January 14, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: CMS-2408-P, Proposed Rule on Medicaid and CHIP Managed Care

Dear Secretary Azar:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on the Proposed Rule on Medicaid and Children's Health Insurance Plan (CHIP) Managed Care. 83 Fed. Reg. 57264 (Nov. 14, 2018).

NHeLP strongly supported HHS' recent update of the Medicaid managed care requirements, particularly the measures enhancing accountability and strengthening beneficiary protections. 81 Fed. Reg. 27489 (May 6, 2016). We therefore commend the decision to preserve many of these measures in this Proposed Rule. We have concerns, however, about HHS' relaxation of certain standards. Our specific concerns and recommendations are set forth below.

§ 438.4 - Actuarial soundness

a. Capitation Rate Development Practices That Increase Federal Costs and Vary With the Rate of Federal Financial Participation (FFP) (§ 438.4(b)(1) and (d)).

We support HHS's effort to ensure that capitation rates are "based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations," and not set by reference to the rate of FFP that happens to be available. That said, HHS must be sure to safeguard variations that correlate to higher FFP when there is a higher needs population with an actual cost difference. Otherwise, HHS risks punishing plans that take on more complex enrollees, and potentially encouraging cherry-picking of lower needs populations.

§ 438.6 - Special contract provisions related to payment

a. Risk-sharing mechanism basic requirements (§ 438.6(b))

We support HHS's policy prohibiting retroactive creation or modification of risk-sharing mechanisms. This will improve transparency and facilitate HHS's oversight of these mechanisms.

b. Delivery System and Provider Payment Initiatives Under MCO, PIHP, or PAHP Contracts (§ 438.6(a) and (c))

We support the changes to § 438.6(a) (adding a definition for state plan approved rates) and § 438.6(c)(1)(iii) (specifically referencing approved state plan methodologies as an option for states to direct plan payments). We urge HHS to support states in using § 438.6(c) to set minimum rates for providers in managed care. We believe this will support access and also help states compensate for reductions in pass-through payments. We also support the clarification that supplemental payments do not constitute § 438.6(a) state plan rates.

We have concerns with the addition of provision § 438.6(c)(1)(iii)(E). While we believe that in practice, Medicare, commercial, and market-based rates might represent rate increases for most providers, this is not necessarily the case for all providers in all markets. It is even less clear how cost-based rates might impact providers. This is particularly problematic in the case of managed care, where HHS has failed to acknowledge its statutory obligation to enforce § 1902(a)(30)(A)'s requirements governing the adequacy of rates. Providers therefore must rely on the indirect standards of actuarial soundness and network adequacy to support rates, and low rates harms access and quality for consumers. We recommend that HHS not make the change at § 438.6(c)(1)(iii)(E) without additional protections to ensure the new methodology has the effect of increasing – not decreasing – Medicaid's widespread low reimbursement rates.

In addition, we support the addition of criteria for multi-year payment arrangements at § 438.6(c)(3)(i).

c. Pass-Through Payments Under MCO, PIHP, and PAHP Contracts (§ 438.6(d))

In principle, we support HHS's long-term plan to phase out pass-through payments. Such payments are not in keeping with the statutory framework for actuarial soundness. Additionally, these Medicaid dollars would be better spent increasing rates (or using other mechanisms in § 438.6(c)) rather than used as quasi-supplemental payments that lack transparency and often are distributed based on politics and not policy. That said, while the phase out should be a long-term goal, in the short-term HHS must ensure that safety-net providers do not lose funding without commensurate rate increases or other provisions to guarantee their financial stability. The pass-through payment valve should not be shut off until HHS is certain that the other faucets (ex. § 438.6(c) flexibilities) are effective replacements.

Therefore, we support the addition of a 3-year transition period as another mechanism to protect safety-net providers transitioning away from FFS supplemental payments. We also believe that added flexibility for states to use directed rate-setting per § 438.6(c) is an important component of HHS's plan to phase out pass-through payments (and we commend HHS for making some improvements in this revised regulation). Finally, we note that HHS already has the most important tool needed to ensure a successful transition away from pass-through payments: the equal access provisions at § 1902(a)(30)(A). If HHS actually enforced these requirements, including on managed care, the pass-through phase out would be of much less concern and consequence.

d. Payments to MCOs and PIHPs for enrollees that are a patient in an Institution for Mental Disease (IMD) (§ 438.6(e))

As we have explained in our comments on the most recent revision of the Medicaid managed care regulations, we oppose HHS' decision to provide FFP for capitation payments for months in which enrollees have short stays in an IMD. Accordingly, we commend HHS for the decision to not extend the availability of FFP to capitation months for Institution for Mental Disease (IMD) stays of more than 15 days for 21-64 year olds. We believe that making payment for months in which enrollees spend more than 15 days in an IMD would create even more incentives to provide care in institutional settings when community based alternatives are the option that maximizes independence and quality of care and produces better outcomes. We also agree with HHS that it would result in a significant cost-shift from states to the federal government.

