Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

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

Dear Administrator Verma,

Thank you for the opportunity to comment on the Proposed Rule, Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (CMS-2408-P). As health care advocates who have come together to speak up for patients and health care consumers, we would like to express our concern with certain provisions in this proposed rule.

The Medicaid Program: Medicaid and Children's Health Insurance Plan (CHIP) Managed Care rule, also known as the "Medicaid MCO" rule, was finalized in 2016 to make it easier for consumers to choose a plan based on quality, to navigate Medicaid health plan information more easily through tools like provider directories, and to have access to an adequate health plan provider network. The rule also made strides in reforming payment and delivery systems.

While the proposed rule seeks to reduce the administrative burden for states, it may also reduce access to quality care for vulnerable Medicaid consumers.

We are particularly concerned with the following provisions that would take effect if the proposed rule is approved in its current state:

- **Network Adequacy**: While the 2016 final rule requires states develop and enforce travel time and distance to ensure an adequate coverage network for patients, this proposed rule would loosen this requirement and allow states to choose among quantitative standards to ensure network adequacy, including provider-to-enrollee ratios, maximum wait times and hours of operations.

  The Medicaid population is complex with diverse needs. While expanding the quantitative measures of network adequacy standards could help maximize patient access to care, CMS must continue to work to ensure that states are setting the right standards and that insurer networks are not too narrow or inaccessible. Otherwise, patients may encounter barriers to accessing care, such as a very limited number of providers in their network or needing to travel long distances to receive care from a doctor who accepts their insurance.

  The rule also proposes allowing states to define the number and types of providers that are classified as "specialists." While we appreciate the need for states to have flexibility

to best meet the needs of state Medicaid enrollees, we believe that the definition of specialist should remain at the Federal level (81 FR 27,661). Should a patient need to travel across state lines for care, the definition of "specialist" could vary, leading to a patient losing access to treatment or specialized care for a specific condition. A disruption in care could also lead to a disruption in continuity of care for specified treatments, including medically necessary prescription medicines.

- **Quality Rating System**: Although the proposed rule would still require states to maintain quality rating systems, it would loosen the uniformity of standards by allowing states to set their own quality rating systems and eliminate the need for those to have prior CMS approval. While we recognize that states need certain flexibility in assessing specific quality improvement needs, we urge CMS to continue to work toward the alignment of state efforts to improve quality for all. As proposed, it would be difficult to control for quality of care if a state is not required to receive CMS approval before implementing its own alternative quality rating system. The Medicare Part D star rating program could be a basis for use and has been looked to as a model for ease of use and comprehension of quality measures, as well as having driven improvements in quality. The state process in developing quality rating systems needs to be transparent, and ensure that measures are relevant to the population, support current clinical standards of care and accurately assess all facets of care.

The 2016 "Medicaid MCO" rule updated the standards governing Medicaid managed care plans for the first time since 2002 and created a structure to ensure consumers were provided with an adequate level of care as part of the Medicaid program. The new proposed rule would scale back the progress of the previous rule, weaken networks and lower quality standards for Medicaid managed care enrollees.

We firmly believe that if approved in its current form, this rule will hurt patients across the United States. We are asking that you add more rigorous requirements or retract this proposal and protect consumer access to quality care.

Sincerely,

Consumers for Quality Care

Consumer Action

The Black Women's Health Imperative

National Health IT Collaborative for the Underserved