January 25, 2018

VIA ELECTRONIC SUBMISSION
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Request for Information – Promoting Health Care Choice and Competition Across the United States

To whom it may concern:

The National Health Law Program (NHeLP) is a public interest organization working to advance access to quality health care and protect the legal rights of low-income and under-served people. NHeLP appreciates the opportunity to provide comments in response to the Department of Health and Human Services' (HHS) Request for Information (RFI) regarding competition and consumer choice in health care markets.

Our comments broadly address the theme posed by the five questions in the RFI. We disagree, however, with ASPE's premise that the protections of the Affordable Care Act (ACA) and its implementing regulations have decreased competition and consumer choice. The ACA has resulted in access to affordable coverage for millions of Americans, while increasing transparency and protecting consumers from discrimination. These protections have ensured that consumers have meaningful choice of quality coverage. NHeLP urges ASPE and HHS to recognize the value of these protections to consumers, and to continue their implementation and enforcement to ensure access to quality care for consumers in public and private health care programs and settings.

1. Strong Essential Health Benefits Protections Are Pro-Competitive

The RFI asks what state or federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) reduce or restrict competition and choice in healthcare markets.

A strong statutory and regulatory framework governing health care programs and services help ensure access and quality while allowing for competition. As discussed below, health care coverage standards and state mandates are critical to ensure comprehensive coverage and allowing competition based on comparable products.

Ensure adequate coverage of EHBs for all enrollees. The ACA established ten categories of Essential Health Benefits (EHBs) which help ensure that consumers have access to the health services they need.[1] The broad applicability of EHB provides insurers an even playing field with a mixed pool of both healthy and sick enrollees. Without EHBs, consumers may need to pay for care or may be unable to afford coverage at all. The EHBs were designed to address a broad range of health needs while also recognizing the specific needs of those historically deprived of important health care services, such as women, individuals with significant health care needs including those living with disabilities, chronic conditions, and HIV.

For example, prior to the implementation of the EHBs, 75 percent of non-group plans did not cover inpatient and delivery services for maternity care and some plans had severe limits or restrictions on mental and behavioral health services.[2] If insurers are able to provide sub-standard benefit packages, the ensuing private market segmentation will result in separate plans for healthy people and for those with more significant health care needs. This, in turn, will drive up the costs of health care for all. Healthy individuals may purchase skimpy plans and then find themselves without needed coverage if they develop an illness or face unanticipated health care costs mid-year. EHBs are also important in ensuring that individuals receive comprehensive coverage. Without comprehensive coverage, consumers are incentivized to pursue forms of uncompensated care like ER visits which—according to a bipartisan joint statement of the Senate Finance Committee from before the ACA was passed—resulted in a "hidden tax" of more than $1,000 per year in premiums for the adequately insured.[3] We urge HHS to guarantee EHBs for all applicable enrollees to ensure a fair and affordable individual market with robust competition for consumers. This includes rethinking planned rules to allow adoption of EHB benchmark plans across state lines, which will incentivize a race to the bottom that reduces benefits and limit meaningful consumer choice in the market.

Increasing state flexibility and competition by incentivizing state mandates. As we noted in our comments on the 2017 Notice of Benefits and Payment Parameters Rule, HHS' current policy on state benefit mandates has effectively ended implementation of new state mandates, particularly as they apply to Marketplace health plans, because of the

[1] 42 U.S.C. § 18022.
[2] Gary Claxton, et. al., *Would States Eliminate Key Benefits If AHCA Waivers Are Enacted?*, THE HENRY J. KAISER FAMILY FOUND. (2017), *available at* http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.
[3] United States Senate Committee on Finance, *Baucus, Grassley Release Policy Options for Expanding Health Care Coverage* (May 11, 2009), *available at* https://www.finance.senate.gov/release/baucus-grassley-release-policy-options-for-expanding-health-care-coverage.

potential costs to the state.[4] We urged HHS to create a process for states to address important market coverage gaps by adding new benefits without additional cost to the state. The proposed 2018 Notice of Benefits and Payment Parameters rule goes in the opposite direction, limiting opportunities to improve and expand benefits—a move that actually *reduces* state flexibility. We are concerned that the changes HHS has recently proposed to the EHB benchmark process will reduce the comprehensiveness of coverage for consumers by allowing states to drop or limit the benefits that are currently covered in their state, give insurers more latitude to deviate from a state's EHB standard, and weaken consumer protections against catastrophic out-of-pocket costs. These changes would disproportionately impact individuals with disabilities and people with pre-existing medical conditions who could face reduced access to the services they need and higher out-of-pocket costs.