Moreover, we again urge HHS to reconsider the decision to allow FFP for these payments and prohibit the practice under any circumstances.

§ 438.7 - Rate certification submission

b. Annual guidance

We commend HHS for adding § 438.7(e) and committing to annual guidance supporting capitation rate development. We believe it will help states develop rates properly.

§ 438.10(d)(2) - Information requirements

Ensuring full access for people with disabilities and Limited English Proficiency (LEP) is critical to ensuring that a state's Medicaid program provides appropriate services to all participants, including managed care enrollees. Disability and language-related barriers to access may severely limit an individual's opportunity to access medical care, assess options, express choices, and ask questions or seek assistance. Managed care plans especially need to protect and promote access because they often have limitations, such as limited networks of providers, which may mean that people with disabilities and LEP are not able to obtain the care they need.

Just two years after enacting much-needed protections for this population, however, HHS now proposes a number of significant changes that would weaken current standards for making information available to enrollees and potential enrollees, which would ultimately lead to limiting access health services for persons with LEP and persons with disabilities. We urge HHS to reconsider.

Access for persons who are visually impaired

Current regulations require taglines in large print no smaller than 18 point font (42 C.F.R. § 438.10(d)(2)). In 2016, HHS explained that it based this standard on guidance from the American Printing House (APH) for the Blind (81 Fed. Reg. 27724). The APH established standards for print documents, including the minimum of 18 point font for large print, to allow "optimal usability for persons with low vision."[1] The APH developed its standards for large print and other features for print document readability based on

[1] J. Elaine Kitchel, Low Vision Project Leader, APH Guidelines for Print Document Design, American Printing House for the Blind, https://www.aph.org/research/design-guidelines/ (accessed Dec. 23, 2018).

"research that originated from the study of the impact of print characteristics on readers."[2]

However, HHS now proposes to replace this evidence-based standard with a vaguer requirement that taglines be "conspicuously visible." We oppose this change.

HHS provides no information or description of what constitutes a "conspicuously visible" tagline; nor does HHS provide any evidentiary basis for how persons with low vision would be able to access health information under this new standard. The potential harm to persons with low vision under an ambiguously defined "conspicuously visible" standard far outweighs any possible benefit for insurers in reducing paperwork. HHS should withdraw this ill-advised proposal.

Limiting information access through taglines

Taglines are an effective and cost-efficient manner of informing persons with disabilities and LEP individuals and will help assist plans in determining in which languages additional materials should be provided. HHS proposes to limit use of taglines to written materials that "are critical to obtaining services." This standard is not only vague, but HHS also fails to specify who decides whether information is critical to obtaining services.

For example, some plans or state Medicaid agencies might not consider information on plan performance and quality to be "critical to obtaining services," yet such information is vitally important to potential enrollees engaged in the process of plan selection.

Further, MCOs, PIHPs, PAHPs, and PCCM entities must provide potential enrollees with information about Medicaid benefits not covered by the entity, including family planning services and supplies and abortion services not covered by a plan due to religious objections. 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. It is unclear whether information "critical to obtaining services" would include services that a plan does not provide.

Moreover, as all of the entities governed by this provision receive federal funds, they are all subject to Section 1557 of the Affordable Care Act, the ACA's nondiscrimination requirements. Under the final regulations implemented by the HHS Office for Civil

[2] *Id.*

Rights, managed care plans are "covered entities" that must provide taglines on all "significant" documents. We strongly oppose HHS's attempt to redefine the requirements under Section 1557 in a manner that directly conflicts with the final regulations issued by the Office for Civil Rights. The regulation issued by OCR were carefully considered with significant input from all stakeholders and HHS should not create a separate requirement solely for Medicaid managed care entities. Moreover, creating a separate standard would make it challenging for entities covered by both sets of regulations to ascertain how to comply – is a document significant yet not critical to obtaining services? Is it critical but not significant? There is no way for entities to answer these questions.

