August 22, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–6068–P
P.O. Box 8016,
Baltimore, MD 21244–8016

Re: CMS-6068-P

Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act

Dear Sir/Madam:

We appreciate the opportunity to comment on the Payment Error Rate Measurement (PERM) Program. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates, and litigates at the federal and state level.

While we support many features of the new PERM regulations, we believe that HHS has not done enough to coordinate these provisions with the important regulations recently released for Medicaid managed care (at 81 Fed. Reg. 27497 (May 6, 2016)). It makes little sense to release new PERM regulations that do not fully address managed care oversight and/or delay such regulations to a later regulatory package. We recommend that HHS fully address managed care oversight in *these* regulations, without further delay, and this is the administratively expeditious solution. Such an approach is completely consistent with the timing of the managed care regulation roll-out and wholly relevant to the purpose of the PERM regulations, and will promote accountability and quality improvement for consumers.

Assessing quality in Medicaid demands data on how Medicaid dollars are spent, including payments to providers in both fee-for-service and managed care systems. While capitation payments made to managed care plans must be proper (i.e., made on behalf

of enrolled beneficiaries, for proper rate cells, etc.), those payments and criteria *alone* do not ensure fully proper payment. To fully assess proper payment, HHS must also understand how managed care plans in turn spend the capitation dollars. HHS should not delegate all oversight plans; HHS should conduct parallel oversight of provider payment in managed care. And when a plan payment to a provider does not match required standards – for example, if encounter data is not collected and validated – there should be a consequence for PERM. Without such a policy, there will be a fundamental misalignment in standards for provider payment across fee-for-service and managed care, and as a result, HHS will lack the same oversight capacity and information needed to meaningfully address breaches in quality. This is all the more important as a growing majority of Medicaid enrollees are in managed care systems. If HHS does not use this compliance tool, we will be less likely to ever understand where and why our clients fail to receive the services they are entitled to.

We recommend that HHS make changes consistent with this approach, including:

§ 431.960(b)(3)(ix)

"Managed care payment errors" should be interpreted to include errors in payments made by plans to providers, in addition to errors in state capitation payments to plans. We recommend making a conforming definition in § 431.804 (definitions).

§ 431.960(c)(3)

"Medical review errors" should be applied to managed care plans and include a broader range of errors, including failure to report required encounter data. HHS should consider defining errors to include compliance failures with requirements in 42 C.F.R. § 455, Subparts (B) and (E).

§ 431.970

Section 431.970 (including both subparts (a) and (b)) should be amended to ensure that states and providers make the necessary claims-level managed care information available to HHS and PERM contractors. This means requiring information on managed care payment to providers (not only capitation payments) and provider information for managed care payments. Terms such as "managed care claims," "rate information," "corrective action plan," "payments," and similar terms should all be interpreted to apply to the managed care plan payment to providers.

Subpart (c) should be correspondingly edited to include managed care payment systems and other systems needed to capture the relevant data (in addition to MMIS, etc.).

We strongly support the use of a federal contractor to conduct PERM eligibility reviews. This should increase the accuracy of the reviews, provide for greater consistency, and lessen the burden on states.

§ 431.972

"Managed care payments," "payments," "paid claims," and similar terms should include managed care payments to providers.

Conclusion

In summary, we believe administrative efficiency demands that HHS coordinate this PERM regulation with recent Medicaid managed care regulations, and include oversight of managed care payments to providers. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

Leonardo D. Cuello