January 14, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: CMS-2408-P; Medicaid Program; Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care (RIN 0938-AT40)

Dear Administrator Verma:

The Disability Rights Education and Defense Fund (“DREDF”) appreciates the opportunity to provide comment on the proposed Medicaid and CHIP Managed Care Rule. DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

DREDF has significant experience in Medicaid law and policy, given that disabled individuals disproportionately live in poverty and depend on Medicaid services and supports. Medicaid is also the only publicly-funded provider of long-term services and supports, and thus is a very significant or sole source of essential healthcare for many people with disabilities. Our comments below do not address the full breadth of the proposed rule. Rather, we focus on provisions with particular relevance to the accessibility in healthcare delivery needed by people with various disabilities, network adequacy, and managed care state quality strategy.

I. Information Standards (42 C.F.R. § 438.10)

A. Tagline Requirements (§ 438.10(d)(2), (3))

DREDF strongly opposes CMS’ proposal to replace the State agency’s and managed care plans’ requirement to include taglines in large print and prevalent non-English languages on “all written materials” with the requirement to only include taglines on materials that “are critical to obtaining services.” As an organization dedicated to promoting the equality of people with all types of disabilities, including eliminating information access barriers in programs that are central to their
health, we are concerned that relaxing the tagline requirement will expand the information divide that people with vision disabilities already face when trying to access and manage their Medicaid benefits.

Large print taglines provide essential information to people with vision disabilities; they explain the availability of written translation and oral interpretation to understand the information provided, explain how to request auxiliary aids and services, and provide the toll free and TTY/TDY phone numbers of relevant entities. All of the written materials of the State Medicaid agency and managed care plans serve some purpose relating to Medicaid enrollment, coverage, or benefits; indeed, it would make no sense to expend public resources on developing and printing written materials unless it served some important function relating to the Medicaid program. By allowing the State agency and managed care plans to only include taglines on some materials—those that they deem “critical to obtaining services”—people with vision disabilities will be denied equal access to important information pertaining to their Medicaid coverage and services.

While we oppose lowering the tagline requirement to anything less than “all written materials” in the first instance, we are also concerned with the content of the alternative standard that CMS has proposed. Its proposal will only require taglines on written materials that “are critical to obtaining services,” however, CMS has provided no definition of these terms. It has asserted that “provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices” must, “at a minimum,” have taglines, however, it has not articulated a standard for objectively determining when other information and notices may be “critical.” There are also no CMS oversight mechanisms referenced in the proposed rule. This new scheme will give the State agencies and managed care plans a dangerous level of discretion to subjectively decide which materials are or are not “critical to obtaining services,” with little accountability. It will also lead to inconsistent uses of taglines across the plans and State agencies.

We are also concerned that the proposed change will lead to confusion among Medicaid enrollees with disabilities. For example, when an enrollee receives a notice in the mail from the State agency or their plan, they know it could be an important message pertaining to their health benefits. If the notice does not contain large print taglines, then an enrollee with a vision disability is faced with a difficult choice of trusting that, since the notice does not contain taglines, it must not be “critical” to their services—or, they could rely on third parties for assistance in reviewing the notice, potentially disclosing confidential health information that they would otherwise not wish to disclose. This is fundamentally inequitable to enrollees who need the large print taglines.

For these reasons, DREDF recommends maintaining the current regulatory requirement that the State Medicaid agency and managed care plans must include large print taglines on “all written materials.”

B. Definition of “Large Print” (§ 438.10(d)(2), (3))

DREDF also opposes CMS’ proposal to change the State agency’s and managed care plans’ definition of “large print” from “no smaller than 18-point” to “conspicuously visible.” We are concerned that this
alternative standard will decrease the accessibility and effectiveness of taglines for the large group of enrollees with vision disabilities who need them.

The “conspicuously visible” standard is vague and inappropriately deferential to the State agencies and managed care plans. CMS’ proposal does not contain a definition or objective standard for which to evaluate whether the tagline’s font size is “conspicuously visible.” The proposed rule states that it is importing the standard codified at 45 C.F.R. § 92.8(f)(1) (HHS regulation implementing Section 1557 of the Affordable Care Act), however, this referenced regulation contains no definition either. Only in non-binding guidance accompanying the Section 1557 Final Rule is there an explanation of what “conspicuously visible” may mean:

The touchstone by which we will assess whether a covered entity’s provision of notice and taglines is effective is whether the content is sufficiently conspicuous and visible that individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information.¹

However, this explanation is imprecise and makes clear that “[c]overed entities have flexibility in determining the exact size [] of notices and taglines . . . .”²

Because of the lack of objective standards, we are concerned that the State agencies and managed care plans, in the name of “flexibility,” will make subjective and inconsistent font size decisions for taglines. The relaxed standard will permit entities to reduce the visual accessibility of taglines, even on those notices that are critical to the enrollee’s Medicaid services.