2. The Administration's Actions Have Destabilized Markets and Will Inhibit Competition

Stability in the health care market is vital for effective competition and meaningful consumer choice and access. The administration has taken actions to undercut the ACA and Medicaid expansion that have destabilized the market, and have thus worked against the RFI's theme of pursuing competition.

Failure to make CSR payments destabilizes markets and hurts consumers. Cost sharing reduction (CSRs) subsidies are a key part of the ACA's framework for offering affordable, high quality insurance to low-income consumers. Without the CSR payments, insurers must raise premiums to compensate for both the difference in revenue and added uncertainty in the market. Some state regulators have addressed this by imposing a surcharge on Silver-level plans, which ensures that consumers who receive subsidies will not experience premium hikes. However, this is an imperfect solution, as those on the individual market who do not receive subsidies will experience large premium spikes. This decreases the consumer's choice of affordable plans. The uncertainty over whether CSR payments will be restored in the future and over whether each individual state will implement a solution will drive insurers out of the market over the long term, further decreasing competition. Finally, uncertainty and the imprecise nature of calculating surcharges makes it so that the increase in premiums will not necessarily be a 1:1 replacement for the CSRs. In fact, they may wind up being greater than what insurers would have received otherwise. As a result, preventing CSR payments could wind up opening the door to regulatory abuse by some, but not all, insurers. Restoration of the CSR payments or support for a bipartisan solution to stabilize markets will increase competition and result in greater consumer choice.

[4] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Ctrs. for Medicare & Medicaid Services (Dec. 21, 2015) (comments on HHS Notice of Benefit and Payment Parameters for 2017), *available at* http://www.healthlaw.org/issues/health-care-reform/2017-Parameters#.WgniTohOkdU.

3. Transparency and Oversight of ACA Exchange Plans Encourages Meaningful Consumer Choice

The RFI posits that there are significant barriers to choice in the health care market that limits competition. Effective enforcement of consumer protections, such as transparency requirements in the ACA, will ensure a competitive market where consumers can make informed choices of plans.

HHS should rigorously monitor and enforce transparency requirements for Marketplace plans. Transparency of plan information – including ensuring plans provide up-to-date and accurate formularies and provider networks to both prospective and current enrollees – is critical to ensure that consumers have the information they need to choose the best plan. We are concerned that formularies and provider network information posted online are oftentimes still outdated, incomplete, and do not provide consumers with accurate information needed to select plans that best meet their prescription drug and provider network needs. This information is especially critical for those living with chronic illnesses and disabilities to ensure that these individuals have the information they need to select plans that cover necessary medications and provide access to providers with the appropriate experience and expertise to treat their conditions. HHS announced last year that it would cease many of its monitoring and review activities for formularies, cost sharing, and other areas subject to discriminatory plan design.[5] We strongly encourage HHS to vigorously enforce transparency and monitoring requirements, as informed consumer choice is vital for a competitive health care market.

HHS' standardized benefit options reduce consumer confusion and facilitate access to plans that meet care, treatment, and affordability needs. HHS' rules facilitate choice by providing options in a standard format, outlined in the 2018 Notice of Benefit and Payment Parameters Rule. Prioritizing standardized plans allows consumers to more easily make apples-to-apples comparisons of provider networks, cost-sharing, and drug formularies. This helps consumers make informed, cost-effective choices about purchasing insurance. HHS should continue to emphasize these standardized plans.

Review and monitor plans for discriminatory benefit design. HHS has established important consumer protections against discriminatory practices by insurers. For example, HHS identified the hazards of adverse tiering, whereby insurers discourage enrollment by persons with significant health needs, such as HIV/AIDS, by placing medications in the highest cost sharing tiers. As a result, plans with more balanced tiering structures become more likely to enroll high-need patients. This can lead to a "race to the bottom" effect where the plans put their medications in the highest-cost tiers to discourage persons with significant health needs from enrolling. Meanwhile, people who most need coverage are left

[5] U.S. Dep't of Health and Human Servs., Ctr. for Consumer Information and Insurance Oversight, 2019 Draft Letter to Issuers (Nov. 27, 2017) at 13-17; *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2019-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf.

with few options. HHS must ensure that plans undergo rigorous compliance review and enforcement of non-discrimination standards instead of weakening standards and compliance monitoring.