Finally, this ill-conceived proposal opens the door to adverse selection whereby plans discourage enrollment by persons with significant health needs. Limiting information access for enrollees and potential enrollees will have harmful consequences, particularly for persons living with disabilities or with LEP. The needs of Medicaid enrollees should outweigh plans' concerns for profitability.

RECOMMENDATION: Retain the protections in the existing regulation.

§ 438.10(h) - Provider directories

Provider access begins with having accurate, up-to-date provider directories available to enrollees and potential enrollees. However, instead of strengthening federal standards, HHS proposes to weaken them. HHS seeks to change requirements for provider directories by allowing MCOs, PIHPs, PAHPs, and PCCM entities to update printed directories quarterly, instead of monthly, if the MCO, PIHP, PAHP, and PCCM also provides a mobile-enabled electronic directory.

HHS cites data on cell phone use by low income persons to justify this change (83 Fed. Reg. 57278), but provides no information related specifically to enrollee use of printed directories. In fact, U.S. Census data shows that low income persons are less likely to have access to broadband and internet services. For example, more than one in five Virginian households (21.4%) lack broadband internet access.[3] Nationwide, half of

[3] Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015* 8 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf.

households with incomes under $25,000 have either no computer or no broadband at home.[4]

The HHS Office of the Inspector General (OIG) identified significant shortcomings in provider access in its 2014 report, Access to Care: Provider Availability in Medicaid Managed Care.[5] In this report, OIG stressed the important role provider directories play in ensuring that enrollees have access to accurate information about provider participation. Therefore, in the absence of additional research on enrollee preferences for print versus mobile/electronic formats and accessibility, we believe it would be premature to ease current requirements for updating provider directories. HHS should maintain current standards and engage in active compliance monitoring and enforcement actions when plans fail to meet those minimum standards.

RECOMMENDATION: Retain the existing regulation.

§ 438.56(d)(5) – Disenrollment Requirements and Limitations

We support the proposed revisions to § 438.56(d)(5) deleting ‘‘PCCMs or PCCM entities’’ as enrollees should not be required to exhaust a PCCM’s (or PCCM entity’s) internal grievance system before the state can make a determination on the enrollee's request to disenroll. As noted in the Preamble, at 57278, the 2016 final rule inadvertently included PCCMs and PCCM entities in § 438.56(d)(5) related to requiring exhaustion of such an entity’s grievance system before the enrollee can request disenrollment. Because PCCMs and PCCM entities are not required by § 438.228 to have such a grievance system, unlike MCOs, PIHPs and PAHPs, deleting this requirement makes sense as a matter of consistency and eliminates a barrier for enrollees to request disenrollment that should not exist. CHIP conforming changes were also made at § 457.1212.

§ 438.68 - Network adequacy standards

We oppose the proposed changes to this rule and urge HHS not to adopt them. Medicaid enrollees continue to experience more difficulty accessing services and

[4] *Id.* at 9; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say

[5] 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.

providers than their privately insured counterparts.[6] Thus, strong network adequacy requirements are crucial to ensuring that Medicaid managed care enrollees can access covered services. When HHS first proposed to add network adequacy standards to these rules in 2015, it requested comment on whether it should set national standards, rather than affording states flexibility to set their own time and distance standards. 80 Fed. Reg. 31097, 31145 (June 1, 2015). As we did then, we urge HHS to set national network adequacy standards.

Prescriptive national standards, like those used in Medicare Advantage, are appropriate in the Medicaid context, given the low-income and high need population served by the program. As described in more detail in our comments to the 2015 proposed rule, we continue to recommend that HHS adopt specific minimum standards in the areas of geographic access, provider-patient ratios, and timely access to care. Setting a national minimum standard for network adequacy in Medicaid Managed Care will provide consistency and continuity for enrollees, and will ensure that enrollees in all states are held to the same basic standards of access. Time and distance standards, which the rule currently requires states to adopt for many services, including LTSS where the enrollee travels to a provider, are a critical component of network adequacy since they ensure that enrollees can access network providers within an appropriate distance. It does an enrollee no good to be given a next day appointment, if the location of that appointment is so far away that the enrollee cannot travel there. [7]

We commend HHS for its proposal to require states to establish standards for LTSS and agree that the standards should be consistent, however, we recommend that it require time and distance standards here as well. As with traditional medical services, network adequacy standards centered in time and distance are highly beneficial to

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[6] *See, e.g.,* Medicaid & CHIP Payment & Access Comm'n, *Medicaid Access in Brief: Children's Difficulties in Obtaining Medical Care* 1 (2016) ("[C]hildren in Medicaid or CHIP are more likely than those with private coverage to report difficulties accessing medical care; these difficulties include finding a provider who will accept their insurance, obtaining a timely appointment, and obtaining a referral to a specialist."), https://www.macpac.gov/wp-content/uploads/2016/11/Adults-Experiences-in-Obtaining-Medical-Care.pdf.

