July 27, 2015

SUBMITTED VIA ELECTRONIC TRANSMISSION

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: **CMS-2390-P**
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Administrator Slavitt:

As organizations that share a strong commitment to the health of our nation's children, we appreciate the opportunity to comment on the recently proposed rules relating to managed care and quality strategies in Medicaid and the Children's Health Insurance Program (CHIP). With the increased utilization of managed care arrangements in Medicaid and CHIP, this rule is of critical importance to ensuring children and pregnant women get the health care they need. In 2013, two-thirds of children in Medicaid and CHIP were served by managed care plans.[1]

The unique needs of children (0-21) in Medicaid and CHIP must be explicitly considered, and we support many of the proposed rule's provisions intended to help accomplish this goal. As the rule is finalized and implemented, we urge you to continuously address pediatric-specific needs, as well as the unique needs of pregnant women. We strongly support the efforts to bolster the protections offered to children through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

We applaud the overall intent of this rule to prioritize information transparency, undertake a comprehensive quality strategy that integrates and includes the specific needs of children, and improve accessibility and quality of information for consumers. Our comments seek to strengthen these areas and ensure that the specific needs of children and pregnant women are successfully addressed and that consumers have the full range of information necessary to make informed choices about their family's health care.

Medical necessity - We commend HHS for including this section to give more guidance to states and plans in defining medical necessity, particularly for children. We strongly support HHS' decision to include—for the first time—an explicit provision that requires plans to comply with the EPSDT requirements in Medicaid. Too often, Medicaid managed care plans are not familiar with their obligations under EPSDT, and attempt to apply an adult medical necessity standard, or the standard used for private insurance enrollees, to Medicaid enrollees under age 21. Adding specific language requiring plans to comply with

EPSDT will help ensure that child enrollees receive the full scope of services to which they are entitled. We also suggest that HHS remove the word "chronic" from this section, as it is inconsistent with the EPSDT statute, which requires states to correct or ameliorate all conditions, not only chronic ones. (*See* 1905(r)(5) of the Social Security Act.)

We also appreciate that HHS will continue to ensure that managed care standards of medical necessity are no more restrictive than the state fee-for-service (FFS) standards. In order to avoid this confusion and any legal violation, we suggest that HHS add specific language to this section to clarify that medical necessity definitions should be no more restrictive than the FFS definition in terms of either quantitative or non-quantitative treatment limits. These concepts, which are widely used in the context of mental health parity, will be familiar to many plans and will help them to better assess whether their medical necessity definitions are appropriate.

Quality Assessment and Improvement - We strongly support the requirement for a comprehensive statewide quality strategy that encompasses all Medicaid and CHIP delivery systems, including FFS. This expanded requirement offers promise to advance state efforts to measure and improve the quality of care provided to children and adults enrolled in public coverage programs. In particular, the proposed rule provides an opportunity for greater integration of the Child Core Set of Health Quality Measures and lessons learned from the Pediatric Quality Measures Program. While we support CMS quality alignment in review and approval of plans, a Medicaid managed care quality rating system, and elsewhere, we request that in doing so CMS and states continue and deepen the necessary focus on children, especially those with special health care needs, as well as pregnant women so their needs are successfully addressed. We appreciate the requirement for a pubic engagement process as states develop their comprehensive statewide quality strategy.

Network Adequacy Standards - We applaud CMS for its recognition that network adequacy is a foundational component of a health plan's ability and capacity to provide services and for proposing standards for network adequacy. We also are pleased that CMS proposed that states ensure that enrollees have access to all services covered in a manner that meets state accessibility and affordability standards. We do note a central tension inherent in the proposed rule that may hinder efforts to regulate network adequacy in managed care plans. On the one hand, the proposed rule seeks to align network adequacy requirements with other coverage programs, particularly Medicare Advantage Plans and Qualified Health Plans sold through the Marketplace. At the same time, the proposed rule aims to maintain state flexibility. Aligning standards across coverage programs and maintaining state flexibility are both worthy goals, but can potentially work at cross-purposes. In light of these issues, we recommend that CMS maintain a degree of state flexibility while also establishing minimum, multi-faceted, quantitative standards for network adequacy, such as appointment wait times, provider-patient ratios for adult and pediatric primary and specialty care, and time and distance standards. We strongly caution against the sole use of time and distance for pediatric specialty care. The lack of access to a pediatric specialty facility resulting from the sole use of a distance standard for network

adequacy could delay services for very sick children or compel them to seek care in settings ill-equipped to address their pediatric service needs.

Any network adequacy standards should ensure that children's health care needs (from primary to tertiary and quaternary) are appropriately addressed and that children are able to receive the full range of services for which they are eligible. Regarding provider-specific time and distance standards §438.68(b)(1), we strongly support the inclusion of pediatric-specific standards and recommend that CMS carefully consider the full range of required types of pediatric providers for whom network adequacy standards should be developed. We strongly believe that additional standards for pediatric and adolescent behavioral health at §438.68(b)(iii) would help ensure that children and adolescents have access to the full range of care they may need. We also encourage CMS to include pediatric-specific standards for emergency rooms, non-physician and physician specialists and subspecialists, pharmacies, and ancillary providers, such as therapists.

We recommend that CMS develop quantitative standards and templates for states that include, but are not limited to, minimum time and distance standards in the categories above as a floor. We also urge CMS to include specific examples of how the methodology and parameters recommended would effectively meet the needs of children (0-21) and pregnant women specifically and where alternative or additional standards may be more appropriate. We also suggest CMS adopt and encourage states to adopt additional standards that take into account the needs of children, including those with special health care needs. States should also be encouraged to continuously monitor the experiences of these populations so that changes can be made as more is known about how they can be better served. These recommendations should be, whenever possible and practicable, applied to CHIP as well (§457.1218).

