrollee handbooks, provider directories and drug formulary lists. Key program information, including network adequacy standards and quality data, which have been difficult to obtain in Missouri as elsewhere, will have to be posted in accessible formats on state websites. While many beneficiaries may still need alternative ways to access this data, posting online provides consumer advocates, safety net providers and the general public easy access to this important data.

We believe that the rule could be improved in terms of transparency by also requiring that managed care contracts and other information specified in §438.602 be posted online where it can be accessed quickly and with minimal cost, rather than allowing states the option of making such information available upon request. In Missouri, Medicaid MCO contract language is publicly posted only as a Request for Proposal (RFP) and only during the bidding process. Even then, the RFPs are not posted on the Medicaid agency’s site, but on the Department of Administration’s website as required by state procurement law.

II. Access to Providers and Network Adequacy


We strongly support the addition of new specific network adequacy standards aimed at ensuring that consumers can actually get care from their Medicaid plans. We support the proposed regulation that requires states to have in place specific standards for the maximum time and distance that patients must travel to access primary care (adult and pediatric), specialist care, behavioral health, hospital, pharmacy, and long term services and support services.

However, we suggest that HHS also require states to promulgate specific standards that address other aspects of access to care including standards for provider-to-patient ratios, wait times for appointments and wait times in the office. Specific, quantitative network adequacy rules assure that patients who have a Medicaid card can find a provider when they need one. They also create a more level playing field among competing MCOs.

We are concerned that HHS is proposing to allow states to set their own time and distance standards without any outside limits set by HHS. We realize that HHS wishes to allow states some flexibility in administering their Medicaid programs to meet local needs and to align Medicaid standards with standards for the Marketplace and/or Medicare. However, such unfettered discretion will result in widely varying standards among states and will make HHS’s oversight responsibility to determine if state-developed standards provide reasonable access for patients more complicated and burdensome. We suggest that HHS adopt specific minimum standards in the areas of geographic access, provider to patient ratios, and wait times but give states discretion to promulgate higher standards as they deem appropriate.
At present, Missouri Medicaid managed care has specific network standards for travel distance and wait times for appointments, but not for provider-to-patient ratios or wait times in office. Missouri’s travel distance standards when compared to the Medicare Advantage standards are less specific and for some services require rural residents to travel substantially greater distances to find a provider: For example, Missouri’s network standard for oncology services in rural areas is 100 miles, compared with 60 miles for Medicare Advantage. HHS’s adoption of specific minimum standards for Medicaid MCOs would provide helpful guidance to states, like Missouri, as they begin the necessary work of updating their Medicaid network access standards.

We also urge CMS to require states to conduct secret shopper surveys to determine if managed care plans are providing the networks they publicize in their provider directories. Missouri’s Medicaid agency recently conducted a secret shopper survey of Medicaid MCO networks and found that only 48% of providers listed in MCO online provider directories were actually taking new patients. According to HHS’s own Office of Inspector General (OIG), such direct testing of provider networks is the most effective means of evaluating compliance with network adequacy standards. Secret shopper surveys should be a regular and ongoing part of both state monitoring and External Quality Review (EQR) activities.

III. Quality and Accountability

Proposed Rule 42 C.F.R. §§431.504-506, 438.310-.370

We strongly support the proposed new federal standard that states have in place comprehensive statewide quality improvement standards for all of Medicaid and CHIP delivery systems, including MCOs, fee-for-service, and primary care case management (PCCM). This expansion of the scope of quality assessment and improvement efforts promises to advance state efforts to measure and improve the quality of care provided to children and adults in public programs by allowing comparisons across different delivery models.

Over the last few months, as the Missouri General Assembly expanded capitated Medicaid managed care, Missouri’s Medicaid agency has, for the first time, released data comparing the quality of care in capitated managed care and the state’s fee-for-service (“traditional”) Medicaid program. A department study presented on June 16, 2015 found that managed care did worse than fee-for-service on 10 out of 18 clinical quality measures studied. The study also found that while managed care had fewer hospitalization admissions and shorter lengths of hospital stays than fee for service, managed care also had more hospital readmissions after discharge, and more emergency room visits. Managed care also had more outpatient visits than fee-for-service Medicaid.