[7] HHS notes that time and distance standards may not be properly account for access to telehealth. Preamble at 57278. This does not mean, however, that time and distance standards should be discarded altogether. Rather, HHS could provide guidance to states on how to account for telehealth when devising time and distance standards, such as counting the time and distance to a spoke site.

guiding how LTSS network adequacy standards are developed and judged. Not only does the certainty and clarity of time and distance apply to LTSS as well, but time and distance standards are particularly relevant for LTSS given the provider shortages for direct-care staff in many areas. Time and distance standards help ensure that there are providers available in a given area and will provide home care agencies, managed care plans, and state agencies with a standard that is easy to use and understand to assess whether provider shortages are due to long travel times that require additional compensation.

The current rule provides significant flexibility, as it permits each state to set its own time and distance standards without any outside limits set by HHS, and its implementation has varied widely among states. The proposed changes to this section of the rule take a further step in the wrong direction. Rather than moving states toward a national network adequacy standard, the proposed rule gives states even more discretion to adopt different standards, as long as those standards are quantitative. If adopted, the proposed changes to this section will lead to more divergent standards, which will mean that Medicaid beneficiaries are more likely to go without care they need, and oversight by HHS will become even more challenging.[8]

We also oppose the proposed deletion of § 438.68(b)(1)(viii), which allows HHS to specify other provider types for which states must develop network adequacy standards if appropriate. The concerns raised by states that this provision could allow HHS to suddenly require states to develop new network adequacy standards for a provider type not previous subject to the network adequacy requirements are overblown. HHS could address these concerns by amending the provision to require HHS to provide states with advanced notice of one year before including a new provider type. It need not excise the provision entirely. The provision serves an important role of providing HHS with flexibility to address emerging access issues without the burden of going through the regulatory process. HHS should preserve this flexibility.

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[8] Suzanne Murrin, Dept. of Health & Human Servs., Office of Inspector General, *State Standards for Access to Care in Medicaid Managed Care* 8-9 (2014) ("CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance."), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf; *see also, e.g.,* Abbi Coursolle, Nat'l Health Law Prog., *Medicaid Managed Care Model Provisions: Network Adequacy* (2014), http://www.healthlaw.org/issues/medicaid/managed-care/medicaid-managed-Care-model-provisions-issue-3 (describing various state standards for travel time and distance, ranging from 5 miles in two states, to 100 miles in two other states).

§ 438.242(c) - Enrollee Encounter Data

Accurate encounter data is foundational to effective planning, rate determination, and oversight of Medicaid managed care entities. This data is used for quality metrics, capitation rates, risk-adjustment of capitation rates, and monitoring network adequacy, among other things. Yet we have repeatedly seen that states shifting to managed care may take years to create accountable systems to ensure that MCOs report accurate, complete, and validated encounter data.[9] Even long-established managed care programs experience persistent problems with encounter data if oversight is not robust.

For example, when Texas used external quality review to validate encounter data against a sample of medical records from 2015, it found that 14 to 15 percent of the procedural codes did not match.[10] Even more concerning, according to a recent GAO report examining encounter data quality in eight states, Texas was the *only* state that had used this oversight validation tool, and one of only three that compared encounter data with externally available sources.[11] Such comparisons are recommended by HHS, actuaries and external quality review experts.[12]

HHS took several steps to push states to improve accountability and transparency when it updated Medicaid managed care regulation in 2016. These include requiring that all contracts between states and MCOs, PIHPs and PAHPs provide for the collection and maintenance of enrollee encounter data, and the submission of all the enrollee encounter data required at the frequency and level of detail specified by the state and HHS. States are also required to review and validate the submitted data, produce an annual report that includes an assessment of encounter data each MCO reports, and arrange for an independent audit of reported data at least every three years.[13] We supported those changes to improve the quality and comprehensiveness of encounter data.

