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July 27, 2015

VIA E-MAIL

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Service
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave SW
Washington, DC 20201

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

Secretary Burwell:

On June 1, 2015, the Department of Health and Human Services, Centers for Medicare and Medicaid Services' ("CMS") published a proposed rule that seeks to improve health care coverage for millions of people. In response to this proposed rule, we are pleased to have the opportunity to provide comments on behalf of our client, Public Citizens for Children and Youth ("PCCY").

PCCY works to improve the lives of children in southeast Pennsylvania by developing initiatives and advocating for quality health care, child care, public education and family

stability. Since our founding in 1980, PCCY has combined comprehensive research and the tools of advocacy to mobilize partner organizations and citizens across the region to change the lives of children for the better.

PCCY tackles a variety of health policy issues and engages in a host of related advocacy efforts to make good on our commitment to address the needs of every child. Every child should be able to see a health care provider for checkups and when they get sick. In southeastern Pennsylvania, more than 46,000 children do not have health insurance. Many children have too few places to turn to when they get hurt or fall ill. PCCY is closing this gap by providing resources to parents to help them get publicly funded health insurance for their children. PCCY's health insurance resources include trainings for child-serving professionals on how to apply for Medical Assistance and CHIP, a child health helpline to assist families over the phone, and reports on the state of child health in the region.

While we generally support the proposed rule, we have concerns regarding the transparency provision, medical loss ratio provisions, CMS's "in lieu of" policy, and time and distance standards. We urge CMS to strongly consider our comments below to strengthen the proposed rule and Medicaid health care coverage.

Time and Distance Standard/ Network Adequacy (42 C.F.R. § 438.68)

We believe that the proposed rule is an important first step toward achieving the goal of ensuring that children have timely access to high quality providers for all covered services. However, we believe that there are many aspects of the proposed rule that must be strengthened to meet the unique needs of children, particularly those with serious, chronic or complex health conditions. A provider network that lacks the full range of pediatric providers, particularly

pediatric specialty care providers, puts children and their families at financial risk and threatens children's long-term quality of life.

The proposed regulation allows wide flexibility for states by requiring them to develop and enforce their own specific network adequacy standards. As we have interpreted the regulation, states would not be required to set specific provider-beneficiary ratios, but rather must develop time and distance standards for primary care and other provider types. While we recognize this approach is consistent with CMS' general approach for the Medicaid program, we are concerned that time and distance standards will have limited practical effect in establishing and maintaining network adequacy. This is particularly true given the states' historical lackluster performance and enforcement of network adequacy standards.

Time and distance standards have limitations, as they do not address whether clinicians are taking new patients, have available appointments, or deliver quality care. States should be required to take other factors into consideration, including (but not limited to): access to initial and follow-up appointments, member experience, and complaints and appeals related to access issues when determining network adequacy. States should also be required to set specific standards for appointment wait times. Standards on appointment wait times would add an additional beneficiary protection that would ensure health care's main entry point, primary care, stays open and easily accessible for patients.

Time and distance standards also do not account for non-traditional services such as telemedicine which can improve access, especially in provider shortage areas, to higher quality providers and more appropriate specialists. We therefore believe it is particularly important for states to have flexibility in determining the appropriate standards for access given the specific

geographic and provider availability constraints they face. Also, continuity of care is a primary objective of pediatric medicine and is consistent with overall quality patient care. We urge CMS to require states to consider the importance of continuity of care while developing network adequacy and patient enrollment policies and to strive to minimize the effect of patient churn between various Medicaid managed care plans.

In addition, time and distance standards do not necessarily account for the needs of children with complex or chronic health care needs. It has been found that 10 percent of children enrolled in Medicaid have complex medical needs and account for approximately 70 percent of the resource utilization in pediatrics.[1] States should therefore also be required to specifically evaluated network adequacy for children with more complex or chronic health care needs (children with special health care needs). As such, states should require payers to demonstrate that their networks are adequate and accessible for the subpopulation of children that represents the majority of their anticipated pediatric spending in any given year.