The justifications for the proposed definition are also misguided. CMS explains that this proposal will facilitate “more user-friendly documents” and allow the use of more “visual[ly] appeal[ing]” documents like “postcards and trifold brochures.” First, while it may be true that smaller taglines will decrease the length of documents, to claim that it will make materials “more user-friendly” ignores a large group of enrollees with vision disabilities who actually need the 18-point font taglines. Additionally, the “postcards and trifold brochures” that CMS specifically references are unlikely to be materials that are “critical to obtaining services,” and thus, it is doubtful they would need to contain taglines to begin with under the proposed rule.

For these reasons, DREDF recommends maintaining the current regulatory definition of “large print,” i.e., a font size “no smaller than 18-point.”

C. Notice of Provider Termination (§ 438.10(f)(1))

DREDF is concerned with CMS’ proposal to allow states to lengthen the period in which they must provide notice to beneficiaries of the termination of a provider from their network. The rules currently require notice within 15 days of the provider’s notice of termination; CMS proposes to give states the

¹ HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,375, 31,397 (May 18, 2016).
² Id. at 31,398.
option to provide notice either 30 days before the actual termination or 15 days after the provider's notice of termination, whichever is later. This significant change will substantially reduce the time period for which a patient has to find another network provider, and the reduction is likely to have a disparate impact on people with disabilities and complex health conditions.

People with disabilities often face difficulty finding health care providers that can accommodate their unique needs, understand the interaction of their potentially multiple complex health conditions, and/or have physically and programmatically accessible offices. It takes time to find a new health care provider, particularly if they are providing specialty care services or if the enrollee is in a rural area. Under the proposed rule, a provider could, for example, provide notice on January 1 that they are terminating their network membership on June 1, yet could delay providing notice to their patients until May 1. This senselessly reduces the period for which a patient could be searching for a new network provider. Thirty days simply may not be enough time, especially in areas with provider shortages, and the patient’s health could suffer as a result.

For these reasons, DREDF recommends maintaining the current requirement that beneficiaries must be provided notice within 15 days of the provider's notice of termination.

D. Indication of Cultural Competence Training (§ 438.10(h)(1)(vii))

DREDF is concerned with CMS’ proposal to eliminate the requirement that provider directories indicate whether the provider has undergone cultural competence training. Cultural competency is an important component of providing effective and appropriate health care. As an organization dedicated to eliminating disparities in health access and health outcomes for people with disabilities, we believe these trainings are essential to promoting disability competent care and informing providers of the rights of people with disabilities and how to effectively accommodate them.

The current regulatory requirement, which requires providers to indicate whether they have completed these essential trainings, serves several purposes. First, it provides helpful information for enrollees with diverse cultural and ethnic backgrounds, disabilities, limited English proficiency, and LGBTQI identities. If an enrollee knows in advance of an appointment whether the provider can provide care in a culturally competent manner, it can save the enrollee (and ultimately, the Medicaid program) time and resources spent searching for a provider who can appropriately meet their needs. Second, the requirement incentivizes providers to complete cultural competency training in the first instance. For these reasons, we recommend maintaining the current requirement.

E. Updating Printed Provider Directories (§ 438.10(h)(3))

DREDF is concerned with CMS’ proposal to relax standards related to updating printed provider directories (requiring only quarterly, as opposed to monthly, updates) if the managed care plan also makes available a mobile-enabled electronic directory. While we recognize that the process of maintaining up-to-date print directories is laborious, we are concerned for the enrollees who do not have access to or who cannot navigate electronic formats, often because of their disability or because
of the website’s, mobile application’s, or smartphone’s lack of accessibility. For these individuals, paper directories are essential for ensuring that they have current information on in-network providers. However, under the proposed rule, these enrollees may only have access to information that could be months out of date.