Since implementation of the final rule, however, the urgency of implementing these

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[9] HHS Office of the Inspector General, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (Washington, D.C.: July 2015); U.S. Govt. Accountability Office, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, GAO-15-481 (Washington, D.C.: May 29, 2015).
[10] U.S. GAO, *Medicaid Managed Care: Additional HHS Actions Needed to Help Ensure Data Reliability*, 16 (Oct. 2018), https://www.gao.gov/assets/700/695069.pdf. (Hereinafter "2018 GAO Report").
[11] *Id.* at 15.
[12] *Id.* at 2.
[13] 42 C.F.R. § 438.818.

oversight measures appears to have waned. Some states and MCOs appear to have balked at providing both the allowed and paid amounts of their claims to HHS, citing this information as a confidential trade secret. HHS rejects this argument and proposes to specify that managed care entities must include both the amount paid and the allowed amount in their reported encounter data. We support this proposed change to clarify the reporting requirements. Advocates frequently encounter circumstances where MCOs deploy a trade secret argument to evade accountability.[14]

However, we do not think the proposed changes to the rule go far enough to ensure the reliability of encounter data, and we encourage HHS to increase its efforts to increase accuracy, transparency and accountability of encounter data. In an October 2018 report, GAO recommended that HHS take additional steps to improve the reliability of encounter data collection and validation. Among its findings, GAO noted that HHS has not yet provided states information on what circumstances will trigger a deferral or disallowance of federal matching fund for failure to comply with T-MSIS data submission standards, though it said in 2016 it would not apply this enforcement tool until such guidance is issued.[15] This the primary enforcement lever to encourage states to comply, but it remains toothless without guidance promised over two years ago.

Similarly, current regulations now require states to submit annual program reports that include an assessment of each MCO's encounter data, show that they adequately review and validate encounter data, and arrange for periodic independent audits of encounter data.[16] GAO noted that states require additional guidance to implement and enforce these oversight tools. GAO also recommends that HHS establish minimum standards for states to fulfill the data validation requirement in § 438.242(d), but HHS has not yet followed through on this guidance.

We continue to support the public disclosure of reports that validate encounter data to maintain state and MCO accountability and ensure that vital encounter data is reliably accurate and complete. As evident from GAO's recent report, HHS must inject more urgency into this process. HHS should add clear timelines for forthcoming guidance to ensure states implement these important elements of encounter data oversight,

[14] We note that while HHS emphasizes its commitment to protect MCOs from disclosure of trade secrets, the argument here is that this information is routinely made public through EOB documents and it not, therefore, a trade secret.
[15] 2018 GAO Report, note 10, *supra,* at 2.
[16] See, respectively, 42 C.F.R. §§ 438.66(e)(2)(ii), 438.242(d), and 438.602(e).

including clarifying when and how it will apply its primary enforcement lever – withholding FFP.

RECOMMENDATION: HHS should implement the GAO recommendations without delay.

§ 438.334 - Medicaid Managed Care Quality Rating System (QRS)

In the 2016 Medicaid managed care final rule, HHS committed to creating a quality rating system (QRS) for MMC plans to promote consumers' ability to compare plans and choose the most appropriate plan for their needs, as well as increasing the ability to compare managed care performance across states. That policy development has proceeded with a stakeholder engagement process that includes a technical expert panel and will lead to public notice and comment. In developing a Medicaid QRS, HHS purports to strike a balance between standardization across states and flexibility to adapt to quality measurement systems states already have in place. As envisioned, QRS must be comprehensive enough to incorporate the unique services provided to a very diverse Medicaid population, including long term supports and services (LTSS) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to children, and allow states to adapt it to the needs of their own covered populations.

Unfortunately, HHS's proposed changes to the QRS system create giant loopholes that will undermine the goals and purpose of the whole endeavor, particularly for Medicaid enrollees with LTSS needs. Specifically, the proposed rule rolls back requirements for state-based alternative QRS systems and eliminates the pre-implementation federal approval process. We will address the problems with these two proposed changes in turn.