Finally, we also note that inaccurate and out-of-date provider directories lead to network adequacy issues. Without accurate provider directories, beneficiaries face unfair, costly, and protracted obstacles to their receiving the care, treatment, and follow-up they need. In the case of family medicine and primary care, accurate and up-to-date physician directories ensure that needed health care is easily accessible for patients. To that end, we believe that states should place specific requirements on Medicaid managed care plans to timely maintain the accuracy of provider directories and information. A Medicaid manage care plan's online provider directory

[1] G. Kenney, J. Ruhter, and T. Selden, "*Containing Costs and Improving Care for Children in Medicaid and CHIP*," Health Affairs 28:6 (2007): w1012- w1036 web exclusive).

should be updated instantaneously or at least within 5 business days to reflect changes submitted by providers. States should also require Medicaid managed care plans to provide uniform information in its provider directories including:

- Provider name;
- Practice street address, city, state, zip code, phone number, website;
- Practice office hours and other information that could affect availability;
- Notice of whether the provider is taking new Medicaid patients; and
- The anticipated time period for accepting or not accepting new Medicaid patients.

Medical Loss Ratio

Imposition of a Medical Loss Ratio Standard

CMS' proposed rule that would establish a minimum 85% medical loss ratio ("MLR") for Medicaid managed care organizations ("MCOs"), prepaid ambulatory health plans ("PAHPs") and prepaid inpatient health plans ("PIHPs") (collectively "Medicaid managed care plans"). 80 Fed. Reg. 31098. PCCY strongly supports CMS's proposal for an MLR standard to be calculated, reported, and used in the development of actuarially sound capitation rates by Medicaid managed care plans. Such a standard would help ensure that capitation rates set for Medicaid managed care programs are actuarially sound and that such rates are based on reasonable medical expenditures for enrollees. For years, states have implemented MLRs to rein in increasing health care costs.[2] In the context of Medicaid specifically, an MLR requirement will help regulate Medicaid managed care plans, especially those that must provide a return to their shareholders, from "skimping on needed care by erecting barriers rather than rolling up

[2] Meghan S. Stubblebine, Note, *The Federal Medical Loss Ratio: A Permissible Federal Regulation or An Encroachment on State Power?,* 55 WM. & MARY L. REV 341, 344-45 (2013).

their sleeves and doing the hard work of actually managing care for better long term health outcomes."[3]

Moreover, MLR standards have been implemented and proven effective in other contexts, including under the Affordable Care Act ("ACA"). The ACA imposed MLR requirements on Medicare health-insurance issuers to protect consumers because, in the absence of an MLR requirement: (1) nothing restrained insurance issuers from raising premiums in order to accommodate administrative expenses or to increase profits; and (2) the insurers were able to engage in "risk classification by design."[4] The MLR requirement in the Medicare arena now places sensible controls and ultimately, protects Medicare consumers.[5] Similarly, an MLR requirement for Medicaid would protect Medicaid beneficiaries. Specifically, it would ensure that program dollars are spent on health care services, benefits, and quality improvement for the beneficiaries rather than on unnecessary administrative activities.

Medical Loss Ratio of At Least 85 Percent

PCCY also strongly supports the proposal that rates for Medicaid managed care plans must be set to achieve a MLR of at least 85 percent. Such a percentage would bring Medicaid in

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[3] Joan Alker, Georgetown Univ. Health Policy Inst., Ctr. for Children & Families, *Holding Insurers Accountable: Should We Add an MLR to Medicaid?* (Mar. 22, 2012), http://ccf.georgetown.edu/ccf-resources/holding_insurers_accountable_should_we_add_and_mlr_to_medicaid/.

[4] J. Angelo DeSantis and Gabriel Ravel, *The Consequences of Repealing Health Care Reform in Early 2013*, 60 CLEV. ST. L. REV. 365, 399 (2012) ("Risk classification by design occurs when an insurer designs its plans so that certain plans will attract healthier enrollees and other plans will attract sicker enrollees.").

