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July 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2390–P
P.O. Box 8016
Baltimore, MD 21244–8016

Submitted electronically to: www.regulations.gov

Re: ANA Comments on 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 (CMS–2390–P)

Dear Acting Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule referenced above, published in the Federal Register on June 1, 2015. As the only full-service professional organization representing the interests of the nation's 3.4 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

ANA supports the overall proposal to align the rules governing Medicaid and CHIP managed care plans with qualified health plans, incorporate new and revised beneficiary protections, and strengthen provider networks, accountability and program integrity safeguards. As discussed below, ANA also supports the goal of modernizing the quality standards for Medicaid Managed Care Organizations (MCOs) in order to develop a comprehensive quality strategy that applies to all beneficiaries regardless of delivery system. We believe these changes would benefit individuals who transition between sources of coverage.

Changes to Part 431(Sections 431.500 – 431.506)

The new provisions in sections 431.500 – 431.506 would establish standards to measure performance and improve quality of care that would be applicable regardless of delivery system. States would be

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

required to develop a comprehensive Medicaid quality strategy to identify measurable goals and objectives that specify quality metrics and performance targets, consider the health status of all populations' services, and annually publish outcomes and metrics on the State's public Medicaid website. ANA applauds these measures, which would promote transparency and quality of care.

Managed Care Definitions (Section 438.2)

The definition section states that a *primary care case manager* (PCCM) "means a physician, a physician group, practice or, at State option, any of the following: (1) A physician assistant; (2) A nurse practitioner; (3) A certified nurse-midwife." ANA recommends expanding this definition to include clinical nurse specialists (CNSs) and RNs.

Care coordination and transition care are fundamental to effective case management. RNs and APRNs, including CNSs, play a pivotal role in providing such care, which is integral to nursing practice. Many RNs and APRNs provide care management as a key component of their nursing practice, in various nursing roles and across all health care settings. For example, Standard 5A of ANA's Nursing Scope and Standards of Practice[2] states that the RN "coordinates care delivery" and details six related competencies. The RN:

- organizes the components of the plan;
- manages a healthcare consumer's care in order to maximize independence and quality of life;
- assists the healthcare consumer in identifying options for alternative care;
- communicates with the healthcare consumer, family, and system during transitions in care;
- advocates for the delivery of dignified and humane care by the interprofessional team; and
- documents the coordination of care.

The APRN has additional competencies which include providing "leadership in the coordination of interprofessional health care for integrated delivery of healthcare consumer care services."

RNs and APRNs, including CNSs, are skilled in developing plans of care and identifying outcomes and are experts in health teaching and health promotion using information technologies (including electronic health records) – all essential elements of care coordination and case management. In addition, APRNs are skilled in assessment and evaluation. Furthermore, APRNs use prescriptive authority, procedures, referrals, treatments, and therapies in care management. Because of the pivotal role played in case management, ANA urges CMS to fully recognize the role of RNs and CNSs in acting as Primary Care Case Managers.

Information Requirements (Section 438.10)

ANA supports the CMS proposal to establish new information requirement standards for all managed care programs including MCOs, Pre-paid Inpatient Health Plans (PIHPs), Pre-paid Ambulatory Health Plans (PAHPs), PCCM, and PCCM entities. ANA also supports the proposals regarding provider directory requirements, including the requirement to provide all required information to enrollees and potential enrollees in a manner and format that may

[2] American Nurses Association. (2010). Nursing: Scope and Standards of Practice, 2nd edition, Standard 5A. Silver Spring, MD: Nursesbooks.org, 32-46.

be easily understood and readily accessible. Providing up-to-date, accurate and complete provider directories would improve transparency for patients seeking contact information, as well as information such as which providers are accepting new patients and where the providers are located. We also support the proposal to make this information publically available in a machine-readable format, as that would also enhance transparency by allowing patients and consumer groups to better analyze data and develop tools to compare plans.