HHS should support community-based navigator programs and consumer assistance. Navigators and other consumer assisters provide information and services to consumers in a fair, accurate, and impartial manner according to conflict of interest rules. Brokers and agents working on commission, by contrast, often steer clients to plans that pay the highest, leading consumers to purchase health coverage that does not fully meet their needs. HHS' rules and funding for navigators ensure that consumers who need special help, including people with disabilities and those with limited English proficiency, get the assistance they need, ensuring that all consumers are empowered. HHS' rules have promoted choice and empowerment by ensuring that consumers have access to trusted advisors who can give consumers information to determine which coverage best suits their needs. Slashing navigator funding or transitioning this duty to commercial actors will result in less informed choices by consumers, and presents serious conflicts of interest. This in turn lessens competition and opens the door to regulatory abuses by commercial brokers. Thus, HHS should make a concerted effort to support nonprofit, community-based navigator groups to ensure that consumers can make informed choices and enroll in plans that are right for them.

Dangers of "skinny exchanges." The administration has shown interest in pursuing "skinny exchanges" – health insurance Marketplaces that are run primarily by commercial, for-profit entities. Implementing this policy will have anticompetitive effects and will likely cause serious conflicts of interest. Similar to the concerns with the use of commercial brokers over non-profit navigators, private companies who have a hand in how exchanges are run are incentivized to direct people to the most profitable plan possible. In addition, a web of privately run "skinny exchanges" will further decrease standardization in how plans are presented to consumers. The result will be less informed consumer choice. Maintaining robust health insurance Marketplaces with strong government oversight is crucial to a competitive insurance market with meaningful choice for consumers.

ACA Section 1557 protects consumers and improves consumer choice. Section 1557 of the ACA guarantees that consumers will not face discrimination on the basis of race, national origin, age, disability, sexual orientation, or gender identity in the health care market. Before the ACA and still today, it is far too often the case that discrimination in health care limits access to care and meaningful consumer choice of care. Thus, maintaining important nondiscrimination protections through the implementing federal regulations and extensive oversight will increase competition, consumer choice, and ensure equitable access to care for our society's most vulnerable citizens.

4. Consolidation of Religiously-Affiliated Providers Limits Competition

The RFI expresses concern about the anticompetitive effects of hospital consolidation. We share that concern and urge HHS to recognize the unique role played by religiously-affiliated providers serving health care markets.

Catholic hospital mergers lead to significant restrictions in competition and choice in the healthcare market. Catholic health systems currently control 16.6 percent of the hospital beds in the U.S.[6] There are 20 states where more than 20 percent of hospital beds, and five states where more than 40 percent of hospital beds are in Catholic hospitals.[7] Four out of the ten largest hospital systems in the U.S. are Catholic-owned.[8] "The number of U.S. hospitals with a Catholic affiliation has increased by 22 percent since 2001" while the number of overall hospitals has dropped by 6 percent.[9] There are 46 Catholic hospitals that are the sole providers in their communities, with full monopolies over the health care industry in their geographic regions.[10]

Catholic health facilities are governed by the Ethical and Religious Directives for Catholic Health Care Services, promulgated by the U.S. Conference of Catholic Bishops.[11] These Religious Directives specify a range of services that are prohibited including abortion, contraceptives, sterilization, and most forms of assisted reproductive technologies, such as *in vitro* fertilization (IVF). The Directives also limit the treatment options for ectopic pregnancy and to prevent pregnancy as a result of sexual assault. As Catholic hospitals merge with other non-Catholic hospitals, they reduce the availability of these basic health care services for patients. These mergers and consolidations also lead to less competition in the health care market more generally as large Catholic health care institutions buy out local hospitals and eliminate choices for health care consumers. Last, large Catholic systems are merging with each other to increase their market share and overwhelm competition.[12] For example, Dignity Health and Catholic Health Initiatives signed a merger agreement; both are already among the five largest non-profit systems in the country and operate in 28 states.[13]

These mergers are eliminating independent and secular hospitals that provide a full range of reproductive health services, leaving few – if any – patient choices.