[5] *Id.* at 400.

line with the minimum threshold created by the ACA for large Medicare group plans, and would also be in line with the current ratio used by the numerous states that have implemented an MLR requirement for Medicaid managed care plans. For example, Washington D.C., Indiana, New Mexico, Maryland, and Ohio have each implemented an MLR requirement of 85 percent for Medicaid managed care plans to ensure program participants are receiving the best quality care.[6] Moreover, most Medicaid managed care plans already have an MLR of 85 percent or higher, so the proposed regulation would not pose an undue burden.[7] Accordingly, PCCY encourage CMS to follow these states in adopting an MLR requirement of 85 percent for Medicaid managed care plans.

Enforcement Provision to Mandate Compliance with the Medical Loss Ratio

Finally, PCCY strongly encourages CMS to adopt an enforcement provision mandating compliance with the proposed minimum MLR of 85 percent. The current proposed regulations do not *require* state rebates (it is up to a state to determine whether a remittance is required); rather, states would only be expected to take excess payments into consideration when setting future rates. Without a penalizing provision targeting plans that do not meet the minimum MLR requirement, much of the benefit of imposing such a minimum would be lost.

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[6] *See* Henry J. Kaiser Family Found., *Quick Take: Medicaid MCOs and Medical Loss Ratio (MLR) Requirements* (Apr. 13, 2012), http://kff.org/medicaid/fact-sheet/medicaid-mcos-and-medical-loss-ratio-mlr/ (providing a chart of Medicaid MLR requirements in states throughout the country).

[7] *Medicaid Managed Care 'Comes of Age' – Highlights from the Proposed Rule*, BRYAN CAVE (Jun. 11, 2015), https://www.bryancave.com/en/thought-leadership/medicaid-managed-care-comes-of-age-highlights-from-the-proposed.html.

A number of states that currently include a minimum MLR for Medicaid plans also include a qualifying enforcement provision. For example, in Illinois, where the minimum MLR is 85 percent, if a plan does not meet this threshold, the plan "shall" refund to the State and CMS the difference between the calculated MLR and the targeted MLR, multiplied by the coverage year revenue.[8] In Ohio, if the plan does not meet the minimum MLR, it must return to the state the difference between 85 percent of the total Net Capitation Payments to the managed care plan and actual allowed medical expenses incurred.[9] Washington also requires a form of remittance if a plan fails to meet the minimum MLR threshold.[10]

In line with these states' models, we propose enforcement of the minimum MLR requirement using remittances. Specifically, we strongly encourage CMS to implement a model identical or similar to that of Medicare Advantage ("MA") plans, which have a remittance requirement and accompanying penalties if a plan fails to meet the minimum MLR requirement. These provisions provide that: (1) if a plan fails to meet a minimum MLR of at least 85 percent, it must "remit to the Secretary an amount equal to the product of (i) the total revenue of the MA

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[8] *Illinois Financial Alignment Demonstration (Medicare-Medicaid Alignment Initiative)*, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Illinois.html (follow link for "Three-Way Contract" and scroll to page 179).

[9] Ohio Dep't of Medicaid, *Combined Provider Agreement*, http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProgramResourceLibrary/CombinedProviderAgreement.aspx (follow link for "July 1, 2015 – June 30, 2016 Managed Care Provider Agreement" and scroll to page 7).

[10] Wash. State Health Care Auth., *Managed Care Medical Programs*, http://www.hca.wa.gov/medicaid/healthyoptions/Documents/Forms/AllItems.aspx (follow link for "2015 Apple Health Contract Jan2015" and scroll to pages 71-72).

plan under this part for the contract year; and (ii) the difference between .85 and the [plan's actual] medical loss ratio"; (2) if the plan fails to meet the minimum MLR requirement for three consecutive contract years, "the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year"; and (3) if the plan fails to meet the minimum MLR for five consecutive years, the Secretary will terminate the plan contract.[11] In In addition, we suggest that any monies remitted back to the Secretary pursuant to these enforcement provisions be re-allocated to other programs center on children's healthcare in the applicable state. Such provisions have proved effective in the MA arena to ensure quality coverage to consumers; we encourage CMS to extend this framework to the Medicaid arena.