Transparency – We applaud HHS for making transparency a priority in this update to the managed care regulations. States will be required to post or link to vital consumer information, including enrollee handbooks, provider directories and formulary drug lists. Additionally, key program information including network adequacy standards and quality, which has often been difficult to obtain in the past, must be posted in accessible formats on state websites. We believe the rule can be further strengthened in regard to transparency by requiring that contracts and important contract information as detailed under §438.602 be posted where it can be accessed quickly and with minimal cost, rather than allowing states the option to make such information available upon request. Items of particular importance include contracts, actuarial soundness data, Medical Loss Ratio (MLR) data, and network adequacy data.

More Robust Consumer Information – We commend HHS for boosting requirements for consumer information, by specifying detailed content that must be posted or linked on state websites for potential enrollees, current enrollees, and the broader public. From establishing standardized definitions for common managed care terms to requiring that specific information be included in enrollee handbooks and provider directories, to making public key quality data, the proposed rule will advance understanding of how managed care works and provide crucial information that consumers need to make an informed plan

choice. To foster efficiency and consistency, we encourage HHS to develop model definitions and materials for states to adopt or adapt. Additionally, all written materials should be subject to consumer testing to promote comprehension and understanding, especially with consideration for individuals with disabilities or limited English-language proficiency.

Enrollment Opportunity and Choice Counseling – All consumers should be allowed adequate time to review information and receive personalized assistance in selecting a managed care plan that best fits their needs. Research has shown that consumers are less likely to make an active choice if they are passively enrolled or auto-assigned to a managed care plan. Offering a specified period of coverage under fee for service and boosting access to information and consumer assistance are important strategies to encourage more beneficiaries to compare their options and make an informed choice, and in doing so, better understand how their managed care plan will work. However, the 14 days proposed in the rule is insufficient for consumers to wade through complex insurance information, and thus, we recommend that the final rule provide a 30-day standard enrollment period, while allowing exempt populations 45 days to choose a plan.

Disenrollment – The proposed rule largely maintains current requirements that allow consumers to disenroll in the first 90 days for any reason, or at any time with cause. We believe that two additional circumstances justify cause for disenrollment – if an enrollee's primary care provider leaves the network or if a provider from whom the enrollee is receiving ongoing care leaves the network – and urge HHS to adopt these reasons. Additionally, we believe that aligning the annual opportunity to switch plans with renewal is a logical time for consumers to re-evaluate plans and will minimize consumer confusion that can result from the two processes not being aligned. Lastly, we believe using the term 'disenrollment' as it applies to the annual opportunity to change plans can be confusing to enrollees and may discourage them from selecting a new plan. We encourage HHS to consider other terminology such as "open enrollment period" or "annual opportunity to change plans."

Medical Loss Ratio - We strongly support the proposed regulation's addition of a Medical Loss Ratio (MLR) as a contractual requirement for MCOs, PIHPs and PAHPs operating in Medicaid and CHIP beginning in 2017. MLRs have the potential to ensure better value for public funds used to purchase coverage for Medicaid and CHIP beneficiaries. MLRs also enhance the ability of states to assess the actuarial soundness of capitation rates and promote the success of better actors in the insurance market— those with lower administrative costs who are devoting higher levels of premium funds to paying for incurred claims. A recent study by researchers at the Urban Institute speaks to the public policy value of having an MLR. This analysis found that "the ACA's minimum MLR rule had a direct effect on insurer behavior that increased value for consumers and increased efficiency in the individual and small group markets."[2]

The value of an MLR is greatly diminished if it is not publicly reported and routinely audited. For consumers choosing plans, as well as for researchers, stakeholders and legislators, a publicly reported MLR that is consistently defined and reported by all plans in

a timely way is an important step toward driving better quality of care in the Medicaid program. To strengthen transparency, we recommend amending §438.74(a) to clarify that states must submit MCO reports themselves (not just a summary) to CMS. We also recommend that subsection(g) be amended to require the state to post the summaries that are submitted to HHS to comply with the above reporting requirement on their website. Finally, we recommend that states be required to post on a website a comprehensive and easily accessible list of Medicaid and CHIP plans and their MLRs.

We greatly appreciate the opportunity to provide feedback on this important proposed rule. Please note many of the themes and recommendations in this letter can be found in more detailed comments by many of the undersigned organizations.

Sincerely,

Alliance for a Just Society
American Academy of Child and Adolescent Psychiatry (AACAP)
American Academy of Pediatrics
American Cochlear Implant Alliance
American Federation of State, County and Municipal Employees (AFSCME)
American Psychological Association
American Thoracic Society
Association of Asian Pacific Community Health Organizations
Autism Speaks
Catholic Health Association of the United States
Children's Defense Fund
Children's Dental Health Project
Children's Health Fund
Epilepsy Foundation
Family Voices
First Focus
Georgetown University Center for Children and Families
March of Dimes
National Alliance to Advance Adolescent Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
Nurse Family Partnership
School-Based Health Alliance

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[1] S. Burwell, "2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP," United States Department of Health and Human Services (November 2014), available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf.

[2] Clemens-Cope et al, "Health Insurer Responses to Medical Loss Ratio Regulation: Increased Efficiency and Value to Consumers" Robert Wood Johnson Foundation, May 2015.