5. Expanded Religious Exemptions Endangers Consumer Choice

Competitive health care markets allow consumers comprehensive access to services. Extensive religious exemptions severely limit consumer choice, and are anathema to the theme of the RFI.

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[6] *Miscarriage of Medicine*, AM. CIVIL LIBERTIES UNION 5 (updated 2016), *available at* http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=H%2Bg7sawTMhFgu%2BEKbKrbYidGfOs%3D.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Ethical and Religious Directives for Catholic Health Care Services*, U.S. CONF. CATH. BISHOPS (2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.
[12] Julie Minda & Betsy Taylor, *CHI, Dignity Health to Combine in New Catholic Nonprofit System*, CATH. HEALTH ASS'N U.S. (Jan. 15, 2018), *available at* https://www.chausa.org/publications/catholic-health-world/archives/issues/january-15-2018/chi-dignity-health-to-combine-in-new-catholic-nonprofit-system.
[13] *Id.*

Regulations expanding religious exemptions decrease choice and competition in the health care market. These exemptions make it more difficult for consumers to obtain the health care, and in particular the reproductive health care, services that they need. The recent regulations expanding the ability of employers to refuse to cover contraception in their employee benefit plans based on an ambiguous "moral" objection, means that many more employers and insurance companies will be able to deny coverage of contraceptives.[14] Under the ACA, plans were required to provide all 18 FDA approved contraceptive methods without cost-sharing. With these expanded exemptions, employers and insurance companies can choose not to offer all/any of these types of contraception because they are morally opposed to them. These expanded exemptions mean that in many cases, women will have fewer choices of contraceptive options that are covered and will not be able to make decisions about family planning based on what is best for their situation and health.

Expansions of religious exemptions also disrupt the efficient and effective operation of health care institutions. The proposed "Protecting Statutory Conscience Rights in Health Care" would allow a wide range of health care providers and workers to refuse to be even remotely involved in services to which they have an objection.[15] Such a wide religious exemption will disrupt the efficient operation of health facilities, which depend on consistent and predictable staff performance. Ultimately, it results in reduced quality in patient care.

6. Threats to Title X, Family Planning and Abortion Clinics, & FQHCs are Anti-Competitive

The anticompetitive effects of hospital consolidation are compounded further by limited consumer choice of other health care options, including family planning and abortion clinics, as well as FQHCs.

Reductions or disruptions in funding for Title X, Planned Parenthood, and federally qualified health centers (FQHCs) encourages anticompetitive behavior. Reductions in Title X funding puts providers of essential health care services around the country at risk. Title X is the only federal program focused solely on providing crucial reproductive health care services, which includes family planning, contraception, physical exams, prescriptions,

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[14] U.S. Dep't of Health and Human Servs., Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 42 Fed. Reg. 47792 (Oct. 10, 2017), *available at* https://www.federalregister.gov/documents/2017/10/13/2017-21851/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the; Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47838 (Oct. 10, 2017), *available at* https://www.federalregister.gov/documents/2017/10/13/2017-21852/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable.

[15] U.S. Dep't of Health and Human Servs., Office for Civil Rights, Statement of Organization, Functions, and Delegations of Authority, 83 Fed. Reg. 2802-2803 (Jan. 19, 2018), *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-01-19/pdf/2018-00820.pdf.

laboratory exams, and referrals.[16] Title X clinics serve approximately four million patients each year and are critically important to the provision of reproductive health care. These organizations serve low-income populations, including uninsured individuals, and rely on Title X funding to provide essential services to their patients. Decreases or disruptions in these funds may force some of these providers to close, decreasing competition in the health care market, reducing patient choice and access to needed care, and resulting in poor health outcomes, unintended pregnancies, and outbreaks of sexually transmitted infections and HIV.

Similarly, attempts to cut funding to Planned Parenthood and other family planning clinics reduce competition in the health care market. Recent federal and state efforts to disqualify Planned Parenthood and other clinics that provide abortion services from participating in any U.S. Department of Health and Human Services programs, including Medicaid, are anticompetitive. These clinics are already prohibited by the Hyde Amendment from receiving federal funds for abortion services (except in the case of life endangerment, rape, or incest). These clinics serve low-income and uninsured populations, and are dependent on federal programs to continue to provide essential health care services. These additional funding restrictions would force many clinics to close their doors, and this would dramatically reduce competition in the health care market.