First, HHS seeks to water down the requirement that a state-based alternative be "substantially comparable" to the federally developed Medicaid quality rating system by adding the clause "to the extent feasible." This introduces an enormous exception states can exploit to implement bare-bones, incomplete rating systems. The term "substantially comparable" already provides enough flexibility for states to account for differences due to covered populations, benefits, and other factors cited by HHS. While subregulatory guidance is needed to clarify the meaning of "substantially comparable, HHS need not gut the standard by allowing states to argue that true comparability is "not feasible." HHS tempers this significant rollback by proposing a limited set of mandatory measures that would apply across states. The proposal suggests that the mandatory measures would pattern after the measures selected for its Scorecard initiative. That initiative,

however, currently only collects voluntary state-reported data on 16 performance measures related to State Health System Performance. This small core set leaves huge measurement gaps relevant to key Medicaid populations, including especially people with disabilities.[17] It has only a placeholder domain for LTSS (with no actual measures), a single measure related to pregnancy and postpartum care, and a single measure that is at best only tangentially related to care affordability. This limited set of measures, even if they all became mandatory for QRS, would hardly provide an adequate base to measure the quality of managed care systems that cover adults, children with disabilities, pregnant women and aging populations.

In sum, the mandatory core measures proposal amounts is meaningless because HHS is giving states authority to implement a less comprehensive alternative QRS that is not actually substantially comparable to the federal system. By making it easier for states to develop their own alternative systems, HHS would severely limit comparability between states and also likely permit states to implement star systems that would not be useful for large segments of their Medicaid populations either for plan selection or for quality/accountability purposes.

Second, HHS further undermines the QRS process by proposing to eliminate a pre-approval requirement for states pursuing an alternative QRS. HHS suggests that pre-approval may cause implementation delays for states developing an alternative QRS. This provision involves two key changes. First, HHS would shift the timing of the public stakeholder process from "prior to submitting a proposal" to "prior to implementing and alternative quality rating system."[18] This change could allow states to develop a proposal behind closed doors and treat the public comment process as a last minute formality after plans for implementation are well under way. Second, the proposed rule would eliminate the pre-approval requirement, instead asking states provide HHS the alternative QRS framework and associated materials for review *upon request*, and that HHS would identify potential deficiencies and work with states to correct them. (83 Fed. Reg. 57281). This passive approach to overseeing alternative QRS encourages states to pursue their own alternative systems and increases the chance that those alternatives will be inadequate, particularly given the large loophole proposed in § 438.334(c)(1)(ii) (see above).

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[17] *State Health System Performance*, Ctrs. for Medicare & Medicaid Servs., Medicaid.gov, (last visited 1/2/2019), https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/index.html.

[18] 83 Fed. Reg. 57296. See § 438.334(c)(2).

In addition, it would put pressure on HHS to accept any state-developed system that may already be designed and implemented before HHS even realizes its shortcomings. We note that in response to public comments on the 2015 managed care NPRM, HHS actually *enhanced* the public process requirements for alternative QRS proposals in the final rule to hold states more accountable and get seek public and expert input early in the planning process.[19] The current proposed changes would completely undercut HHS's vetting of alternative state QRS' and so would undermine the thrust of prior comments that pushed for stronger HHS oversight in this area.

HHS proposes other minor changes that would pattern the Medicaid QRS after the Qualified Health Plan (QHP) QRS and the Medicare star-rating system where appropriate. We appreciate that HHS has acknowledged that Medicaid covers services that neither Medicare nor the QHPs routinely provide, including LTSS, making alignment potentially problematic. But we think HHS could go further to ensure that the federal Medicaid managed care QRS includes adequate LTSS measures, such as requiring that it address at least the domains listed in § 438.330(c)(1)(ii) on quality of life, rebalancing, and community integration.

The best pathway to creating a more uniform quality accountability system is to design a robust federal QRS that provides a broad, shared base upon which individual states can expand as needed. We oppose HHS's proposed changes because they will make it too easy for states to disregard the federal process and instead cobble together a makeshift system based on what they currently have in place. This undermines comparability of plan quality between states and the comprehensiveness of the QRS for unique Medicaid populations. It also devalues the whole endeavor to create a federal Medicaid QRS in the first place, since it enables, even encourages states to implement less comprehensive and less comparable alternatives.

RECOMMENDATION: HHS should not change the current regulations, except to require that the federal QRS and any alternatives, at minimum, include measures in each of the three measure domains for LTSS listed in 438.330(c)(1)(ii).

§ 438.340 - Managed Care Quality Strategy

We support the proposed changes that clarify the parts of the state quality strategy that apply to PCCM entities.

[19] 81 Fed. Reg. at 27691.

§ 438.340(b)(6)

We appreciate that HHS has acknowledged that its current definition of disability status, which includes only individuals who qualify for Medicaid on the basis of disability, is overly restrictive and will undercount Medicaid managed care enrollees with disabilities. Many people with disabilities on Medicaid qualify through other eligibility pathways, or have disabilities that do not meet all the Social Security criteria. Given that this provision is intended to improve data reporting for the purposes of reducing health disparities, states should not rely on a definition sure to undercount people with disabilities, and so may mischaracterize the barriers to health care people with disabilities face.

