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July 27, 2015
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2367-P
P.O. Box 8012
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

RE: 42 CFR Parts 431, 433, 438, 440, 457 and 495. Proposed Rule: Medicaid and Children's Health Insurance (CHIP) Programs; Medicaid Managed Care …

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased offer comments regarding the Proposed Rule regarding Medicaid Managed Care. The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comment to rural-specific issues.

PROPOSED RULE: §438.8(e)(3) defines categories of activities that improve health care quality (for the purposes of calculating the numerator in minimum loss ratios) in a way that is believed (page 31110) to include activities related to service care coordination, case management, and community integration of individuals with more complex needs."

COMMENT #1: The Panel applauds CMS intent to include these activities in the numerator when calculating a minimum loss ratio. The activities are essential to coordinating care and may be substantial when the coordination requires including providers and services in a large geography. We agree that the language in 45 CFR 158.150 is broad enough to encompass appropriate activities.

PROPOSED RULE: §438.6 supports State practices to assure access to certain services, including those that would pay primary care providers rates at lease equivalent to Medicare reimbursement.

COMMENT #2: The Panel supports this section and agrees that these States will be able to demonstrate the value of such policies in advancing comprehensive quality strategies. Raising reimbursement rates to enhance accessibility and quality is particularly important in underserved rural areas, and particularly important for primary care services. We support the CMS intent that the rates be *at least* Medicare reimbursement levels, including levels used to pay Rural Health Clinics and Federally Qualified Health Centers. Since this is a floor level, we would encourage States to leave in place requirements they may have that higher levels be paid.

PROPOSED RULE: §438.62assures access to services for Medicaid beneficiaries who are compelled to transition among plans (including transitioning to and from fee-for-service).

COMMENT #3: The Panel supports the changes to this rule, in particular we support requiring that State plans describe standards applied to transition that account for critical services including Long Term Support Services, prescription drugs (and we would include pharmaceutical consultation services), and locally provided primary care and emergency services. A critical phrase in the rule is "access to services consistent with the access they previously had." The transition policy is particularly important to rural Medicaid beneficiaries because of the oftentimes scarcity of providers accepting Medicaid patients; disrupting access to those providers because of transitions to a different provider network could jeopardize access to essential services.

PROPOSED RULE: §438.208 extends rules regarding care coordination activities to include those beyond primary care, including community based support services, and with services provided outside the MCO.

COMMENT #4: The Panel concurs that the previous rule has become dated given advances in care coordination, particularly the inclusion of community-based services in successful care coordination programs. CMS requests comments about including additional standards relating to community or social support services. We also suggest CMS consider a clause requiring that States include requirements that MCOs insure that health plan efforts support local locally established community-based care coordination efforts. CMS should work with States to develop ways for MCOs (and others) to harmonize reporting and other processes across care coordination programs

PROPOSED RULE: § 438.68 establishes requirements for network adequacy that require States to establish time and distance standards for different types of providers.

COMMENT #5: The Panel concurs with the decision to require time and distance standards. Published research shows a relationship between distance and quality, making distance an appropriate criteria, superior to population-provider ratios. CMS seeks comment on whether to define actual measures as national standards. Given the importance of rural access to services, and that the reason to assure adequate access is to assure optimum quality of care and outcomes, we encourage CMS to develop national standards, with options for variation as appropriate. For example, CMS could set a standard of 30 minutes or 30 miles for access to primary care services and states with widely dispersed populations could submit plans with some variation from standard that includes alternative ways of meeting the primary care needs of Medicaid beneficiaries.

PROPOSED RULE: § 438.52 uses a county-based classification in creating a waiver of the requirement residents have access to more than one MCO, PIHP, or PAHP.

COMMENT #. The Panel agrees with the general reasoning of CMS that the counties are an appropriate geography for the purposes of determining where States might approve a single managed care entity and follow the rule's conditions for a waiver. However, given that the concern CMS expressed about using a sub-county definition similar to that used by the Federal Office of Rural Health Policy for its programs was the burden on states, we suggest states be given the option of using that definition if appropriate for their circumstances. Thus, they would be accepting the burden because of compelling policy reasons in their States.

Sincerely,

The Rural Policy Research Institute Health Panel

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