Enforcement provisions obligate managed care plans to meet a minimum threshold. Adding teeth to the proposed regulation will ensure quality coverage for Medicaid beneficiaries. The proposed Medicaid regulations emphasize aligning Medicaid practices with that of mainstream Medicare to improve consistency across programs. Without an enforcement provision that applies across the states, this desired uniformity and consistency will not be reached: states will have the freedom to impose lean provisions, or even no enforcement provisions at all. Accordingly, PCCY urges CMS to adopt an enforcement provision identical or similar to that in its proposed regulations to mandate compliance by Medicaid managed care plans with the proposed minimum MLR.

[11] 42 U.S.C. § 1395w-27(e)(4) (2010).

Calculation and Reporting of the MLR

The 85% MLR represents the percentage of revenue that a Medicaid managed care plan must spend on direct care and quality improvement activities as opposed to administrative costs and profits. Under the proposed rule, a State must develop actuarially sound capitation rates for Medicaid managed care plans that are "developed in such a way that the [managed care plans] would reasonably achieve" a MLR that is least 85%, as established by the State. Proposed 42 CFR § 438.4(b)(8). The State must ensure that under contracts effective on or after January 1, 2017, each Medicaid managed care plan must calculate and report its MLR for the rating period beginning in 2017. Proposed § 438.8(a). If a Medicaid managed care plan fails to achieve the State-required MLR, the State could require a remittance. Proposed § 438.8(j). There are limited circumstances under which an entity may adjust its MLR (a credibility adjustment) to account for a statistical variation and not be penalized.

Here are some comments regarding the proposed MLR provisions:

- The main purpose of establishing a Medicaid managed care MLR is to limit a managed care entity's administrative costs and profits. The commercial and MA programs have already applied MLRs. However, the Medicaid managed care population is sicker and poorer than the commercial and MA programs. Consequently it is critical for the calculation of the Medicaid MLR to appropriately reflect the amount of direct care costs necessary to support the Medicaid population.
- Given the changes in the Medicaid managed care market under health care reform and the fact that Medicaid managed care entities tend to enter and leave the marketplace more frequently than other plans, it is important that the data used to calculate the MLR, including the credibility adjustment, is as current as possible.

- States bear enormous responsibility for ensuring that a Medicaid managed care plan's MLR is correctly calculated and reported and for setting proper rates based on an entity's MLR. Although some States already include an MLR in rate-setting, many do not. Further, some will have to adjust their existing MLRs to meet the federal standard. Given the financial condition of many States' Medicaid programs, CMS should ensure that States have the capability to perform these tasks and related enforcement, and consider whether additional funding is necessary.
- The calculation of the MLR is based on a ratio of a numerator that is the sum of specific incurred claims, activities that improve quality, and program integrity activities to a denominator that is equal to the adjusted premium revenue. Proposed § 438.8(d), (e) and (f). The rule defines each of these terms to some extent. Although the proposed rule is intended to provide States with flexibility with respect to how to calculate the MLR, CMS should ensure that these terms are defined and applied uniformly. For instance, an "incurred claim" includes incurred but not reported claims "based on past experience, and modified to reflect exposure, claim frequency or severity." These terms are not defined.
- In the Preamble CMS requests comments on whether its definition of activities that improve quality is sufficiently broad enough to include "the costs of appropriate outreach, engagement, and service coordination" including case management/care coordination activities with respect to the Medicaid population P. 31110. In the proposed rule, the definition of these activities incorporates existing § 158.150(b) which defines quality activities for the private market. This section requires that an activity that improves health care quality must increase desired health outcomes "in ways that are capable of being "objectively measured" and of "producing verifiable results and achievements, and "be grounded in evidence-based medicine." In general, the Medicaid population suffers from more compromised medical conditions, and it may be more difficult

to measure outcomes and improvements in the same way as for other populations. In some cases, maintaining the status quo with respect to a health condition is the optimum outcome. With respect to case management that includes patient education, success rates may vary based on non-health-related issues (*e.g.*, when a beneficiary moves and is unreachable). There may also be activities that can lead to better health outcomes (e.g., transport vans, air conditioners in homes). The Medicaid MLR should reflect quality-related costs that are appropriate for the Medicaid population.

