July 27, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed Rule for Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on the proposed rule published by CMS on June 1, 2015. The National Health Care for the Homeless Council (NHCHC) is a membership organization representing federally qualified health centers (FQHCs) and other organizations providing health services to homeless populations. In 2013, there were 250 Health Care for the Homeless (HCH) health center grantees serving approximately 850,000 patients in over 2,000 locations across the United States.

The Affordable Care Act (ACA) has prompted a sea-change in the care our members provide to very vulnerable people living on the streets and in shelters, cars, supportive & transitional housing programs, and doubled up in unstable living situations. In 2013, over half (57%) of our patients were uninsured, with only 32% receiving Medicaid—despite nearly all of our patients having income below 100% of the federal poverty level. While HCH health centers provide a wide range of outpatient primary and behavioral health care services (as well as support services) regardless of insurance status or ability to pay, the depth and breadth of service needed for this population often warrants additional hospital and specialty care that is not easily obtained without insurance. The expansion of Medicaid to single, non-disabled adults under 133% of poverty (in states that have opted to do so) has meant a significant increase in the number of our patients who now are enrolled in Medicaid and able to access the comprehensive health care they need to address very high rates of chronic and acute conditions (data from the Health Resources and Services Administration on final enrollment for 2014 is forthcoming).

Summary of Comments

We are commenting on the following eight areas of the proposed rule:

1. **Standard Contract Provisions [§438.3(s)(3)]:** Ensuring access to the 340B prescription drug program
2. **Standard Contract Provisions (§438.3, §438.6)/IMD Exclusion**: Ensuring access to appropriate levels of care and ensuring continuity of Medicaid benefits

3. **Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs/Rate Development Standards (§438.5)**: Ensuring provider rates consider/adjust for depth and breadth of services to acutely ill population

4. **Beneficiary Protections/Enrollment (§438.54)**: Ensuring clear communications to enrollees, longer active choice periods, and multiple opportunities to change plans

5. **Beneficiary Protections/Beneficiary Support System (§438.71)**: Ensuring equity with Navigators in the private market

6. **Continued Services to Beneficiaries and Coordination and Continuity of Care (§438.62, §438.208)**: Ensuring protections against being dropped from coverage and requesting social determinants of health be explicitly included in risk assessments

7. **Modernize Regulatory Standards/Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards (§438.68)**: Ensuring states are required to develop adequate service capacity

8. **Modernize Regulatory Standards/Quality of Care (Subparts D & E of §438)**: Ensuring a level playing field for Medicaid providers who serve complex populations

**Comments**

**Standard Contract Provisions [§438.3(s)(3)]**

Safety net providers such as HCH grantees and many others serving homeless populations are vested in the strength of the 340B program that allows access to discounts for prescription drugs. *Our colleagues at the National Association of Community Health Centers (NACHC) have provided in-depth comments about how to strengthen the interaction between the 340B program and Medicaid managed care. These comments relate to prohibiting MCOs from paying lower rates, preventing MCOs from introducing barriers to providers for participating in the program, and allowing providers to report claims data directly to the state. We fully endorse these comments.*

**Standard Contract Provisions (§438.3, §438.6)/IMD Exclusion**

We agree that MCOs should receive a capitation payment from the state for an enrollee who is admitted to an institution for mental disease (IMD), but we are concerned that the proposed time period (15 days or less) is both insufficient and perpetuates the lack of parity with other inpatient settings (such as hospitals, nursing homes, etc.) simply due to the nature of the disorder. Individuals experiencing homelessness have higher rates of mental health and substance use disorders, more frequent hospitalizations, and longer lengths of stay when admitted to an IMD compared to their housed counterparts. While the evidence shows that the average length of an IMD stay is 8.2 days, those with greater vulnerabilities need much more time for stabilization and effective discharge planning (which includes identifying stable housing at discharge—a provision that is often lacking). At the same time, we hope that any provision that continues MCO involvement with an enrollee will help increase access to treatment, and continuity of coverage since current practice often results in discontinued Medicaid coverage while hospitalized, leading to uninsured status upon discharge. Ultimately, we endorse any provision that increases access to longer-term residential mental health and SUD treatment as there is currently very limited capacity in most communities to meet the demand.
Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs/Rate Development Standards (§438.5)