DREDF appreciates and supports CMS’ recognition that “some individuals with disabilities, who are unable to access web applications or require the use of assistive technology to access the Internet, may require auxiliary aids and services to access the provider director.” We also appreciate CMS’ reminder to plans that they must provide these auxiliary aids and services upon request, including the provision of the most current provider directory in a format accessible for them (including, paper, if required). However, we believe that it would be a simpler and less segregated process to continue to make the monthly-updated printed directories available to all enrollees and not just enrollees with disabilities via the accommodation process. We stand with our allies in expressing concern that this proposed rule would disparately impact the most impoverished enrollees, seniors, and individuals in rural areas with little or no access to the internet. For these reasons, we recommend maintaining the current requirement.3

II. Network Adequacy (42 C.F.R. § 438.68)

DREDF strongly opposes CMS’ proposal to withdraw the requirement for states to develop and apply time-distance standards for Medicaid plan network adequacy. CMS points to the need for state flexibility in the application of quantitative standards such as time-distance standards as the purpose for the change, and cites to the 2017 Brookings/Schaefer Center report4 as support for the proposition that “in some clinical areas, telemedicine could make proximity measures obsolete, or counterproductive.” However, by its own terms, the Brookings/Schaefer Center report does not support CMS’s proposal to retrench to a single quantitative access standard as the sole requirement that states must apply to specified healthcare and long-term services and supports (LTSS) providers.

First, the telehealth example that CMS draws from the Brookings/Schaefer Center report clearly is not meant to apply to all clinical areas or provider types, and is conditional upon “developments in telemedicine.”5 CMS’s proposed change to the rule would apply to all of the provider types listed in § 438.68(b)(1) of the rule, including specialists, without any apparent regard for clinical area. Telemedicine can make a significant contribution in a number of healthcare areas such as mental health therapy and for a number of wellness and prevention checks, but telemedicine has obvious limits when it comes to something like the practice of Obstetrics and Gynecology. Moreover, telehealth can only be practice where online connections are both strong and consistent enough to allow for effective clinical practice. Psychologists may be popularly perceived as “talk therapists,” but ethical and clinical considerations point to the importance of receiving facial and body language cues

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3 In the event that CMS does decide to change the current requirement, then we would suggest in the alternative that CMS retain the current provision as an option for States to elect under their contract.
5 Id. at 10.
that can only be provided through an in-person or video connection, and confidentiality concerns require sufficient bandwidth for secure encryption of the communication.

CMS’s concern that existing time and distance standards in the current Medicaid Managed Care rule could stifle Medicaid plan innovation would be assuaged through a provision that recognized the state’s ability to modify time and distance standards in some clinical areas upon verification that a plan has maintained technically sufficient telehealth coverage for a particular geographic area. In the event that a plan beneficiary within the area does not have sufficient technical capacity due to inadequate infrastructure or insufficient personal training or equipment to benefit from telehealth, the beneficiary should have the capacity to go out of network for medically necessary care that the plan cannot provide within applicable time and distance standards. Such an approach recognizes a state’s interest in encouraging technology-based plan innovation, while ensuring that Medicaid Managed Care quantitative standards perform the needed function of ensuring a floor of access to a full range of Medicaid services and supports, including LTSS.

Second, the Brookings/Schaefer Center report analyzes healthcare plans that are operating in a private commercial context, and the authors note that their goal is to guide states toward achieving effective regulation of individual marketplace plans that are incorporating much narrower provider networks. While substantially narrower networks are recognized in the report as a potentially valuable market innovation for consumers who are free to take their healthcare dollars to shop among various plan options, this differs markedly from a low-income Medicaid population that is older, has a higher incidence of disability and chronic conditions, and where no one is free to choose among differing networks.6 Within its own context, the report authors acknowledge that narrow networks “present a variety of potential patient protection concerns”7 such as insufficient capacity to serve plan enrollees, a network that is too geographically dispersed to be reasonably accessible, or acute shortages among specific specialty providers. These are the very concerns that prompt the report to recommend an approach to network adequacy standards that extend well beyond the requirement for “a quantitative network adequacy standard” as put forth in CMS’ proposal.

We appreciate that the Medicaid program can also benefit from state and plan innovation, but it should be innovation directed toward increasing effective care, maintaining function and independence, achieving care coordination for beneficiaries with disabilities and chronic conditions, and ensuring quality of care while addressing long-term sustainability. The goals of flexibility and innovation should never, in and of themselves, compromise the choice and well-being of beneficiaries by cutting back network adequacy standards for a full range of providers, from acute to mental health to LTSS.

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6 As the authors expressly state: “In competitive insurance markets where consumers have the motivation and means to choose between broad and narrow networks, regulators have good reason to specify only minimally acceptable adequacy standards, leaving it to market forces to determine what levels above the minimum might be broadly acceptable or optimal. However, under Medicaid, many patients have little or no choice about which managed care plan covers them, or, if they have choice, they suffer from vulnerabilities that impair consumer engagement. Where market forces are less active, regulatory protections, with good reason, tend to be stronger.”