- With respect to program integrity activities that are included in the numerator of the MLR, the proposed rule incorporates the program integrity activities at § 438.608 that are required for Medicaid managed care plans. The costs related to some of these activities could vary widely. For instance, under § 438.608, a plan must establish a Compliance Program. It is feasible that a plan could inflate the soft costs of a Compliance Program, which in term would inflate its numerator. Also, fraud prevention activities may be included as a program integrity activity, with a cap of .5% of premium revenue. Despite the cap, States should carefully review costs associated with these activities to ensure that a managed care entity is not misreporting fraud and abuse investigation costs in order to maximize the numerator.
- States should be required to collect remittances from managed care entities that do not satisfy the MLR provisions (including with the credibility adjustment) except in limited circumstances (e.g., financial hardship). The remittance further incentivizes these entities to be compliant.

Transparency: Section 438.602(g)

The proposed regulations, through Section 438.602(g), will increase public access to information about the administration and financing of Medicaid managed-care plans. PCCY supports these steps, and PCCY encourages CMS to add clarifying language to Section

438.602(g) to ensure that the transparency provisions will function as intended. Greater transparency in state Medicaid programs will drive improvement in the delivery of high-quality care by providing a window into the efficacy of the programs and the quality of care delivered to Medicaid beneficiaries.[12] Transparency for Medicaid and other healthcare programs has the potential to dramatically advance the quality and the efficiency of healthcare by providing researchers and policymakers with comprehensive data.[13]

Unfortunately, public access to data about state Medicaid managed care programs is spotty. In a few states, the release of "downstream" information, such as the rates paid by Medicaid managed care plans to providers, has enabled the public to scrutinize the effectiveness and economy of state Medicaid managed care programs. *See, e.g.*, Hilary Waldman, *Specialists See Low Rates From State-Paid HMOs*, Hartford Courant, Oct. 19, 2005, at B1; *see also Wilmington Star-News v. New Hanover Reg'l Med. Ctr.*, 480 S.E.2d 53 (N.C. Ct. App. 1997)

[12] CMS officials have publicly recognized the importance of access to data from state Medicaid programs. Niall Brennan, Patrick H. Conway & Marilyn Tavenner, *The Medicare Physician-Data Release—Context and Rationale*, 371 New Eng. J. Med. 99, 100 (2014) ("We agree that the value of these data would be enhanced with the inclusion of claims data from other sources, and we would welcome a dialogue about how . . . state Medicaid programs . . . could contribute their own provider-level utilization information in order to build a fuller picture of care.").

[13] *See, e.g.*, U.S. Dep't of Health & Human Servs., *Open Government Plan, available at* http://www.hhs.gov/open/plan/opengovernmentplan/index.html; Centers for Medicare and Medicaid Services, *Medicare Provider Utilization and Payment Data: Physician and Other Supplier, available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html; U.S. Dep't of Health & Human Servs., *HHS Releases New Data and Tools to Increase Transparency on Hospital Utilization and Other Trends*, June 2, 2014, *available at* http://www.hhs.gov/news/press/2014pres/06/20140602a.html.

(ordering the release of price lists in a contract between a public hospital and a private HMO).[14] But elsewhere, members of the public have had to wage protracted legal battles in order to access even such basic information as historical capitation rates paid by state Medicaid agencies to MCOs. *E.g.*, *Commonwealth v. Eiseman*, 85 A.3d 1117, 1131 (Pa. Commw. Ct. 2014) (requiring disclosure of certain such rates under state public records law); *see also* Attorney General Letter Opinion 98-L-17 (N.D. Att'y Gen. Mar. 2, 1998), *available at* http://www.ag.state.nd.us/opinions/1998/Letter/98olso02.pdf (same).

