July 27, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

BY ELECTRONIC DELIVERY

Re: 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 to Related to Third Party Liability (CMS 2390-P)

Dear Administrator Slavitt:

The Association of Community Cancer Centers (ACCC) appreciates this opportunity to comment on the Medicaid and CHIP managed care proposed rule (the "Proposed Rule").[1] ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 20,000 cancer care professionals from approximately 1,100 hospitals and more than 1,000 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 32 state oncology societies. It is estimated that 60 percent of cancer patients nationwide are treated by a member of ACCC.

Cancer care is continuously evolving, and our members' ability to provide the best possible care to their patients depends on appropriate payment for the innovative and cutting-edge therapies our patients require to win their battles against this deadly disease. Our members are deeply committed to ensuring that their lowest-income patients, many of whom are Medicaid beneficiaries, have access to the same high quality care and innovative treatments as other patients. That requires, at a minimum, ensuring that each Medicaid managed care plan provides coverage for services furnished by a broad range and variety of network

[1] 80 Fed. Reg. 31,098 (June 1, 2015).

providers located throughout the communities in the plan's service area and provides coverage of and timely access to new therapies. That also requires protecting continuity of care for Medicaid beneficiaries who are responding well to their cancer treatment and monitoring states' and their Medicaid managed care contractors' innovative payment arrangements and quality of care initiatives to ensure that those initiatives do not jeopardize access to care. Given our commitment to these issues, ACCC is pleased to respond to the requests for comments on proposals by the Centers for Medicare & Medicare Services (CMS) regarding network adequacy standards, beneficiary protections, and innovative payment arrangements for Medicaid managed care plans.[2]

I. Robust network adequacy standards that reflect the local geographic area are critical to ensure meaningful access to cancer care.

ACCC's members provide highly-specialized cancer care in a wide variety of health care settings and therefore know firsthand that when it comes to cancer treatment, ensuring that patients can choose the doctor, cancer care team, or treatment facility that is right for them can mean the difference between life and death. ACCC believes that a robust provider network is essential to ensure that Medicaid beneficiaries with cancer will have meaningful access to the care that they need. ACCC therefore supports CMS's proposal to require states to develop network adequacy standards for managed care networks for certain provider types, and also agrees that is appropriate to maintain state flexibility to develop additional standards for network adequacy.[3] ACCC offers a number of suggestions for further strengthening the network adequacy standards in the Proposed Rule.

A. CMS should clarify that network adequacy standards must be met for at least certain types of specialists and should consider applying the same standards to certain sub-specialty providers as well.

The Proposed Rule requires states to establish time and distance standards for primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental and "additional provider types when it promotes the objectives of the Medicaid program."[4] CMS notes that given the large number of pediatric enrollees, it "believe[s] it is important for states and plans to specifically include pediatric primary, specialty, and dental providers in their network adequacy standards."[5]

ACCC strongly supports CMS's proposal to require states to adopt minimum network adequacy standards for at least these types of providers, including pediatric and adult health care providers, as the necessary foundation for ensuring that Medicaid managed care enrollees have

[2] The Proposed Rule adopts many of the same standards for managed care delivery in states' Children's Health Insurance Program (CHIP) programs. ACCC supports CMS's efforts to extend many of the same protections described with respect to Medicaid managed care to CHIP and thus where applicable, its comments should be read to apply to both programs.
[3] 80 Fed. Reg. at 31,145-46.
[4] 80 Fed. Reg. at 31,145 (proposed to be codified at 42 C.F.R. § 438.68(b)(1)).
[5] 80 Fed. Reg. at 31,145.

timely access to cancer care. Not only do the treatment needs of pediatric cancer patients differ significantly from those of adult cancer patients, but treatment needs vary dramatically depending on the type of cancer and the stage of progression of the disease. Pediatric cancer care differs from adult care both due to treatment options for pediatric patients and the need for surveillance for long-term toxicities in cured pediatric cancer patients. Virtually all cancer patients require the care of multiple specialists, such as oncologists, hematologists, surgeons, radiologists and pain specialists, to name only a few, and often receive treatment on both an inpatient and outpatient basis. In fact, many cancer patients will receive care from sub-specialists that are experts in a particular type of cancer. Not all cancers are the same, and as a result, a patient with leukemia will have a different set of doctors and other health care providers and a different course of treatment than a patient with breast cancer.