NHCHC supports the proposed effort to develop risk adjustment methods to account for the health status of enrollees when predicting costs of services under contract. Because our members work with homeless clients, we see many patients with multiple complex conditions that are further complicated by social determinants of health (e.g., poverty, lack of housing, poor nutrition, etc.). Current risk adjustment methodologies do not adequately capture non-clinical risk factors (such as homelessness), putting safety net providers such as HCH grantees at a disadvantage with regard to payment methodologies and outcomes reporting. Further, the depth and breadth of services needed for a very vulnerable population needs to be reflected in payment structures, and considered when evaluating quality of care measures and progress toward larger population health goals. Failure to take into consideration these factors (the status quo) only creates a disincentive for providers to take complex patients, exacerbating barriers to care for those who have the greatest needs. Finally, we request CMS to take a strong role in standardizing social determinants of health data collection across states/MCOs to ensure health care disparities based on income/economic status can be highlighted for targeted interventions.

Beneficiary Protections/Enrollment (§438.54)

We agree that there should be ample time for a beneficiary to select an MCO plan to “ensure the beneficiary has an opportunity to make an informed choice of managed care plan and that the state processes support a seamless transition to managed care.” We also agree that there should be a consistent standard for all managed care enrollment processes, and that states must consider “existing provider-individual relationships” and have flexibility to use other criteria when making default assignments, such as “the geographic location of the beneficiary, enrollment preferences of family members, and previous plan assignments…” The proposed rule suggests that state develop informational notices to “clearly explain” to the enrollee the implications of not making a decision, but we suggest CMS require states to ensure these notices are written at a sixth grade reading level, or other standardized criteria that would better define for MCOs what constitutes “clear.” Setting consistent guidelines would not only standardize literacy levels across states, but would be in keeping with standards that already exist in many states. For example, a 2007 survey of Medicaid programs found that the majority have reading level guidelines but they vary between third grade and eighth grade (though 56% call for a sixth grade reading level).1 We believe standardizing this aspect of communications would ensure beneficiaries better understand the information being conveyed, no matter where they live. It is our experience that many of the letters to beneficiaries from both state Medicaid agencies and MCOs is difficult to understand (even for the providers who are trying to read forms for clients), thus compromising timely responses and jeopardizing continuity of benefits and care.

The proposed rule suggests a 14-day active choice period by which beneficiaries select an MCO, however, we strongly request that this period be longer—such as 30 or 45 days—to accommodate the reality that many people do not receive mail daily and are not able to read through, understand, and seek assistance (if needed) with a decision. We also request that CMS encourage states to allow special populations a non-time-limited ability to change plans outside the initial window, and encourage states to allow beneficiaries to switch providers/MCOs more than one time in a 90-day window. In addition, we are keenly aware of the shortcomings associated with the current methods of “MCO auto-assignment”

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whereby our patients are randomly assigned to providers who are unable/uninterested/untrained in providing culturally competent care to patients with intensive needs coupled with a history of homelessness. We hope that introducing more refined methodologies and significant flexibilities into MCO enrollment practices will help both beneficiaries and the providers who serve them find the best medical home that fits each client’s needs. This should yield increased patient satisfaction, higher engagement in care, and better health outcomes.

**Beneficiary Protections/Beneficiary Support System (§438.71)**

NHCHC endorses the expansion of Choice Counseling for Medicaid enrollees, however, we are concerned about the provision requiring such positions be registered with the state as enrollment brokers. We note that the preamble to the proposed rule has an expressed goal to align MCO policies with those governing Medicare Advantage and the private market; however, we note that Navigators working with QHPs do not have to be registered with the state as brokers.

*The National Association of Community Health Centers (NACHC) has more extensive comments on this topic, which we fully endorse.*

**Continued Services to Beneficiaries and Coordination and Continuity of Care (§438.62, §438.208)**

Care coordination activities (§438.208(b)) are vital for our population, and should include a full range of community-based support services needed by the beneficiary, to include connection with intensive case management, medical respite care, housing/shelter placement, disability assistance, and other services needed to ensure greater stability and better health outcomes. We agree with the proposal to expand the standards so that care coordination activities cross multiple care settings, MCOs and other partners providing services. However, while we agree with a proposal that MCOs complete an initial health risk assessment within 90 days of the effective date of enrollment, we are very concerned that failure to complete these assessments will serve as a basis to terminate coverage, and restrict eligibility and/or benefits. The patients we serve frequently do not have stable mailing addresses, phone numbers or other contact information. It is our experience that risk assessments (typically done over the phone by MCO personnel not familiar with the client or the circumstances of homelessness) are difficult for our patients to navigate. We also request that any risk assessments should explicitly include social determinants of health as crucial factors that impact service needs (e.g., lack of housing, lack of access to food, lack of income, etc.). Likewise, CMS could encourage states or MCOs to maximize the ICD-10 codes affiliated with social determinants of health (examples include Z55.0 = illiteracy and low-level literacy; Z56.0 = unemployment; Z59.0 = lack of housing; Z59.4 = lack of adequate food, etc.)