However, we recognize that HHS's intent for defining disability status, albeit narrowly, may have been to facilitate data comparisons across states (as well as minimize data collection or data privacy concerns). If HHS proceeds with the proposed change to encourage states to share more detailed or up-to-date information with managed care entities beyond eligibility-related disability status, it could complicate the evaluation of disparities across states. If one state relies only on eligibility status, while another includes any individual who self-reported a disability on her application, for example, it would become more difficult to compare health disparities related to disability across those two states. For the purposes of drawing informed comparisons across states and for data analysis on health disparities, we recommend that states should be encouraged to share with MCOs the most current demographic information available, but should also be required to publicly disclose in their quality strategy how they define disability in this context and what additional sources of information share with MCOs.

RECOMMENDATION: Retain the existing regulation.

§ 438.362 - Exemption from External Quality Review

We support the proposed changes that require states to publicly identify any exempted plans along with the beginning date of their current exemption period. This represents little burden to plans or states, but improves transparency and accountability. We recommend the exempted plans should be identified in both the EQR annual technical report and directly on the state's website where EQR reports are located. Some states engage multiple EQROs and produce multiple technical reports. Therefore, consigning the exemption notices to technical reports would make that information difficult to locate.

HHS should require states to provide a direct link to the most recent Medicare performance reviews for any exempted plan on the state's website featuring EQR

reports to allow consumers and advocates to easily find relevant performance data on exempted plans. This improves transparency without adding any burden to plans or states in terms of redundant reporting.

RECOMMENDATION: HHS should require states to identify exempted plans and provide direct links to the most current Medicare performance review.

§ 438.400 – Grievances and appeals: statutory basis, definitions, and applicability.

Adverse Benefit Determination. We do not object to HHS' decision to exclude denials of payment for failure to submit clean claims from this definition. We do, however, urge HHS to emphasize in guidance or in the preamble to the final rule that states and managed care plans must make it clear to providers that they are prohibited from billing Medicaid enrollees if they do not get paid.

§ 438.402 – Grievances and appeals - general requirements, § 438.406 – Handling of grievances and appeals

We support HHS' decision to remove the requirement that enrollees must confirm oral hearing requests in writing. While we are concerned that managed care plans may fail to acknowledge these requests, the inclusion of the requirement that oral inquiries be treated as appeals is welcome protection against this risk.

Part 457 Children's Health Insurance Program

We support the clarifications and technical corrections to the following regulatory sections applicable to the Children's Health Insurance Program (CHIP): compliance dates for part 457, information requirements at § 457.1207, structure and operations standards at § 457.1233, sanctions at § 457.1270, and program integrity safeguards at § 457.1285. Specifically, we support the clarification to require submission of enrollee encounter data to HHS at § 457.1233(d) and the application of the requirements to collect and submit quality performance measurement data to PCCM entities at § 457.1240(b).

§ 457.1240 - Quality measurement and improvement

In the 2016 update to Medicaid managed care regulations, HHS recognized the value of stakeholder engagement and input by enhancing the role of Medical Care Advisory Committees (MCAC) and creating new stakeholder advisory groups for LTSS.[20]

HHS proposes to eliminate references to MCAC consultation when developing CHIP quality measurement and improvement. However, the proposed rule offers no alternate means or opportunity for input from child health advocates, providers, consumers, and other key stakeholders to provide input on a state's CHIP quality assessment and performance improvement program. We disagree with this approach.

Currently, HHS requires states to involve the public in the design of CHIP, as well as ongoing public involvement once the state plan has been implemented.[21] It is not clear how effective states have been in maintaining stakeholder advisory groups in their CHIP programs. For example, in its state CHIP plan, Texas reports establishing regional advisory committees and local advisory groups in 1998 and 1999 "to provide ongoing direction and input on outreach strategies for Texas CHIP."[22] The Texas CHIP program website provides no information on meeting times and locations for such groups, so it is unclear if they continue to meet.

HHS should require states to consult with stakeholders when developing CHIP quality assessment and performance improvement program.[23] We further urge HHS to take a more active role in supporting MCACs and other advisory groups so that stakeholders have a meaningful opportunity to share their expertise and provide input.

RECOMMENDATION: Require states provide meaningful opportunities for stakeholder input when developing and implementing CHIP quality measurement and improvement.