We do recommend a number of changes to Section 438.10. Under section 438.10(a)(4), states would be required to develop common terminology for terms such as primary care provider and primary care physician, and must require the consistent use of such terminology by each MCO, PIHP, PAHP and PCCM entity. ANA supports the use of common terminology. In order to promote greater consistency between the various states, ANA recommends that in addition to describing the specific terms that must be defined, CMS also develop language defining these terms.

Section 438.10(h)(2) requires that the provider directory include information for the following provider types: (i) physicians including specialists; (ii) hospitals; (iii) pharmacies; (iv) behavioral health providers; and (v) Long-Term Services and Supports (LTTS) providers. ANA recommends revising section 438.10(h)(i) to include references to providers other than physicians who are authorized to provide care (such as health care professionals, defined earlier in the rule).

The proposed rule notes that CMS is considering requiring the best available provider directory standard as listed in the ONC draft of the "2015 Interoperability Standards Advisory," and requests comments on such a requirement. ANA has previously expressed support for the broad mission of the 2015 Interoperability Standards Advisory regarding clinical health information technology interoperability – particularly the standards and implementation specifications associated with Vocabulary/code sets/terminology – and would support such a requirement in this rule.

Continued services to enrollees (Section 438.62)

It is essential to have standards to ensure care coordination and protect beneficiaries when they move to a new managed care plan. ANA supports the new requirement in section 438.62(a) to ensure continued access to services when a plan's contract is terminated or following beneficiary disenrollment. ANA also supports the requirement, in section 438.62(b), for a transition of care policy to ensure continued access to services for beneficiaries at risk of suffering deterioration of health, hospitalization or institutionalization. Care coordination would also be enhanced by the requirement for states to make transition of care policies publicly available and to provide instructions on how to access continued services upon transition. ANA also supports the proposal to allow the Secretary flexibility to include additional procedures to ensure continued access to services.

State Monitoring Requirements (Section 438.66)

ANA applauds the CMS proposals for extending the areas that must be included in states' monitoring operations, clarifying that monitoring includes oversight activities, and requiring the use of data to improve the performance of managed care programs. All of these requirements have the potential to improve the quality of care provided to beneficiaries.

Network Adequacy Standards (Section 438.68)

A new proposal in this rule would require states contracting with MCOs, PIHPs, or PAHPs to develop and enforce network adequacy standards that, at a minimum, include time and distance standards for certain services, including primary care (adult and pediatric), OB/GYN, behavioral health, specialists (adult and pediatric), hospital, pharmacy, pediatric dentist, and other provider types as determined by CMS. In developing such standards, states would be required to consider a wide range of issues, including such factors as: anticipated Medicaid enrollment and utilization of services; the characteristics and health care needs of the specific Medicaid populations covered by the contract; the number of types of health care professionals needed to furnish the services under the contract; the numbers of network health care professionals who are not accepting new Medicaid patients; the geographic location of the health care providers and Medicaid enrollees; the ability of the providers to communicate with limited English enrollees; and the ability of the providers to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment for Medicaid enrollees with physical or mental disabilities. States would also need to consider elements that support an enrollee's choice of providers, an enrollee's health and welfare, and the best interest of enrollees needing LTSS. Ongoing monitoring of enrollee access would be required, and network adequacy standards would be available on request and publically available on state Medicaid websites.

ANA supports the development and enforcement of network adequacy standards described above, including time and distance standards for the essential categories of providers. In order to ensure that the prevalence of certified nurse-midwives is consistently recognized in network adequacy standards, we recommend revising section 438.68(b)(1)(ii) to read "OB/GYNs and CNMs," and section 438.68(c)(1)(iv) to require that state network adequacy standards explicitly require plans to include in their networks providers whose services are statutorily mandated under section 1902(a)(10), including CNMs and birth centers. We also recommend revising section 438.207(b)(1) to state: "Offers an appropriate range of preventive, primary care, specialty services, LTSS, and the services or providers identified under Section 1902(a)(10), that is adequate for the anticipated number of enrollees for the service area."

In order to promote consistency between state programs, ANA supports having measures required at the national level (rather than have states select and define the type of measure for the network's adequacy), and also supports having CMS define the actual measures to be used by states.

