Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

August 22, 2016

VIA ELECTRONIC SUBMISSION

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

Attention: CMS-6068-P
Medicaid/CHIP Program: Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS–6068-P, "Medicaid/CHIP Program: Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs."

The Center for Children and Families is based at Georgetown University's Health Policy Institute with the mission of improving access to health care coverage among the nation's children and families, particularly those with low and moderate incomes. Much of our work relates to access to services in public programs and assuring the accuracy of eligibility determinations and payments is critical to accountability and transparency in their operation.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Tricia Brooks at pab62@georgetown.edu or Kelly Whitener at kdw29@georgetown.edu.

Sincerely,

Joan C. Alker

Joan Alker

Overall, we believe that CMS has taken a realistic and sensible approach to updating and harmonizing its regulations regarding the Medicaid Eligibility Quality Control (MEQC) and the Payment Error Rate Measurement (PERM) programs. While we address specific comments below, we also believe there are missed opportunities to ensure that this alignment takes an expansive approach to quality control beyond measuring payment errors to more robustly ensure overall program integrity. In particular, we would like to emphasize four general topics.

Transparency

First, the proposed rule neglects to address a critical aspect of public programs – transparency. Payment errors are a key indicator of program performance, and to this end, we encourage CMS to amend the rules to provide for public release of state-specific payment error rates, as well as MEQC pilot planning documents, findings, and corrective action plans. Recognizing that PERM operates on a three-year cycle that runs adjacent to MEQC periods, we recommend that CMS phase in state-level reporting and release of PERM/MEQC related documents for cycles that begin following publication of the final rule in order to provide states with advance notice of public reporting requirements. We also recommend that CMS post this information collectively for all states on Medicaid.gov, however, minimally states should be required to post the information in a manner similar to consumer information requirements for managed care (§ 438.10) in a prominent location on the state's Website and not limit its availability to upon request only.

Proper Payments to Providers in Managed Care

Second, the proposed rule neglects to address a significant portion of the Medicaid and CHIP programs – managed care. In 2014, 43.3 million Medicaid beneficiaries were enrolled in comprehensive managed care organizations.[1] Children make up the largest group of Medicaid beneficiaries, and nearly nine out of ten children are enrolled in some type of managed care arrangement.[2] Medicaid managed care also represents the largest category of Medicaid expenditures, accounting for $191.6 billion or 41 percent of Medicaid benefit expenditures in 2014.[3] Yet, the proposed rule limits CMS oversight of managed care payments to whether the beneficiary was eligible and whether the proper capitation rate was paid, without looking further into whether the proper services were delivered and proper payments made to providers. This significantly contrasts with fee-for-service (FFS) reviews, which include a medical chart review in addition to the data processing reviews. The current and proposed regulatory structure penalizes states that rely more on FFS while rewarding states that rely more on managed care simply by failing to review the provider payment errors that underlay capitation payments in managed care.

Understanding that historically it has been difficult to obtain needed data to oversee managed care more fully, the recently finalized Medicaid and CHIP managed care rule makes significant strides in improving this data transparency. For example, the rule requires providers in Medicaid and CHIP managed care to be enrolled in the program (§ 438.602(b)) and requires robust reporting of encounter data (§438.604(a)). At the very least, CMS should incorporate compliance with these requirements in the error rate now that this information is available. While there are additional sampling and attribution

challenges in the managed care context that will need to be overcome, we believe this is an imperative given the size and growth of Medicaid managed care. While review of these two elements should be incorporated immediately, CMS should also test methods to incorporate more detailed managed care reviews that parallel the medical review in FFS. For example, CMS could develop a process for selecting a sample of managed care capitated payments that are also associated with a claim payment within the capitated payment month.

Negative Case Reviews

Third, by requiring that only 'active' cases be reviewed in PERM, 'negative' case reviews will not receive proper oversight. Accurate eligibility determinations, both determinations and denials, are critical to overall program integrity. The Affordable Care Act (ACA) emphasized the need for streamlined enrollment processes that are not unnecessarily burdensome on beneficiaries and states, oftentimes preventing eligible individuals from enrolling. By emphasizing positive case reviews only, the proposed rule encourages states to err on the side of keeping people out of Medicaid and CHIP, even those who may be eligible. A more balanced approach would oversee positive and negative cases proportionally, thus encouraging states to enroll all eligible individuals without unnecessary steps as the ACA requires. The proposed rule excludes negative case reviews from PERM (except those that few cases that are caught via a claim denial) and instead requires more negative case reviews in MEQC. But, in order for the error rate to be accurate, it must include both positive and negative eligibility determinations.