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[20] E.g., 42 C.F.R. §§ 438.334(c)(2)(i) requiring consultation with MCAC in developing star rating system; 438.340(c)(1), requiring consultation with MCAC in developing state quality strategy; 438.66(e)(3), providing managed care program report to MCAC, and 438.70 and 438.110 creating LTSS stakeholder groups.

[21] 42 C.F.R. § 457.120.

[22] See Texas CHIP State Plan, § 9.9 (May 21, 2018), https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/state-plan/chip/chip-state-plan.pdf.

[23] We see no obstacle to MCACs fulfilling that role for CHIP. The most often cited statutory authority for MCACs is 42 U.S.C. 42 U.S.C. § 1396a(a)(4), which allows "assisting any advisory committees established by the State agency."

§ 457.1260 - Grievance system

We welcome HHS' clarification of the applicability of Medicaid requirements governing grievances and appeals to CHIP. However, we oppose the proposal regarding continuation of benefits while an appeal is pending. In the preamble, HHS states that it did not intend the continuation of benefits provided under Medicaid to apply to CHIP (83 Fed. Reg. 57286), and proposes to eliminate informing requirements regarding the right to continued benefits (amending § 457.1207 to exclude the reference to § 438.10(g)(2)(xi)(E)). We believe that CHIP enrollees should have the right to continue to receive benefits pending an appeal. CHIP managed care plans cover behavioral health care and other ongoing services vital for children with complex medical needs and long-term chronic conditions. Due process requires that an enrollee be guaranteed continuation of these services regardless of whether a utilization control system's "authorization period" has expired.

RECOMMENDATION: HHS should provide for the continuation of benefits for CHIP enrollees while an appeal is pending and require plans to inform enrollees of this option.

Additional issues in CHIP not addressed by the proposed rule

Reporting and Monitoring

HHS currently requires states with separate CHIP programs, Medicaid expansion, and hybrid programs to submit an annual report describing enrollment, eligibility, and other features (42 C.F.R. § 457.750). However, the information provided is too limited to provide effective program evaluation and oversight.

We urge HHS to extend the state monitoring, oversight, and transparency requirements at 42 C.F.R. § 438.66 to CHIP. This would include, *inter alia*, information on plan performance, utilization management, grievances and appeals, audited financial information, and medical loss ratio data.

Strong state management and oversight is critical to program integrity and the effective delivery of services to low income enrollees. The more robust monitoring and oversight requirements under § 438.66 would hold CHIP plans and programs to the same standard as Medicaid managed care plans to help ensure that CHIP meets the needs of enrollees.

RECOMMENDATION: Apply the requirements of 42 C.F.R. § 438.66 to CHIP.

Beneficiary Support System

The proposed rule does not require a beneficiary support system (BSS) in CHIP like the one in Medicaid authorized under 42 C.F.R. § 438.71. It should.

Managed care has proven to be a difficult system to navigate for many. Enrollees often encounter problems in connection with enrollment and disenrollment, service denials, enrollee rights, and provider network limitations. We often hear enrollees and their caregivers report frustrations in accessing services, understanding their rights and how to enforce them, and the lack of assistance when they encounter problems.

Therefore, we strongly support the creation of a mandatory beneficiary support system to help enrollees choose the most appropriate managed care plan to meet their needs; provide assistance and education in understanding managed care, including enrollee rights and mechanisms for advocacy; and provide assistance in navigating the grievance and appeal process. Such activities must be performed by knowledgeable professionals in a conflict-free manner that is accessible and meaningful for that individual and/or their caregivers.

While we recognize that choice counseling is not always relevant to CHIP because there may only be one option at enrollment, we believe that other aspects of the beneficiary support system are applicable and therefore recommend adding a new section to subpart L of part 457. The health insurance market is complex, and CHIP enrollees would benefit from assistance navigating it. CHIP enrollees would benefit from assistance understanding managed care, outreach activities promoting enrollment, and assistance with the grievance and appeals processes.

When possible, the CHIP beneficiary support components could be integrated in the larger, Medicaid beneficiary support system. When such integration is not possible, the burden of developing a beneficiary support system just for CHIP increases, but we believe consumers need this additional assistance.

RECOMMENDATION: Add a new section to subpart L requiring a beneficiary support system tailored to meet the needs of CHIP beneficiaries

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We appreciate your consideration of our comments. If you have questions about them, please contact Sarah Somers (somers@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director