ACCC therefore asks CMS to clarify that a state's minimum network adequacy standards apply separately to each type of specialty provider, depending on a plan's geographic area, or at a minimum, to identify certain types of specialty providers, such as oncologists or pain specialists, to which those standards would apply. For example, CMS should explain that a state must establish a specific time and distance standard for oncologists and not just "adult specialists" generally. Without that clarification, ACCC is concerned that a managed care plan could attempt to meet a state's network adequacy standard for "adult specialists" by contracting with only a few types of specialists, and not with oncologists or radiologists or other specialists that are integral to cancer care. ACCC also respectfully requests that CMS consider whether and when it would be desirable to specify provider subspecialties, at least in certain geographic areas, for which states must establish minimum network adequacy requirements in order to ensure that Medicaid managed care enrollees have timely and meaningful access to cancer care.

B. Measures and Criteria for Evaluating Network Adequacy

The Proposed Rule requires states to establish time and distance standards with respect to the specified provider types listed above, but CMS specifically requests comments on whether it should propose a different measure for network adequacy, such as provider-to-enrollee ratios, or whether it should give states flexibility to select the type of measure for the network adequacy of those provider types.[6]

CMS explains that its proposal "would not limit states to only the mandatory time and distance standards but also would have states consider additional elements when developing network adequacy standards."[7] CMS proposes to expand the minimum factors that a state must consider in developing its network adequacy standards, which include anticipated Medicaid enrollment, expected utilization of services, the characteristics and health needs of the covered population, geographic location of providers, and the number of network providers that are not accepting new patients, to specifically take into account the ability of providers to ensure physical access and accommodations for Medicaid enrollees with physical or mental disabilities and the ability of providers to ensure culturally competent communications with limited English

[6] 80 Fed. Reg. at 31,145
[7] 80 Fed. Reg. at 31,146.

proficient enrollees.[8] CMS urges the states to look to network adequacy standards established by the insurance regulator in their state, the standards set under the Medicare Advantage program, and historical patterns of Medicaid utilization, to inform their network adequacy standards.[9]

ACCC strongly supports this approach, as it allows states to draw on their local expertise to develop network adequacy standards that are informed by the geographic area, the Medicaid population, and the standards in the comparable commercial market, to ensure that Medicaid managed care enrollees have meaningful access to care in the state.

C. Requirements for Network Provider Screening and Enrollment

The Proposed Rule requires that States screen and enroll, and periodically revalidate, all network providers of managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), and pre-paid ambulatory health plans (PAHPs), in accordance with the same requirements that apply to Medicaid fee-for-service (FFS) providers. The requirement also applies to primary care case managers (PCCMs) and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the state to provide services to FFS beneficiaries. CMS expressly states that this provision does not require network providers to render services to FFS beneficiaries.[10] ACCC supports the need for robust program integrity, but is concerned that requiring all network providers to be screened and enrolled by the state, in addition to the credentialing process administered by the MCO, PIHP or PAHP, could be duplicative and/or burdensome and may run counter to network adequacy objectives and related efforts to increase the number of network providers that serve beneficiaries enrolled in Medicaid managed care.

D. Requiring managed care companies to make provider network information available to Medicaid enrollees and potential enrollees enhances beneficiary choice.

Given that cancer patients undergo complicated treatment regimens and receive services from multiple health care providers, ACCC believes that it is especially important for Medicaid beneficiaries with cancer to easily determine whether a specific doctor, hospital or pharmacy is in a managed care plan's network so that those beneficiaries can enroll in the plan that provides the most appropriate coverage for them. That information must be accurate and up-to-date. Thus ACCC also supports the Proposed Rule's requirement that Medicaid managed care entities make a provider directory available for at least five provider types: physicians, hospitals, pharmacies, behavioral health, and long-term services and supports (LTSS), and update those directories at least monthly (if in paper form) or within 3 business days (if electronic) of receiving updated provider information. [11] That information must include the provider's name as well as any group affiliation, street address, telephone number, website URL, specialty (if appropriate), ability to accept new enrollees, cultural and linguistic capabilities, and whether the

[8] 80 Fed. Reg. at 31,146 (proposed to be codified at 42 C.F.R. § 438.68(c)(1)).
[9] 80 Fed. Reg. at 31,146.
[10] 42 C.F.R. §§ 438.602(b), 438.608(b) (proposed).
[11] 80 Fed. Reg. at 31,162 (proposed to be codified at 42 C.F.R. § 438.10(h)).

provider's office/facility is accessible for people with physical disabilities.[12] The Proposed Rule also requires provider directory information to be available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's websites in a machine readable file and format specified by the Secretary.[13] ACCC agrees that allowing software developers to develop other tools to help enrollees better understand the availability of providers in a specific plan will enhance beneficiaries' ability to choose the managed care plan that best meets their needs, and thus also supports this requirement.

