American Physical Therapy Association

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January 11, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2408-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: CMS-2408-P; Medicaid Program; Medicaid and Children's Health Insurance Plan Managed Care

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments on the Centers for Medicare and Medicaid Services' (CMS) proposed changes to the Medicaid and Children's Health Insurance Plan (CHIP) Managed Care regulatory framework. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA appreciates the opportunity to provide comments on the proposals to streamline the Medicaid and CHIP managed care regulations. We support efforts to reduce regulatory burdens and increase transparency, flexibility, and innovation in the delivery of care while

ensuring that Medicaid and CHIP enrollees continue to have guaranteed access to all covered services, including physical therapy. Please find our detailed comments below.

Pass-Through Payments Under Managed Care Organizations (MCOs), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP) Contracts (42 CFR §438.6(d))

APTA supports CMS's proposal to allow states to make pass-through payments under new managed care contracts during a specified transition period if certain criteria are met. Pass-through payments are critical for ensuring that safety-net providers remain profitable enough to continue to treat their patients. States have long used these payments to combat provider shortages in areas of need by increasing reimbursement for providers who accept a proportionately large number of Medicaid patients. These providers may become especially vulnerable during the period of transition from fee-for-service Medicaid to managed care, as MCOs adjust to the demands of the market. We appreciate CMS's recognition that as more states continue to transition to benefits delivered via Medicaid managed care, the transition period must continue to allow pass-through payments while the market stabilizes. Therefore, APTA supports this proposal and encourages CMS to finalize this requirement as proposed.

Network Adequacy Standards (42 CFR §438.68)

While APTA recognizes that time and distance standards are not always the most appropriate measure of provider availability, we have concerns with the proposal to eliminate time and distance standards as a metric to assess the adequacy of a plan's provider network. States have long utilized time and distance standards to assess network adequacy.[1] These quantitative standard are also the easiest for states to assess and enforce. [2] We recognize, however, that merely having a physical proximity to a provider does not ensure access to quality care. Proximity does not mean that providers are taking new patients, that wait times are reasonable, or that the provider has the necessary cultural competency to effectively treat the patient. Further, given the variability between states in provider availability, population density, health care needs, etc, we agree that states are in the best position to determine the needs of their own markets. Accordingly, while APTA supports the proposal, we urge CMS to require state network adequacy requirements to undergo a strict review to ensure that they are generating adequate networks from a patient's perspective.

For instance, while minimum provider-to-enrollee ratios can be a valuable measure of provider availability, the standard can be easily abused. If the ratio is based on enrollees of a given plan, as opposed to total number of enrollees the provider may see across all plans, then the measurement of that provider's actual availability will be inaccurate. Accordingly, we encourage CMS to closely scrutinize states' standards to ensure that provider networks are thoughtfully designed to give patients adequate access, and not merely to satisfy arbitrary criteria.

[1] Murrin S. State Standards for Access to Care in Medicaid Managed Care. (No. OEI-02-11-00320.) Washington, DC: US Office of Inspector General, Department of Health and Human Services, 2014.
[2] Murrin S. State Standards for Access to Care in Medicaid Managed Care. (No. OEI-02-11-00320.) Washington, DC: US Office of Inspector General, Department of Health and Human Services, 2014.

We also recommend that CMS require states to fully enforce network adequacy standards as well as enact them. States vary in their level of scrutiny of network adequacy compliance.[3] Many rely on MCO self-reporting network data to determine compliance. While quantitative standards such as time and distance are easier to measure and assess, both quantitative and qualitative measures require third-party or direct testing to ensure that they are sufficiently adequate from the patient's perspective. The US Department of Health and Human Services Office of the Inspector General specifically recommended direct testing in 2014 when it investigated Medicaid managed care provider network adequacy in 33 states.[4] APTA appreciates that CMS recognizes the importance of network adequacy and how it impacts patient access to quality care. Accordingly, we encourage CMS to continually seek ways to improve the way it regulates this area.