When Texas prohibited these clinics from receiving state funds, twenty-five percent of family planning clinics were forced to close.[17] In 2011, 71 percent of organizations offered long acting contraception and in 2012 to 2013, that number shrank to only 46 percent.[18] Many of the organizations that were not forced to close had to shorten their hours of operation.[19] Overall, organizations could only serve around half of the number of patients they had previously served.[20] Any similar federal actions will harm patient choice and access to care.

The failure to re-fund FQHCs also could lead to significant reductions in competition, patient choice, and patient access to care. If Congress fails to allocate funds to FQHCs, over 10,400 FQHCs that serve more than 27 million Americans will lose in excess of 70 percent of their funding. This would force at least 2,800 of these health centers to shut down, leaving 9 million Americans without access to critical health care services and putting 50,000 health care workers out of jobs.[21] These clinics serve the most vulnerable

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[16] NARAL Pro-Choice America, *Title X Family Planning Services: Fast Facts* (2016), *available at* http://www.prochoiceamerica.org/media/fact-sheets/birth-control-family-planning-title-x-fast-facts.pdf.

[17] Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUBLIC HEALTH 851-58 (May 2015), *available at* http://sites.utexas.edu/txpep/files/2017/04/White-et-al-Impact-of-Reproductive-Health-Legislation-AJPH-pre-print-2015.pdf.

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] Gaby Galvin, *Future Uncertain for Federal Health Program*, U.S. NEWS (Sept. 7, 2017), *available at* https://www.usnews.com/news/health-care-news/articles/2017-09-07/federal-health-program-funding-may-come-too-little-too-late.

Americans, including the working class poor, impoverished, homeless, and uninsured. These clinics often serve urban and rural communities, and clinic closures would be particularly devastating for rural communities where there is already little to no existing competition in the health care market. FQHC closures would cause significant harms overall to competition in the health care market and to patient access to care. To the greatest extent possible, HHS should work to protect and expand funding for FQHCs.

7. Medicaid Managed Care Protections Help Ensure Quality and Consumer Choice

Consumer choice and competition are central themes of the RFI. The need for strong consumer protections applies not only to the regulation of private insurance under the ACA, but also to Medicaid managed care.

In 1976, in response to Medicaid managed care scandals in California and Illinois involving egregious, unlawful denials of care, Congress established standards for managed care organizations and other prepaid entities wishing to participate in Medicaid.[22] That law prohibits federal funding to states unless managed care plans comply with specified accountability and stewardship requirements.[23] Among other things, the contracts between the state and each managed care entity must assure that it does not discriminate on the basis of health status or need, that beneficiaries have right to disenroll consistent with federal requirements, that the state can audit and inspect the managed care entity's books and records, and that the plan will maintain adequate patient encounter data to identify the providers who deliver the services to patients.[24]

Strong regulations governing Medicaid managed care, designed to address past abuses, foster competition by creating an even playing field for plans. The Medicaid managed care regulatory framework, robust monitoring, and enforcement, are essential to protect enrollees and ensure that the state and federal governments are getting value for taxpayer dollars. Moreover, federal and state oversight has become even more important as managed care companies increasingly provide Long Term Services and Supports (LTSS) for the most vulnerable among us – the elderly and persons with disabilities. HHS should fully implement the Medicaid managed care regulations finalized in 2016, which include important consumer protections.[25]

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[22] S. Rep. No. 95-749, 95th Cong., 2d Sess. (1978) (investigative report); H. Rep. No. 94-1513, 94th Cong., 2d Sess. (1976) (Conference Committee Reporting to accompany H.R. 9019), as reprinted in 1976 U.S.C.C.A.N. 4371. *See also* Andreas Schneider & Joanne Stern, Health Maintenance Organizations and the Poor: Problems and Prospects, 70 NW.U.L.REV. 90, 126-38 (1975).

[23] *See* 42 U.S.C. § 1396b(m).

[24] *Id*.

[25] U.S. Dep't of Health and Human Servs., Ctrs. for Medicaid & Medicare Servs., *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
See also NHeLP Comments, (July 27, 2015) available at http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care.

Helping consumers make informed choices. States that require beneficiaries to enroll in Medicaid managed care must, with limited exceptions, provide each enrollee a choice between at least two managed care plans.[26] In theory, consumer choice provides plans with the incentive to provide high quality services and care to attract enrollees, while poorly performing plans are effectively penalized with fewer enrollees. However, in practice, consumers may be unaware of their healthcare options, as well as protections and rights for obtaining care. They also may not know whether a particular plan is performing well. Federal regulations require states to provide Medicaid beneficiaries information about plan design to help enrollees and potential enrollees understand their available options.[27] When states implement mandatory Medicaid managed care and require enrollment in MCOs or PCCMs, agencies must provide enrollees and potential enrollees information on:

- managed care plan benefits;
- how to access services; and
- quality and performance indicators.[28]

Regulatory protections help ensure access to needed benefits. Federal law and regulations provide consumer protections to ensure that managed care enrollees have access to important health care services and benefits provided through a state's Medicaid plan.[29] States must also ensure that enrollees receive information on managed care plans' responsibilities to coordinate care, including any cost sharing – as well as Medicaid benefits not covered under the managed care contract, including how and where the enrollee can obtain such services.[30] States must inform children and families enrolled in Medicaid managed care about coverage of immunizations, the benefits of preventive care, and their choice of providers.[31]

If potential enrollees know that a particular plan does not cover certain services, and obtaining these services through the plan is important to them, they can choose a plan that does cover the services. Federal laws and regulations requiring plan transparency on benefits, services, and cost sharing allow consumers to make informed choices when selecting plans, facilitate competition among plans, and ultimately lead to improved quality and health care outcomes.

Regulatory protections help ensure access to providers. Medicaid managed care enrollees cannot receive the services they need unless they have access to adequate provider networks; however, federal regulations do not currently prescribe specific

[26] *Id.* § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a). In rural areas, states can require enrollment in just a single managed care entity; however, that plan must provide consumers a choice of more than one physician or case manager. 42 U.S.C. § 1396u-2(a)(3)(B). Certain county-operated plans, such as those operated under the MediCal program in California, also do not have to offer a choice in MCOs. *See* 42 U.S.C. § 1396u-2(a)(3)(C).
[27] 42 C.F.R. § 438.10.
[28] 42 U.S.C. § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10.
[29] 42 C.F.R. § 438.206(a).
[30] *Id.* §§ 438.10, 438.206(b).
[31] 42 U.S.C. § 1396a(a)(43).

standards governing, for example, the types of providers who must be included or maximum travel times and distances.[32] Thus, it is up the states to establish such standards – or not. Moreover, active monitoring and enforcement of those standards is frequently lacking, as noted by the OIG.[33] Accordingly, it often falls to stakeholders to advocate for specific network standards and to identify problems with networks that may be failing to meet enrollees' needs.

In December 2014, the HHS OIG published a report – Access to Care: Provider Availability in Medicaid Managed Care. The report found that 51% of providers on Medicaid managed care provider lists were either no longer in business, were not longer participating in Medicaid or the managed care plan, or were not accepting Medicaid enrollees.[34] The OIG also faulted state Medicaid agencies and CMS for poor oversight of managed care companies.

Availability of providers is at the heart of network adequacy. If enrollees are unable to find a doctor who provides needed services or accepts Medicaid, they will not obtain the services to which they are entitled, regardless of what the state Medicaid plan or managed care contract requires.

Moreover, being able to see the same primary care provider and specialists promotes continuity of care, improved coordination of care. Thus, for many enrollees, having access to the right providers represents a key factor in selecting a managed care plan. However, enrollees and advocates often discover that plan provider lists are out of date, and including providers who are no longer part of the network, no longer accepting Medicaid patients, or even no longer in business.[35]

Robust federal standards for Medicaid managed care network adequacy would promote competition by providing an even playing field for plans. Moreover, effective monitoring and enforcement of those standards help ensure that consumers can access the services and care they need.

Monitoring and reporting managed care quality. Capitated managed care establishes a payment system that is designed to reward plans that avoid providing unnecessary services. This delivery system needs robust mechanisms to monitor and evaluate care quality; otherwise, the structure of capitated managed care could encourage plans to deny

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[32] 42 C.F.R. § 441.68.

[33] U.S. Dep't of Health and Human Servs., Office Inspector Gen. ("OIG"), *State Standards for Access to Care in Medicaid Managed Care*, No. 09-25-2014, (Sept. 29, 2014), *available at* https://oig.hhs.gov/oei/reports/oei-02-11-00320.asp.

[34] OIG, *Access to Care: Provider Availability in Medicaid Managed Care*, OEI-02-13-00670 (Dec. 2014), *available at* http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

[35] For example, a 2011 survey conducted by the DC Behavioral Health Association found that more than 50% of identified mental health practitioner listed in each of the District of Columbia Medicaid MCOs' provider directories were no longer employed or in business. *See* Medical Care Advisory Committee, Behavioral Health Subcommittee, *FY 2011 Year-end Report and Recommendations* (Apr. 12, 2012), *available at* https://docs.google.com/a/healthlaw.org/file/d/0BwhX1B9WJhhVLUZ6RlNKdXdKUFE/edit?pli=1.

or delay even medically necessary care simply to save money. Performance measurement is the principal mechanism for evaluating quality of care.

The federal government has recognized the importance of this information. Regulations require that managed care plans make available to enrollees and others all information related to quality and performance, which may include HEDIS® data.[36] Finally, as performance measurement becomes more standardized, it allows more meaningful comparisons between health plans, which may help guide consumers' enrollment and disenrollment decisions, as well as states' decisions regarding contracting.

Part of the overall Medicaid managed care quality strategy mandated by federal law requires annual independent external quality reviews (EQRs) in all managed care contracts with MCOs.[37] Contracts typically require plans to engage an independent organization to evaluate the performance of Medicaid managed care plans.[38] EQR can provide meaningful independent oversight of managed care plan compliance with Medicaid requirements and quality control. The best EQRs standardize the reporting of quality metrics to allow comparisons between plans, and take an active role in testing plan compliance.

Federal regulations also require states to produce an annual managed care program assessment report that includes: an assessment of the availability and accessibility of services within capitated plans, performance on quality measures, activities of the beneficiary support system, compliance with state network adequacy standards, information on grievances, appeals and state fair hearings, the financial performance of each plan including MLR, encounter data reporting, and enrollment.[39] States must submit the report to CMS no later than 180 days after the end of each contract year, and make the report publicly available.[40]

Oversight of MCOs Providing Long Term Support & Services. Consumers who receive LTSS through Medicaid are some of society's most vulnerable. MCOs who proved these services have significant leverage when there are few alternatives, and can use Medicaid market leverage to pressure cuts in facilities costs and buy low quality services. For example, MCOs may sometimes push consumers into assisted living homes that are not subject to federal consumer protections for nursing homes to cut costs. Thus, the quality of care provided by the MCO can become suspect. We strongly encourage HHS to stringently enforce MCO oversight rules in the LTSS realm to ensure that these organizations are providing high quality, and if possible community-based, care to Medicaid consumers. This includes disallowing states to waive the requirement that Medicaid consumers have a choice of at least two managed care plans. The result will be more competitive market

[36] 42 C.F.R. §§ 438.236-242.
[37] Federal regulations require EQRs for Managed Care Organizations (MCOs), Prepaid Inpatient Hospital Plans (PIHPs), and certain Health Insurance Organizations (HIOs), as defined in 42 C.F.R. §§ 438.2 and 438.310. *See also* 42 U.S.C. § 1396u-2.
[38] States may enlist a state department other than the Medicaid agency to conduct EQR, but do not receive enhanced federal match if the reviewing department does not qualify as an EQRO.
[39] 42 C.F.R. § 438.66(e)
[40] *Id*.

behavior in Medicaid and more efficient, quality care for Medicaid consumers receiving LTSS.

Conclusion

Thank you for your attention to our comments. NHeLP urges ASPE and HHS not to focus on increasing competition as an end in itself, but as a tool to ensure access to quality care for consumers in public and private health care settings. Thus, the faithful implementation and enforcement of the consumer protections detailed above should be at the forefront of federal and state policymaking. If you have any questions or need further information, please contact Wayne Turner (turner@healthlaw.org) at the National Health Law Program.

Sincerely,

Elizabeth G. Taylor
Executive Director