II. ACCC commends CMS for its focus on critical beneficiary protections and urges CMS to adopt those proposals with a few modifications.

ACCC appreciates CMS's efforts to address the "gap" in the current Medicaid managed care regulations regarding the enrollment process, including the mechanisms for enrollment in voluntary and mandatory managed care programs, beneficiary "lock-in" upon enrollment, and continuity of coverage for items and services that treat serious or chronic conditions and during transitions in coverage. CMS also proposes a number of other changes to vital protections for Medicaid managed care enrollees and potential enrollees, including expanding beneficiary appeal rights for all "adverse benefit determinations," similar to the standards for the commercial market, and establishing standardized procedures and time frames for those appeals. In addition, CMS reaffirms its commitment to protecting Medicaid managed care enrollees from discriminatory policies and practices by managed care plans by requiring states to expressly prohibit discrimination in their contracts with MCOs, PIHPs, and PAHPs.

Each cancer patient responds differently to treatment, and often patients need complex, multi-pronged treatment regimens. Timely access to a new therapy, particularly after a cancer patient already has tried multiple therapies, may present new hope for survival. Continuity of care during transitions in coverage, a streamlined appeals process that safeguards timely access to innovative therapies, and a prohibition against discriminatory practices are fundamental protections to ensure that Medicaid beneficiaries have access to the cancer treatment that they need. ACCC commends CMS for its comprehensive examination of these beneficiary protections and offers a few specific comments on those protections that are most important to ACCC members and their patients.

A. ACCC supports seamless coverage to allow Medicaid beneficiaries time to select a plan.

ACCC agrees with CMS that Medicaid beneficiaries are best served when they affirmatively exercise their right to make a choice of delivery system (that is, managed care versus fee-for-service) or plan enrollment (that is, in a particular managed care plan). [14] ACCC also agrees that "[o]ptimally, this involves both an active exercise of choice and requisite time and information to make an informed choice."[15] That is especially true for cancer patients, for

[12] 42 C.F.R. § 438.10(h)(1) (proposed).
[13] 42 C.F.R. § 438.10(h)(4) (proposed).
[14] 80 Fed. Reg. at 31,133.
[15] Id.

whom inclusion of a particular specialist or a specific hospital location in a plan's network may be a critical factor in their decisions. It also will be particularly important if CMS implements its proposal to "lock in" a Medicaid beneficiary into a particular plan after 90 days for the remainder of the plan year. ACCC therefore believes that at a minimum, CMS should implement the Proposed Rule requiring the state to provide 14 days of fee-for-service coverage to allow the beneficiary to choose to enroll in managed care (for voluntary managed care programs) and to select a managed care plan (for both voluntary and mandatory managed care programs) before applying any default enrollment process.[16]

ACCC strongly supports CMS's proposal to require states to establish a default enrollment process that "seek[s] to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries."[17] If that is "not possible," the state must equitably distribute individuals among the entities available to enroll them, which may include considering additional criteria such as the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, and procurement evaluation elements.[18] Because cancer care often involves such complex treatment regimens and an array of health care professionals, it is vital not to disrupt cancer patients' relationships with their care teams during transitions in health insurance coverage from fee-for-service to managed care or between managed care plans. CMS proposes to define an "existing provider-beneficiary relationship" as one in which the provider was the main source of Medicaid services for the beneficiary during the previous year, which may be established through state records, encounter data, or through contact with the beneficiary. ACCC asks CMS to ensure the definition of "existing provider-beneficiary relationship" capture existing relationships between an oncologist or other cancer treatment provider and the beneficiary, ensuring continuity in cancer care.