Therefore, CMS should incorporate negative case reviews in the PERM program and in the actual error rate. We understand that this means that CMS will not be able to rely exclusively on a universe of claims/payments for the PERM sample. We also understand that this means CMS will need to determine how to account for negative cases in calculating the error rate. If CMS is unable to do this, we think additional oversight of negative cases in the MEQC process is critical. For example, CMS should direct all negative case reviews rather than leaving them to state discretion, and all results should be made public. Only through greater federal oversight can we be sure that eligibility determinations are truly accurate for negative cases.

Account Transfers

Finally, the MEQC pilots should also be used to assess state processes for transferring cases to and from the marketplace. Currently, very little is known about how well states are adhering to ACA requirements for Medicaid agencies to coordinate with state-based marketplaces or the Federally Facilitated Marketplace. Account transfers should be monitored to ensure that states are using the information applicants provide to the marketplace and not asking for information or documentation that has already been provided, and that states are appropriately transferring all denied Medicaid cases that originate with the state Medicaid agency to the marketplaces.

More detailed comments on specific provisions follow.

§ 431.812 Review Procedures

The rule provides states with considerable flexibility for its active case reviews in the MEQC program. CMS will only direct the MEQC reviews if a state has a PERM eligibility improper payment rate that exceeds the three percent national standard for two consecutive PERM cycles. Given the length of time between PERM reviews, CMS should consider directing the MEQC reviews after a state has **one** PERM eligibility improper rate that exceeds the three percent limit rather than waiting for two PERM cycles spanning six years. Alternatively, CMS could implement a staged oversight plan such that after one PERM cycle with an error rate above the three percent threshold some additional oversight is required, but the level of CMS direction increases after two consecutive cycles with error rates above the threshold.

§ 431.814 Pilot Planning Document

It is logical that reviews would be focused on recent changes to eligibility policies and processes, error prone areas, and areas where the state suspects vulnerabilities. However, there is no direct linkage of reviews to prior PERM findings. We recommend that CMS strengthen this rule by requiring states to include a justification for the focus of the case review in the pilot planning document, which addresses prior PERM findings.

§ 431.950 Purpose

We strongly support the use of a federal contractor in conducting PERM reviews. This approach will provide for consistent application of these regulations and provide an independent and objective assessment of each state's performance. In particular, we believe that a federal contractor will consistently examine the state's policy – such as the application of reasonable compatibility standards (an area that is being misapplied in some states) – against federal standards and state policy options to ensure that accurate determinations and proper payments.

§ 431.960 Types of Payment Errors

The limitation of payment errors at the managed care capitated payment level misses an opportunity to assure that direct payments to providers by managed care entities are accurate. We recommend that CMS include additional oversight of provider payments in managed care immediately, while developing a plan for managed care chart reviews in the future (see above for more detail).

We support the clarifications that improper payments are defined as both federal and state improper payments rather than relying on the total computable amount only.

§ 431.970 Information Submission and Systems Access Requirements

In order for the federal contractor to appropriately conduct reviews, it is essential that they have access to eligibility systems, document management systems, application information, third party data verification results, case notes, and copies of required documentation.

§ 431.972 Claims Sampling Procedures

We strongly recommend that CMS reinstate negative eligibility determination case reviews and incorporate the results in the payment error rate (see above for more detail). Without a method to detect improper denials, which has been a problem for eligible individuals over the years, program integrity suffers. From a public benefits perspective, it is as important that we assure that all eligible individuals are enrolled, rather than making sure that only enrolled individuals are eligible.

§ 431.992 Corrective Action Plan

We recommend that CMS impose a maximum of a one-year timeframe for completing the corrective actions, with tighter timeframes when feasible. Understanding that not every error can be corrected in the time planned, we support the requirement that the corrective action plan (CAP) include an evaluation of the CAP from the previous measurement in order to continually monitor known errors until they are resolved. We suggest that CMS clarify that the evaluation lookback period applies to all previous CAPs and is not limited to the CAP from the most recent past measurement only.

§ 431.1010 Disallowance of Federal Financial Participation for Erroneous State Payments

We understand that CMS is aiming to provide states with flexibility as they work, in good faith, to resolve errors. However, we do not believe that states should be eligible for a good faith waiver indefinitely. Therefore, we suggest that CMS clarify that the good faith waiver is limited to one PERM cycle and will not be extended. Good faith waivers could be granted for consecutive PERM cycles, but only when new circumstances require it, not simply as an extension of the previous waiver. Additionally, to receive an extended waiver, states should be required to show some improvement over the prior period.

§ 457.628 Other Applicable Federal Regulations

We support applicability of the Medicaid rules for CHIP.

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[1] CMS, "Medicaid Managed Care Enrollment and Program Characteristics, 2014" published Spring 2016, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf

[2] MACPAC, "Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2012," available at https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2012.pdf

[3] Department of Health and Human Services, "2015 Actuarial Report On the Financial Outlook for Medicaid," available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf