NHeLP
NATIONAL HEALTH LAW PROGRAM

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VIA ELECTRONIC SUBMISSION

October 4, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Baltimore, MD 21244-8010

Re: OCIIO-9989-NC

Dear Mr. Angoff:

The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, disability advocates, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. As the health care system changes during the implementation of the new health reform law, it is critical to focus on ensuring that the private market can improve health delivery for all populations, including diverse and low-income vulnerable populations. Accordingly, NHeLP is pleased to offer comments on the Office of Consumer Information and Insurance Oversight's (OCIIO) Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (PPACA).

We have separately submitted joint comments with a number of other organizations as well as individual comments discussing access for individuals with limited English proficiency. In the discussion below, we provide additional information in response to some of the questions posed in the August 3, 2010 Request for Comments.

Planning

- **What are some of the major considerations for States in planning for and establishing Exchanges?**

Due Process Exchanges will be responsible for establishing and administering an appeals process for individuals denied eligibility for premium tax credits. These tax credits are the key to ensuring that health care coverage is affordable and available to individuals and families. It is therefore crucial that Exchanges establish appropriate due process protections to protect the rights of applicants.

Individuals who meet relevant eligibility criteria and qualify for premium tax credits have a legitimate claim of entitlement to them. And, the Exchanges that will determine eligibility for these credits will either be state entities, or will be operated with significant State and federal funding. Thus, they must comply with constitutional protections set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), just as state

Medicaid agencies must do when determining eligibility for Medicaid coverage. These protections are embodied in the federal Medicaid regulations governing notice and appeal at 42 C.F.R. §§ 431.200-.250. Exchanges should be required to comply with the requirements of these regulations when eligibility for tax credits is denied in whole or in part. Among other requirements, notices must clearly state the reason for the denial and the authority upon which the decision is based. And, hearings must include the right to an impartial hearing officer, to be represented, to examine the evidence relied upon by the Exchange, and to present evidence and witness. *See* 42 C.F.R. §§ 431.206, .244.

This is particularly true because, in many cases, the Exchanges will also be responsible for determining eligibility for Medicaid. It makes no operational sense to have two sets of notice and appeals procedures that are administered by one entity. Moreover, compliance with due process requirements helps assure transparency and accountability for the significant public funding that is provided to states, Exchanges, and private health insurance plans.

Quality and Qualified Health Plans

- **What factors are most important for consideration in establishing standards for a plan rating system?**
- **What factors should be considered in developing the Section 1311(c) certification criteria?**

Any plan rating system must be transparent, publicly available, and easy for consumers to understand. Information derived through this system must also be broadly disseminated and should be accessible on line and in written form. And, like all information provided in connection with the Exchanges, the measures must be conveyed in a manner that is easily understood and accessible to people with low literacy, LEP, and disabilities.

The HEDIS and CAPHS measures are good and useful tools and we note the PPACA that recommends that they be used as standards. OCIIO should, however, be mindful of some issues related to the HEDIS measures. First, there are limitations on how much HEDIS information is accessible. The National Committee for Quality Assurance (NCQA), which develops and publishes the HEDIS measures, makes only some data available to the public. The primary source of public data is the organization's annual *State of Health Care Quality*, in which it provides data from Medicaid and commercial plans on selected HEDIS measures.[1] Other information, including some data from individual plans and states, can only be obtained from NCQA by purchasing its "Quality Compass" product, which costs thousands of dollars.[2] Thus, it is crucial that HHS ensures that all information necessary to help individuals, employers, and the public is widely available without restrictions on proprietary information.

Use of HEDIS measures also has particular significance for Medicaid enrollees and other working poor people. Due to fluctuations in income, many individuals are likely to move among Exchange, Medicaid, and CHIP plans. Section 1311 of the ACA requires that Exchange plans be accredited with respect to measures such as HEDIS. Given this explicit recommendation, it is likely that HEDIS will frequently be used. But, according to NCQA, only about half of the 20.5 million Medicaid beneficiaries who are in

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[1] *See, e.g.,* NCQA, *The State of Health Care Quality 2009* (Wash. D.C.) available, with other annual reports, at www.ncqa.org.

[2] *See* NCQA, "Quality Compass 2010," http://www.ncqa.org/tabid/177/Default.aspx.

traditional risk-based MCOs are enrolled in accredited plans.[3] If only NCQA-accredited plans can be offered through an Exchange, individuals who are enrolled in unaccredited Medicaid plans will have to change plans if they move to the Exchange, which will create disruptions in continuity of care. For this and other reasons, it is therefore advisable to ensure that some plans offered in an Exchange also serve Medicaid/CHIP beneficiaries, create overlapping provider networks, and to require plans to help facilitate transitions for those in the middle of treatment. HHS should also consider mandating HEDIS accreditation and reporting for Medicaid managed care plans.

The Centers for Medicare & Medicaid Services (CMS) encourages but does not require states to report HEDIS data from Medicaid managed care plans. In contrast, CMS requires managed care plans participating in Medicare to report audited summary data on specified HEDIS measures.[4] According to NCQA, only 25% of Medicaid beneficiaries are enrolled in plans that publicly report HEDIS data. [5] HEDIS data are unavailable for many Medicaid managed care plans. Thus, many individuals who are receiving care from plans offered through Exchanges will be impacted by this lack of information about Medicaid plans. Accordingly, CMS should consider requiring Medicaid managed care plans to report HEDIS data.

The fluidity of the population enrolled in Exchange plans may also affect the reliability of many measures. For example, HEDIS data are reported by individual plans and are expressed as a percentage of all enrolled individuals who have received a particular treatment during a given year. Thus, the number of individuals included in the denominator for various measures will be changing throughout a measurement period. This is true under the current system and will be even more of an issue once the Exchanges plans are operational. Thus, measures may not give a true picture of a plan's performance because individuals who are enrolled for only part of a year may not be included in the denominator.

Conclusion

NHeLP looks forward to working with OCIIO on the implementation of requirements related to the Exchanges and continuing to provide feedback that improves the health of low-income populations and communities. If there is any information or assistance we can provide or if you need additional information about these comments, please do not hesitate to contact Sarah Somers at somers@healthlaw.org or (919) 968-6308, ext. 102.

Sincerely,

Emily Spitzer
Executive Director

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[3] NCQA, *2010 NCQA Medicaid Managed Care Toolkit*, 5, at http://www.ncqa.org/tabid/134/Default.aspx.
[4] 42 C.F.R. § 422.152, .516; NCQA, "HEDIS Data Submission," http://www.ncqa.org/tabid/219/Default.aspx.
[5] NCQA, *The State of Health Care Quality 2009*, 8.