ACCC also supports CMS's proposal to require states to develop and implement a "beneficiary support system" to provide personalized assistance before and after managed care enrollment that includes at a minimum, choice counseling for all beneficiaries, training for network providers, assistance for enrollees in understanding managed care, and assistance for enrollees who use or desire to use long-term services and supports.[19]

B. Comprehensive transition of care policies are critical to avoid disruptions in life-saving cancer care.

Because continuity of care is of such paramount importance for cancer patients, especially those who are responding well to treatment, ACCC strongly supports the requirement in the Proposed Rule for states to establish a "transition of care policy" to ensure continued access to services during a Medicaid beneficiary's transition from fee-for-service to managed care or during a transition from one managed care entity or PCCM to another, when an enrollee without continued services would experience serious detriment to their health or put them at risk

[16] Id. § 438.54(c)(2), (d)(2).
[17] Id. § 438.54(c)(6), (d)(6).
[18] Id. § 438.54(c)(7), (d)(7).
[19] Id. § 438.71.

of hospitalization or institutionalization.[20] States retain the flexibility to define the policy, as long as it meets the broad standards specified in the Proposed Rule, and would have flexibility to determine the types of enrollees for which the MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities would need to provide transition activities. ACCC knows that any disruption in care for a Medicaid beneficiary undergoing cancer therapy could be life-threatening, and urges CMS to provide more specific criteria or at a minimum, some examples of the types of enrollees states should ensure are protected by transition of care policies. ACCC asks CMS to establish standards, or at a minimum, specific criteria for a state to consider when determining the type of enrollees for which transition of care policies would apply.

The standards outlined in the Proposed Rule include (1) permitting an enrollee to continue to receive the services he or she is currently receiving from his or her current provider for a specified period of time if that provider is not in the managed care entity's network, (2) referring the enrollee to an appropriate participating provider, (3) assuring that the state or managed care entity comply with requests for historical utilization data, and (4) assuring that the enrollee's new provider is able to obtain appropriate medical records.[21] CMS explains that the transition of care policy would apply to "services" covered under the managed care entity's contract with the state, including prescription drugs if the managed care entity is obligated to cover drugs.[22] States must require managed care entities by contract to implement a transition of care policy that is consistent with the standards in the federal regulations and the standards in the policy developed by the state.[23]

ACCC also supports the Proposed Rule's requirement that states make their transition of care policies publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition.[24]

C. Medicaid beneficiaries and their treating providers need access to a streamlined appeals process to ensure timely access to medically necessary care.

As a safeguard to ensure that Medicaid beneficiaries undergoing cancer treatment have timely access to medically necessary care, including new therapies that become available on the market, the Medicaid appeals process must be streamlined, transparent, timely, and easy for beneficiaries and their providers to navigate. ACCC therefore generally supports the Proposed Rule's standardization of the Medicaid managed care appeals and grievances procedures across Medicaid managed care entities (including MCOs, PIHPs, and most PAHPs) and CMS's efforts to better align them with the existing procedures required for Medicare Advantage plans and commercial plans. ACCC applauds in particular the extension of appeal rights for Medicaid beneficiaries to all "adverse benefit determinations," as that term is used in the commercial market, which includes determinations based on medical necessity, appropriateness, health care

[20] 80 Fed. Reg. at 31,139 (proposed to be codified at 42 C.F.R. § 438.62).
[21] 42 C.F.R. § 438.62(b)(1) (proposed).
[22] 80 Fed. Reg. at 31,139.
[23] 42 C.F.R. § 438.62(b).
[24] Id. § 438.62(b)(3) (proposed).

setting or effectiveness of a covered benefit.[25] Given the complex and often innovative treatment regimens needed to beat cancer, Medicaid managed care enrollees and their health care providers may well find themselves facing managed care plan utilization restrictions that may not match the treating provider's determination about the appropriate course of treatment and may need to avail themselves of the appeals process.

Thus, ACCC also supports CMS's efforts to streamline the appeals process and import other standards from the commercial market into Medicaid managed care. First, ACCC supports the Proposed Rule's standardization of the appeals process such that a Medicaid managed care entity (i.e., an MCO, PIHP, or PAHP) may require a beneficiary or provider to go through only one level of "internal appeal" (i.e., review by the managed care entity) before exhausting the internal appeal process and being allowed to request a "state fair hearing."[26] This proposal parallels the appeals process required for commercial coverage in the individual market and MA organizations.[27] As is required in the commercial context, the Proposed Rule requires a managed care entity to provide a written explanation for the reason for any adverse determination, which includes reasonable access to and copies of all documents, records and other information relevant to the enrollee's claim such as medical necessity criteria or evidentiary standards used in setting coverage limits.[28] ACCC agrees that providing access to this information is an integral part of a meaningful, robust appeals process.

