



January 14, 2019

TO: Centers for Medicare & Medicaid Services

FROM: Teryl Eisinger, Executive Director

SUBJECT: Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (CMS-2408-P)

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health (SORH). Our mission is to work with the fifty State Offices of Rural Health to improve health in rural America. State Offices of Rural Health are anchors of information and neutral observers and conveners for rural health. State Offices of Rural Health are dedicated to ensuring access to care for the nations nearly sixty million rural Americans.

NOSORH submits these comments are to ensure issues that the unique issues which impact rural communities throughout rural America are understood. Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities and the providers who serve them please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

Teryl E. Eisinger, MA
Executive Director
National Organization of State Offices of Rural Health

NOSORH Comments on Proposed Rule Governing Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Overview:

On November 14, 2018 the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services proposed rule entitled ***Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (CMS-2408-P)***. The proposed rule would provide additional flexibility to states in their administration of CHIP and Medicaid managed care programs, reducing potentially unnecessary administrative burdens. In this communication, the National Organization of State Offices of Rural Health (NOSORH) makes specific comments related to this proposed rule. While the proposed rule covers multiple topics, NOSORH is limiting its comments to the proposed changes to Section 438.68, covering provider network adequacy.

NOSORH is supportive of the direction provided by the recently enacted ***CMS Rural Health Strategy***. In that document CMS commits to applying a 'rural lens' in the assessment of its programs and policies. The Strategy seeks to find ways to *improve service delivery and payment models in rural areas* and to *improve access to services and providers for residents of rural communities*. NOSORH believes that providing states flexibility in the operation of their CHIP and Medicaid managed care programs could potentially improve rural health service access. NOSORH provides these comments to help provide a rural perspective on the impact of the proposed network adequacy requirements.

NOSORH believes that quantitative standards are useful in assuring adequate access to a health network's services and providers. NOSORH supports the flexibility granted to states in the proposed rule, providing CHIP and Medicaid program administrators the choice of appropriate quantitative standards. NOSORH believes that state program administrators can choose standards that are most appropriate for their residents.

NOSORH is concerned, however, that the flexibility granted in the language of the proposed rule may be overly broad, and may lead to preventable accessibility problems for residents of rural communities. NOSORH believes that some additional structure can be established for network adequacy requirements that would improve the guarantee of access for rural residents. This could be done while still permitting state programs substantial flexibility in the choice of quantitative standards. NOSORH's observations and recommendations related to this concern are detailed below.

Issue – Require separate standards for rural and urban networks:

NOSORH recommends that CMS require states to establish separate sets of CHIP/Medicaid managed care network adequacy standards for rural and urban areas. Under this requirement states should be given the flexibility to choose their own quantitative standards. This structural requirement would help assure that states give adequate consideration to the needs of rural communities.

Separate network adequacy requirements for rural and urban areas are already established for the Medicare Advantage managed care program. That program specifies separate network adequacy requirements for five categories of urban and rural counties:

- Large Metro
- Metro,
- Micro,
- Rural, and
- CEAC (Counties with Extreme Access Considerations), i.e. frontier counties.

CMS may want to consider requiring states to establish separate quantitative standards for the same categories of rural and urban counties. This would promote consistency between Medicare and Medicaid programs. It would also provide a common framework for managed care organizations that contract to provide both Medicare and Medicaid services.

Issue - Require capacity, availability and accessibility standards:

Fully defined network adequacy standards contain three components: **capacity** standards, **availability** standards and **accessibility** standards. Capacity standards define the extent of facility and provider resources considered adequate for an enrolled population. Enrollee-to-provider ratio maximums are an example of capacity standards. Availability standards define how those resources should be deployed to be within reasonable geographic reach of an enrolled population. Time and distance maximums are an example of availability standards. Accessibility standards set out the expected performance of a deployed network of providers and facilities. Maximum wait times for access to providers and facilities are an example of accessibility standards.

NOSORH recommends that CMS require states to establish CHIP/Medicaid managed care network adequacy standards for capacity, availability and accessibility. States should be given flexibility to choose specific quantitative standards within each of the three components. NOSORH believes, however, if any of the three components are not addressed states might approve inadequate managed care networks which would put rural communities at risk.

Issue - Require monitoring/evaluation of network adequacy:

NOSORH believes that CHIP and Medicaid managed care network adequacy can only be assured through a robust monitoring and evaluation effort. It is not enough to approve a proposed network at the beginning of a managed care contract. States must monitor the networks to assure that they are actually put into operation and are maintained. Many states have experienced problems with inadequate networks of Qualified Health Plans on the Affordable Care Act marketplace. These problems have developed after approval of what appeared to be adequate networks. States have responded with new oversight mechanisms. An overview discussion of state oversight of network adequacy can be found in the following brief:

<https://www.commonwealthfund.org/blog/2017/regulation-narrow-networks-federal-protections-jeopardy-state-approaches-take-added>

NOSORH recommends that CMS require states to implement a network adequacy monitoring and evaluation plan for CHIP and Medicaid managed care. This plan should extend to all three components of network adequacy - capacity, availability and accessibility. States should have flexibility in choosing the methods for this monitoring and evaluation.

NOSORH notes that several states have implemented particularly effective monitoring and evaluation efforts for Medicaid network adequacy. Nevada conducted a ‘secret shopper’ survey effort which disclosed serious deficiencies in its network of Medicaid providers and facilities. A report on this evaluation effort can be seen at:

<https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/nv-amrp-16.pdf>

NOSORH believes that CMS should support this requirement by disseminating information on effective state initiatives designed to monitor and evaluate network adequacy.