IV. Medical Loss Ratio

Proposed Rule: 42 C.F.R. §438.4, §438.5, §438.8 and §438.74)

Medicaid Medical Loss Ratio (MLR) calculation and reporting requirements promote transparency and accountability with public dollars. The MLR indicates the portion of a managed care plan expenditures that are for claims and quality improvement activities compared to spending on administrative expenses and profit. Plans in both the large group market and Medicare Advantage are required to maintain an MLR of at least 85%. Both plans in the private market and Medicare Advantage plans that do not meet this minimum MLR must refund the difference as a premium rebate to their policy holders. Medicare Advantage plans that fail to meet the MLR for three year consecutive years are disallowed from enrolling new members and those that fail to comply for five years are terminated.

We support the proposed rule that requires that an MLR of at least 85% be used in determining an actuarially sound payment rate for managed care plans. We also support the proposal that requires MCOs and others to
calculate and report their MLR annually. At present in Missouri, Medicaid MCO MLRs are not available on the Medicaid agency’s website and are not provided to people when they are selecting among managed care plans.\(^8\)

However, the proposed rules do not require states to set minimum MLRs for Medicaid managed care, although they provide that states to set a minimum MLR must set it at least at 85%. **We urge HHS to require states to set a minimum MLR of at least 85%, require that plans provide a refund to the state if they fail to meet their minimum MLR, and impose the same penalties as used in Medicare Advantage.** Such an MLR requirement creates parity across Medicaid, private insurance, and Medicare. The refund requirement creates a strong—and easily enforced—compliance incentive.

Medicaid Managed care plans generally seem to be able to meet an 85% MLR standard. In 2013, the average Missouri Medicaid MCO MLR was 87%.\(^9\) The three Medicaid MCO plans operating in the state that year reported MLRs ranging from a high of 94.3% for Home State Health Plan, to 84.0% for Healthcare USA of Missouri, with Missouri Care reporting 89.5%.\(^10\) A federally mandated minimum MLR would institute a more level playing field among competing plans, like these.

These comments were prepared in partnership with Professor Sidney Watson, Jane and Bruce Robert Professor of Law, Center for Health Law Studies, Saint Louis University School of Law. If you have any questions, please contact Professor Watson at watsons@slu.edu or 314-977-2751.

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1. See, Comparing Performance: Managed Care and Fee-For-Services, Missouri Department of Social Services (December 2009), 2, [http://www.dss.mo.gov/mhd/oversight/pdf/ffsmgdcare10feb18.pdf](http://www.dss.mo.gov/mhd/oversight/pdf/ffsmgdcare10feb18.pdf) (showing that geographic expansion of Medicaid adds 238,165 beneficiaries to the 458,338 already enrolled in capitated managed care).
2. See, RFP NO.: B3Z15077, MO HealthNet Managed Care – Central, Eastern, and Western Regions, Issue date, 10/31/14, Section 2.5 Service Accessibility Standards. Some of the Missouri network adequacy standards are imported from state HMO licensing regulations that apply to all commercial and Medicare Advantage plans as well as Medicaid MCOs. Other standards are specified in the Medicaid Managed Care Request for Proposal (RFP).
3. See and compare 20 CSR 400-7.095 and 400-7, Exhibit A, and Centers for Medicare and Medicaid Services, CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance and CMS CY2016_MA_HSD_Reference File. The Missouri access standards are separated into three categories of counties (urban, basic and rural) whereas the Medicare Advantage (MA) standards are separated into five more specific categories based on population size. MA plans must ensure that at least 90 percent of the beneficiaries reside in the county have access to at least one provider/facility of each type within the published time and distance standard. Missouri regulations state that its travel standards represent the maximum number of miles an enrollee may be required to travel in order access participating providers of the managed care plans, and that the standards will be used to evaluate enrollee access.
4. MO HealthNet Oversight Committee Meeting February 17, 2015, Provider Directory Survey. The department surveyed 621 providers and found that 325 (52.3%) providers were either not practicing at the address indicated or were not taking new patients. This process led to corrective action plans and improvements (i.e., increased accuracy) when MHN followed up with the providers in the networks. *Id.*
5. See HHS Office of the Inspector General (OIG), State Standards for Access to Care in Medicaid Managed Care (September 2014) and OIG, Access to Care: Provider Availability in Medicaid Managed Care (December 2014).
6. Missouri Department of Social Services, Comparing Performance, Managed Care and Fee-for-Service, June 16, 2015, at 27, 29.
7. *Id.*