The proposed Section 438.602(g) will foster transparency and accountability by guaranteeing public access to capitation rate data, *see* Section 438.602(g)(1), and a range of downstream data, *see* Section 438.602(g)(2)-(3). PCCY strongly supports the proposed Section 438.602(g) and urges adoption of the proposed regulation without any weakening. In addition, PCCY urges an addition to the proposed regulation, as shown here in bold:

> (g) *Transparency*. The State must post on its Web site or make available upon request the following documents and reports**, without charge, in unredacted form, to any member of the public, within 60 days**:

These additions are crucial to making the proposed Section 438.602(g) an effective tool:

- **"in unredacted form":** Some states already post Section 438.602(g)-type documents online, but with crucial information redacted. For example, Pennsylvania posts MCO entity contracts online, as would be required by Section 438.602(g)(1). *E.g.*, MCO entity contract of Aetna Better Health, Inc., for

[14] The Supreme Court of Pennsylvania is currently considering whether such information must be released under Pennsylvania's public records law. *See Commonwealth v. Eiseman*, 106 A.3d 610 (Pa. 2014); *Dental Benefit Providers, Inc. v. Eiseman*, 106 A.3d 609 (Pa. 2014).

Southeastern Pennsylvania, in effect from 2010 through 2015, *available at* http://contracts.patreasury.gov/View.aspx?ContractID=88205. However, Pennsylvania redacts from the online versions the capitation rates paid to the MCOs—information that is of particularly high interest to healthcare researchers and to taxpayers in general. *See, e.g.*, Appendix 3f to *id.*, *available at* http://contracts.patreasury.gov/Admin/Upload/88205_4000014647%20pt%20a.pdf, at 17 ("PAGE REMOVED CONFIDENTIAL INFORMATION"). Even though the redacted information from that and several similar contracts was released over a year ago to a member of the public via Pennsylvania's public records law following two years of legal proceedings, *Commonwealth v. Eiseman*, 85 A.3d 1117, 1131 (Pa. Commw. Ct. 2014), the information remains redacted on the state's website. The proposed addition would help ensure that states make available **complete** information under Section 438.602(g).

- **"to any member of the public":** States sometimes post information online but restrict who may access it. For example, Pennsylvania posts an outpatient fee schedule for the fee-for-service component of its Medicaid program, but only providers can access this portion of the state's website. *See* Pennsylvania Department of Human Services, *MA Fee Schedules*, http://www.dhs.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm ("The PROMISe™ Outpatient Fee Schedule is available for download in the following formats: Excel, PDF, and Comma Delimited. This link will take you to the PROMISe™ website where you will be required to log in using your

Provider ID and Password."). More generally, in some states only citizens of the state may file public records requests. *McBurney v. Young*, 133 S. Ct. 1709, 1714 (2013) (collecting state statutes). The proposed addition would, for example, make certain that a health economist could readily collect data from all fifty states as part of a research project.

- **"within 60 days":** The current proposed regulation lacks any safeguards against the dilatory release of information. The proposed addition provides a simple fix. Sixty days is a generous amount of time for a state agency to upload files to its web server.

CMS' "In Lieu Of" Policy (42 C.F.R. 438.3(u))

Although not entirely clear, CMS appears to view proposed Section 438.3(u) as a clarification of a pre-existing policy with regard to Medicaid managed care plans' coverage of services for enrollees in Institution of Mental Disease ("IMD") as "in lieu of" services. In lieu of services" are alternative services in a setting that are not included in the state plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for state plan services included within a contract. CMS (in authorizing the payment for services provided in an IMD) states that a Medicad managed care plan may not require an enrollee to use an "in lieu of arrangement" as a substitute for a state plan coverage service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost effective manner. We appreciate CMS' clarifications with regard to the use of "in lieu of services" in the proposed rule. However, we recommend that CMS further clarify that Medicaid

managed care plans may not require beneficiaries to accept "in lieu of services" in all settings not merely with regard to IMD services.

Thank you for your time and the opportunity to offer comments on the proposed regulations. We hope that CMS will adopt these comments to strengthen the proposed Medicaid regulations.

Very truly yours,

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