Second, ACCC supports the Proposed Rule's alignment of the time frames in which the Medicaid managed care entity must issue decisions on beneficiary appeals with the time frames that apply to Medicare Advantage plans: (1) shortening the current maximum time of up to 45 days (as determined by the state) and to 30 calendar days for standard appeals and establishing 30 calendar days as the required time frame in all states, and (2) shortening the time frame for expedited appeals from 3 working days to within 72 hours.[29] ACCC likewise endorses the Proposed Rule's requirement that an MCO, PIHP, or PAHP effectuate a reversal of an adverse benefit determination and authorize or provide such services within 72 hours from the date that it receives notice of the decision being overturned.[30] These shorter time frames help facilitate more timely access to cancer treatment for ACCC members' patients.

Finally, ACCC also supports CMS's proposals to establish standard record-keeping requirements for each appeal and grievance and to require the state to review the information as part of its monitoring of managed care programs and to revise and update its comprehensive quality strategy.[31] ACCC believes that strong oversight by state Medicaid agencies will help ensure that Medicaid beneficiaries and their providers do have a meaningful opportunity to appeal an adverse benefit determination and that managed care plans do not impermissibly deny or delay medically necessary care.

[25] 80 Fed. Reg. at 31,103.
[26] 80 Fed. Reg. at 31,104; 42 C.F.R § 438.402.
[27] 80 Fed. Reg. at 31,104.
[28] 42 C.F.R. § 438.404.
[29] 42 C.F.R. §§ 438.210(d), 438.408.
[30] 80 Fed. Reg. at 31,107.
[31] 42 C.F.R. §§ 438.66, 438.416 (proposed).

D. States should closely monitor their Medicaid managed care contractors to prevent discrimination against cancer patients.

ACCC applauds CMS's proposal to adopt specific language that states must include in their contracts with Medicaid managed care entities that prohibits discrimination against individuals eligible to enroll in the MCO, PIHP, PAHP, or PCCM on the basis of their health status or need for health care services and prohibits the entity from using "any *policy or practice* that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability."[32] The Proposed Rule also revises the list of federal statutes with which all managed care contracts must comply to include Section 1557 of the Affordable Care Act.[33] ACCC believes that the broader prohibition against discriminatory policies or practices on the basis of sex, sexual orientation, gender identity and disability is consistent with the applicable federal laws and confirms the important role that a state Medicaid agency plays in ensuring that managed care plans do not discriminate against Medicaid beneficiaries. The Proposed Rule also provides that a state may impose intermediate sanctions, such as civil money penalties, if an MCO acts to discriminate among enrollees on the basis of their health status or need for health care services.[34]

III. CMS should strengthen its oversight over innovative payment arrangements to ensure that they do not jeopardize access to care.

ACCC supports CMS's and states' shared desire to improve the quality of care beneficiaries receive while reducing costs to the Medicaid program, as part of achieving overall delivery system and payment reform. Cancer patients require complicated treatment regimens that involve services furnished by several providers, including inpatient and outpatient hospital departments, physicians, and home health agencies. Patients clearly benefit from improved coordination among members of their care team. ACCC recognizes that innovative payment arrangements between states and managed care plans, and between managed care plans and their network providers, are important tools to improve population health and provide better care at lower costs. But to achieve these objectives, CMS and states also must ensure that they offer appropriate incentives and protections for access to care. In particular, these alternative payment arrangements should not penalize health care providers for furnishing innovative therapies to their patients. These therapies might increase costs during the immediate episode of care while improving the patient's outcomes in the long term.

For example, in the Proposed Rule, CMS proposes to create three exceptions its general rule that states are not allowed to direct the MCO's, PIHP's, or PAHP's expenditures under the managed care contract to give states flexibility to (1) specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement in which reimbursement is based on quality or care or health outcomes, rather than the volume of services, (2) require MCOs, PIHPs, or PAHPS to participate in broad-ranging delivery system reform or performance improvement initiatives, such as patient-centered medical homes, and (3) direct that MCO,

[32] 42 C.F.R. § 438.3(d), (f) (proposed) (emphasis added).
[33] 80 Fed. Reg. at 31,114.
[34] 42 C.F.R. § 438.700, .702 (proposed).