Should the initial risk assessment provision be adopted, we ask that MCOs be prohibited from terminating coverage (or any other limitation to eligibility) for failure to complete a risk assessment, and we further request that MCOs be given the authority to contract out to community-based providers the task of completing assessments (particularly for vulnerable populations) and/or to contract with safety net providers for ongoing care coordination services (in lieu of those provided via telephone by MCO staff). Particularly for homeless patients, who can be difficult for MCOs to locate, community providers would be more familiar with the patient and/or patient’s circumstances and likely able to complete a more accurate and comprehensive assessment as well as continuing services.
Modernize Regulatory Standards/Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards (§438.68)

NCHCH supports the intention to ensure network adequacy, specifically the proposal to require all states “establish, at a minimum, network adequacy standards for specified provider types.” We are particularly interested in ensuring that states and MCOs are able to ensure timely access to behavioral health services, pediatric and adult dental care, and specialty care—all of which are particularly essential for meeting the needs of a homeless population but are all-too-frequently difficult to obtain. Proposed paragraph (c)(1) proposes that states “consider” minimum factors in developing network adequacy, to include “expected utilization of services, taking into account the characteristics and health needs of the covered population; number and types of health care professionals needed to provide covered services; number of network providers that are not accepting new Medicaid patients; and geographic location and accessibility of the providers and enrollees.” **We endorse this approach, but would like to see states and MCOs be required to meet a minimum standard in this regard, rather than just “consider” these elements in concept.** [Note that our colleagues at the National Association of Community Health Centers (NACHC) have also expressed concerns with the lack of minimum standards and soft language.]

Modernize Regulatory Standards/Quality of Care (Subparts D & E of §438)

We are very pleased to see a new approach to ensuring quality of care that embraces transparency, alignment with other systems of care, and consumer and stakeholder engagement. Given that private-market qualified health plans must be accredited and evaluated based on a number of criteria (to include clinical quality measures, patient experience, complaints and appeals, and network adequacy and access), we whole-heartedly would like to see equity for the Medicaid program. We strongly believe low-income people deserve the same standard of care as their higher-income neighbors, and we embrace an opportunity to demonstrate that Medicaid providers can deliver the same high-quality care and can be evaluated to the same standards (accounting for acuity and patient demographics, of course).

We would like to take this opportunity to highlight the work of the **Partnership for Medicaid**, a nonpartisan, nationwide coalition made up of 23 organizations representing doctors, health care providers, safety net health plans, counties and labor. The goal of the coalition is to preserve and improve the Medicaid program. In March 2014, the Partnership released “The Next Step: Improving Health Care Quality and Reducing Cost in the Medicaid Program,” containing recommendations similar to those proposed in the rule, to include:

- Measuring and reporting quality outcomes that are comprehensive, appropriately adjust for patient characteristics when comparing results, appropriately balance the cost of measuring and reporting with needed improvements in health care, ensure stakeholder input, and ensure protections for data collection.
- The report envisions a four-step process to achieving a standardized quality reporting system: establish a succinct common reporting set, develop federal reporting infrastructure, establish federal incentives to report data, and establish mandatory reporting by all states in a timely fashion.

Because our members provide care to patients with disproportionately high rates of chronic and acute illnesses and require a broad range of services often needing to be coordinated across multiple providers and care venues, **we are especially interested to see quality reporting account for patient acuity and**
demographics, as well as ensure providers for this Medicaid patients are able to compete on a level playing field with their clinical peers who see a less complex patient population.

Thank you for the opportunity to comment on these proposed rules for Managed Care Organizations. Please contact us if you should wish to discuss any aspect of these comments further. I can be reached at jlozier@nhchc.org or at 615-226-2262.

Sincerely,

John N. Lozier, MSSW
Executive Director