Exemption From External Quality Review (42 CFR §438.362)

APTA supports CMS's proposed requirement that states annually identify on their website, in the same location where external quality review (EQR) technical reports are posted, the names of MCOs the states have exempted from EQR, and when the current exemption period began. EQRs are an important tool states use to ensure that MCOs are delivering quality health care services as contractually required. These reviews serve as a primary enforcement mechanism for compliance with state and federal requirements. Further, we support CMS's proposal that when certain criteria are satisfied, a state should have the authority to exempt an MCO from an EQR, particularly when the MCO is already undergoing federal review for a Medicare contract in the same geographical area. We also strongly agree that information on which plans are exempt from this review should be publicly available on the same webpage where the technical reports are posted. It is logical and convenient for CMS to require states to display these 2 items together.

CMS states within the proposed rule that it is instead considering requiring states to identify the exempted plans and the beginning date of the current exemption period in the annual EQR technical report rather than requiring the state to post such information on the state's website. Should CMS proceed with this alternative requirement, APTA recommends that CMS require both; that is, requiring the information to be included in the EQR technical report as well as displayed on the website. Any person examining EQR results should have immediate access to information regarding which plans are exempted from undergoing review. Otherwise, the annual EQR technical report may be misinterpreted as a comprehensive account of the quality of all MCOs in a state, when in actuality there may be many omitted from the report.

Medicaid Managed Care Quality Rating System (QRS) (42 CFR §438.334)

APTA supports the requirement that states operate a Medicaid managed care QRS. The QRS program will hold MCOs accountable for the quality of care they provide, empowers consumers to choose the best plan for their needs, and aids in innovation by helping to identify areas for targeted improvement. We strongly support the proposed requirement that

[3] Wishner JB, Marks J. Ensuring Compliance with Network Adequacy Standards: Lessons from Four States. The Urban Institute; March 2017.

[4] Murrin S. State Standards for Access to Care in Medicaid Managed Care. (No. OEI-02-11-00320.) Washington, DC: US Office of Inspector General, Department of Health and Human Services, 2014.

states' programs produce substantially comparable data to allow cross-state comparisons, but we also recognize the need for balance between the interests of standardization and state flexibility. Accordingly, we support CMS's proposed revision that would require states' QRS programs to produce substantially comparable information to the extent feasible so as to enable meaningful comparison across states.

However, APTA encourages CMS to maintain the appropriate level of oversight of state QRS programs, to ensure that the less stringent requirement is not abused. For instance, we recommend that CMS require measures used in such programs to be endorsed by the National Quality Forum to ensure that they are truly comparable across states. We also strongly support CMS's proposal to develop a set of mandatory performance measures to ensure a minimum dataset that can be tracked across all states.

Grievance and Appeal System: Statutory Basis and Definitions (42 CFR §438.400)
APTA supports the proposed clarification that a denial, in whole or in part, of a payment for a service because the claim does not meet the definition of a clean claim is not an adverse benefit determination. Medicaid enrollees currently are inundated with communications from providers and insurers, adding to the stress and confusion consumers feel when navigating the health care system. Accordingly, they should not be notified when a denial is based on a technical error that providers and issuers can correct without enrollee input. Eliminating this unnecessary notice will reduce burden for consumers, providers, and insurers alike.

Grievance and Appeal System: General Requirements (42 CFR §§438.402 and 438.406)
APTA supports eliminating the requirement for Medicaid enrollees to submit a written, signed appeal after an oral appeal is submitted. An oral appeal should be sufficient to begin the appeals process alone, and subsequent written, signed requirements add an unnecessary barrier to enrollees filing an appeal with the managed care plan. We appreciate CMS's continued efforts to eliminate regulatory burdens such as these, which unnecessarily hinder the appeals process.

Conclusion
APTA thanks CMS for the opportunity to comment on the proposed changes to Medicaid and CHIP managed care requirements. We look forward to working with CMS to ensure that the Medicaid and CHIP programs continue to provide high-quality accessible coverage without imposing unnecessary burdens on patients, providers, and insurers. Should you have any questions regarding our comments, please Kate Gilliard, senior regulatory affairs specialist, at 703/706-8549 or kategilliard@apta.org. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President
SLD: kwg