PIHPs or PAHPs set minimum reimbursement standards or fee schedules that delivery a particular covered service or raise provider rates (through negotiation in their specific provider agreements) in an effort to enhance the accessibility or quality of covered services.[35] CMS proposes that as a part of the federal approval process, states would demonstrate that such arrangements are based on utilization and delivery of high-quality services and would link approval of the arrangement to supporting at least one of the objectives in the state's comprehensive quality strategy.[36] States would be required to implement an evaluation plan to measure how the arrangements support the comprehensive quality strategy objectives.

ACCC generally supports CMS's approach to allow states greater flexibility to work with managed care plans as partners to test alternative payment approaches with contracted health care providers to ensure high-quality care. At the same time, ACCC believes that CMS oversight is critical to ensure that these arrangements do not inappropriately undermine Medicaid managed care enrollees' access to care, especially with respect to some of the innovative therapies that are needed to treat cancer patients. Any value-based payment approach or performance improvement initiative must appropriately weigh the quality of care provided and it may be difficult to determine how to value a new innovative therapy that may increase costs during the immediate episode of care while improving the patient's outcomes in the long term. ACCC therefore also supports CMS's proposal to link alternative payment arrangements to a state's comprehensive quality strategy and respectfully requests that CMS use that process to ensure that such approaches do not unintentionally jeopardize access to innovative therapies.

ACCC also appreciates CMS's recognition that allowing states flexibility to require MCOs, PIHPs, and PAHPS to set minimum reimbursement rates or to raise reimbursement rates is "critical to ensuring timely access to high-quality, integrated care."[37] ACCC supports the proposed flexibility to allow states to require MCOs, PIHPs, and PAHPs to set minimum reimbursement rates for certain types of health care providers or to pay higher reimbursement rates to improve access to care. ACCC suggests increased reimbursement rates could be linked to provider network adequacy standards.

IV. Other comments

A. CMS should require formulary drug lists be made publically available.

ACCC strongly supports CMS's proposal to ensure managed care plans provide enrollees with clear information on coverage of medications.[38] CMS proposes to require managed care entities provide formulary details including coverage and tier information upon request, and make formulary drug lists available on entity websites. For patients with chronic conditions, a clear understanding of covered medications is essential to choosing a managed care plan. ACCC agrees that this information should be provided upon request, but also be made publically available to enable the development of third party resources comparing health plans.

[35] 80 Fed. Reg. at 31,124; 42 C.F.R. § 438.6(c) (proposed)
[36] 80 Fed. Reg. at 31,124-25.
[37] 80 Fed. Reg. at 31,124.
[38] 80 Fed. Reg. at 31, 162.

B. CMS should require coverage of medically necessary outpatient drugs through a prior authorization process.

ACCC supports CMS's proposal to require state contracts with managed care entities that provide coverage of "covered outpatient drugs," (as that term is defined in section 1927(k) of the Social Security Act), to conduct a prior authorization program that complies with "the standards for coverage of such drugs imposed by section 1927 of the Act as if such standards applied directly to the [managed care entity]."[39] Managed care entities may maintain their own formularies but when there is a medical need for a "covered outpatient drug" but they must cover the drug through a prior authorization process. ACCC agrees that prior authorization requirements imposed by section 1972(d)(5), including coverage decision within 24 hours of request and dispensation of a 72 hour supply of a covered outpatient drug in emergency situations, would provide appropriate protections for patients.

C. CMS should extend "care coordination activities" beyond primary care.

ACCC supports CMS's proposal to extend "care coordination activities" beyond primary care to other types of community-based support services (i.e., not just health care services).[40] Care coordination should include both horizontal integration of traditional healthcare providers, as well as delivery of care through non-traditional means.

D. CMS should include stakeholder input in development of comprehensive quality strategy.

ACCC supports CMS's proposed standards for state development of a comprehensive quality strategy.[41] However, ACCC would like to emphasize the importance of a robust public process and an opportunity for stakeholders to be heard on these issues going forward.

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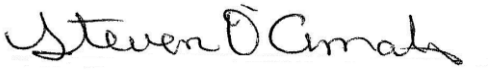
ACCC appreciates the opportunity to comment on the Proposed Rule. Please feel free to contact Leah Ralph, Manager, Provider Economics and Public Policy, at (301) 984-5071 if you have any questions regarding these comments or need any additional information. Thank you for your attention to this very important matter.

Respectfully submitted,



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[39] 42 C.F.R. § 438.3(s) (proposed).
[40] 80 Fed. Reg. at 31,140.
[41] 80 Fed. Reg. at 31,153-55.