MCO, PIHP and PAHP Standards (Section 438.206 – 438.207)

ANA supports CMS' proposal to ensure that states, through contracts with managed care plans, provide access to beneficiaries with limited English proficiency or physical or mental disabilities, the proposal to broaden culturally competent care, and the proposed standard to require MCOs, PIHPs and PAHPs to ensure that network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. ANA also supports the proposal to add an annual submission requirement for MCOs, PIHPs, and PAHPs, and a requirement that states submit to CMS an assurance that the plans documentation has been reviewed.

Coordination and Continuity of Care (Section 438.208 and 438.210)

ANA strongly supports the CMS proposal to expand the existing list of activities that are included as care coordination, including requirements to coordinate services between care settings, provide discharge planning for certain hospital and institutional stays, and make a "best effort" to conduct an initial assessment of an enrollee's needs within 90 days of enrollment with the plan. ANA also supports expanding the list of care coordination activities to include coordinating with community or social support services and the proposed modifications to section 438.208(c) to address the care coordination for enrollees with special health care needs. ANA also supports the proposal to modify §438.210 to improve standards for states to ensure, through managed care contracts, the use of management strategies that adequately support people with ongoing or chronic conditions or who require long-term services and supports.

Quality Measurement and Improvement; External Quality Review (Sections §438.310 and 438.370)

ANA supports the proposed revision to the existing definition of quality in section 438.320 to reference "*the provision of services that are consistent with current professional, evidenced-based knowledge*," and "*positive trends in performance measures and clinically significant results from interventions for performance improvement*." ANA supports the proposal to authorize CMS to specify performance measures and methodologies for calculating quality ratings through public notice and comment, and the proposal to add a new paragraph on LTSS performance measurement, as well as the new section requiring MCOs, PIHPs and PAHPs, as a condition of contracting with a state, to undergo a performance review in accordance with standards at least as stringent as those used by private accreditation entities approved or recognized by CMS. Similarly, ANA supports the proposed addition of the Medicaid managed care quality rating system (section 438.334), which would establish minimum standards for state use in contracts to develop and implement a Medicaid managed care rating system. ANA also supports the new section on activities related to external quality review (EQR) (section 458.358), which would add an additional mandatory EQR activity for each MCO, PIHP, and PAHP.

Requiring states to report on performance outcomes and standardized metrics to the public and to CMS, and the requirement to develop a comprehensive quality strategy, will allow quality to be compared across plans. For this reason, ANA does not support the provisions allowing states to select their own performance improvement projects, topics, and performance measures. While flexibility would allow states to design activities to meet their own needs, it would decrease the alignment between states, which would limit the ability to make important comparisons between states.

Grievance System (Sections 438.400 – 438.424)

The proposed rule includes a number of changes to the current grievance and appeals systems to increase uniformity across plans, including Medicare Advantage (MA) and private health insurance plans. ANA supports the proposal to revise the timeline for appeals to further consistency with MA and private health plan rules, as well as the proposal to streamline the appeals and grievance process, including the proposal to have one level of appeal to exhaust the managed care plan's internal appeals process. ANA also supports the requirement that documentation must be provided to an enrollee as part of a notice of an adverse benefit determination, and that certain minimum record retention

requirements must be maintained. The proposed changes to the regulation provide a more consistent and coherent framework for beneficiaries navigating the appeals process.

Children's Health Insurance Program

The proposed updates to the CHIP regulations would codify guidance related to the Children's Health Insurance Program Reauthorization Act of 2009 and the Affordable Care Act and bring the program into greater alignment with Medicaid. Revisions include establishing enrollment standards similar to those proposed for Medicaid, incorporating Medicaid standards regarding access and availability of services, capacity, coordination and continuity of care, and aligning CHIP with Medicaid grievance and appeals sections. The proposed rule would also incorporate many of the Medicaid program integrity standards. ANA supports these changes, as they would increase uniformity and alignment across plans.

We appreciate the opportunity to share our views on this matter. If you have questions, please contact Jane Clare Joyner, Senior Policy Fellow (janeclare.joyner@ana.org or 301.628.5083).

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
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