7 Id. at 2.
Third, CMS’s proposal requires states to choose only one quantitative measure, an approach that actually flies in the face of the primary final recommendation made in the Brookings/Schaefer Center report which concluded that “‘well-designed regulation of network adequacy is not easy to achieve. Because no single regulatory approach is likely to be sufficient, we need to think more in terms of a layered approach – one that thoughtfully melds together different dimensions and techniques of oversight.’” That is, even in a commercial insurance environment where consumers have greater resources and control and fewer healthcare conditions, regulators require more than one quantitative standard, incorporation of a qualitative standard, and a strong and well-known consumer capacity to apply for and go out of network to achieve network adequacy among plans.

We recommend that CMS do more than simply “encourage states to use the quantitative standards in combination—not separately—to ensure that there are not gaps in access to and availability of services for enrollees.” For example, requiring states to choose at minimum two different quantitative standards, as well as an outcome measure such as beneficiary surveys or grievance/complaint reviews focused on network adequacy, will allow each state to flexibly design a network adequacy system that will still have a greater chance of achieving Medicaid network adequacy than the mere choice of a quantitative measure.

In the area of LTSS, where CMS acknowledges an all too common dearth of qualified providers for a population that requires assistance due to functional limitations, it would be especially easy to miss the fact that Medicaid plan enrollees face gaps in access to and availability of service. LTSS providers can be sparse in rural areas, where providers have to travel significant distances, and they can be sparse in densely populated high rent urban areas, where LTSS providers cannot afford to live anywhere near the beneficiaries to whom they provide services. This is not an area where most managed care plans have particular expertise, and it is a situation that cannot be improved with the application of technologies such as telehealth, placing LTSS providers in one regional centralized location, or giving consideration to Accountable Care Organizations’ desire to enter exclusive “integrated” contracts. Those Medicaid beneficiaries who are capable of and wish to direct their own LTSS provider relationships should not be required to enter into particular “innovative” care arrangements simply because one healthcare plan or entity controls Medicaid LTSS for the area.

Given the complexity of both LTSS beneficiary needs and questions of network adequacy, DREDF strongly recommends that CMS make mandatory its “encouragement” of states to solicit stakeholder input in the development of their network standards. States and plans need to hear directly from Medicaid beneficiaries and advocates, and particularly users of LTSS, before they can profess to design a system of standards that will ensure that plans create and maintain adequate provider networks that are sufficiently responsive to dynamic healthcare systems.

Finally, on the topic of responsiveness and flexibility, DREDF recommends maintaining federal flexibility to add provider types to the list of providers that should be covered by network adequacy standards per § 438.68(b)(1)(viii). Removing this subsection will remove CMS’s administrative capacity to quickly add provider types as dictated by national conditions (e.g., geriatricians as the U.S.

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8 Id. at 12
population ages, specialists in Substance Use Disorder due to the national opioid crisis, and so forth). If CMS does not wish to place plans in a position of insufficient time to build up their networks in terms of newly-added providers, CMS can add additional time after the required solicitation of public input before the addition of additional providers will take effect. It should even be possible for a state to solicit input from multiple stakeholders, including plans, on the amount of additional time that plans should have to come up to speed on meeting newly added provider network adequacy requirements.

The point of network adequacy is to protect consumers. State flexibility and encouragement of plan innovation can and should occur within a framework that first requires states to use layers of quantitative and qualitative standards and outcome measures, and then allows states to grant controlled exemptions to plans that have demonstrated their ongoing capacity to provide network adequacy to Medicaid beneficiaries in a particular area, including beneficiaries with disabilities and chronic conditions. Medicaid plans should not be allowed to experiment with the health of their Medicaid plan members in the name of innovation.

III. Managed Care State Quality Strategy (§ 438.340)

DREDF supports CMS’s proposal to remove section § 438.340(b)(6), which defines disability status solely in terms of whether an individual qualified for Medicaid on the basis of a disability, for the purposes of identifying, evaluating, and reducing health disparities as a managed care quality strategy. We agree with the agency’s assessment that a current Medicaid beneficiary may acquire a disability or disabilities regardless of how he or she originally qualified for Medicaid, and states should seek accurate and updated information concerning every Medicaid beneficiary’s disability status. We further recommend CMS work with states to include voluntary disability status questions, such as the six disability questions contained in the American Community, in the Medicaid eligibility application. The information provided, when communicated to plans, would allow plans to efficiently develop a strategy to specifically address the health and healthcare disparities experienced by people with disabilities since such strategies cannot even begin to form without accurate identification of Medicaid beneficiaries with disabilities. The collection of information related to disability identification would also pave the way for tracking and consistent provision of needed reasonable accommodations needed by people with disabilities to receive equally effective healthcare services.

Thank you again for the opportunity to comment on the proposed rule. Please do not hesitate to contact us if you have any questions about the above.

Sincerely,

Carly A. Myers
Staff Attorney

Silvia Yee
Senior Staff Attorney