July 27, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 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 (CMS-2390-P)

Dear Administrator Slavitt,

The National Partnership for Women & Families appreciates the opportunity to offer comments on the proposed rule on 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. The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

We commend the Centers for Medicare & Medicaid Services (CMS) for its commitment to modernizing the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives to improve health care outcomes and beneficiary experience while also lowering costs. Medicaid managed care reforms have the potential to provide the comprehensive, coordinated, patient- and family-centered care patients want and need while helping to drive down costs. Realizing this promise, however, requires meaningful collaboration with patients and families at all levels of care – including at the point of care, in care and payment redesign, in governance and policy, and in the community. Only through meaningful partnership with consumers and family caregivers will we arrive at a transformed health care system that delivers on all three tenets of the Triple Aim – better care, better experience, and lower cost.

If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President
Part 431—State Organization and General Administration

§431.502, 504, and 506 State comprehensive quality strategy.

We strongly support the three provisions of §431.502, §431.504, and §431.506, which will require each State to develop and implement a comprehensive quality strategy across all of the State’s Medicaid component programs – at-risk managed care, primary care case management (PCCM), and straight fee for service (FFS). Further, we strongly support the inclusion of quality metrics and performance targets, public reporting, multi-stakeholder review, and opportunities for public comment.

For more than 25 years, under Federal law, States have been developing and monitoring quality of care measurement and improvement goals for the health plans with which they contract on an at-risk basis. Only a few States, however, have programs in place to review the quality performance of their FFS Medicaid programs. As a result, much less is known about the quality of care provided to those Medicaid beneficiaries not enrolled in a managed care plan, especially those eligible for Medicaid coverage due to disability and children with special needs, as these populations are often excluded from managed care enrollment mandates. Adoption of this requirement will greatly enhance our knowledge of the quality of care provided to a State’s entire Medicaid population.

We especially support the requirement set forth in §431.504(a), which dictates the involvement of the State’s Medical Care Advisory Committee and other beneficiaries in the development of the quality strategy and also the requirement that the draft strategy be made available for public comment and revision before adoption. Having robust beneficiary participation in this process will help assure the final plan is one that will be meaningful for beneficiaries as well as providers. However, we urge CMS to strengthen and add specificity to this requirement for public input. Without clear requirements to solicit, consider and respond to public comment, meaningful stakeholder engagement is difficult to secure. To avoid such problems and ensure meaningful stakeholder engagement in the proposed drafting process, we urge the Centers for Medicare & Medicaid Services (CMS) to add significant detail to flesh out its vision for a robust public comment process.

Section 431.500(b) states that comprehensive quality strategies must “ensure the delivery of quality health care to all Medicaid beneficiaries,” and §431.502(a) and §431.502(b)(2) reiterate this point. To help states operationalize this requirement, we recommend identifying the relevant population segments from the “Bridges to Health” model article by CMS leaders. This model divides the entire population into eight non-overlapping sufficiently homogeneous groups with distinctive definitions of optimal health and distinctive service and health information technology needs. In the context of Medicaid and CHIP, the most relevant groups from this model are: people in good health, childbearing women and infants, people with an acute illness, people with a stable chronic condition, and people with a serious but stable disability. The remaining groups – those with failing health near death, those with advanced organ system failure, and those with long-term frailty – are more likely to be found among Medicare beneficiaries. As the authors clarify, this is a person-centered model that focuses on health prospects and priorities and commonly

needed supports and services. Specifying these broad population segments will help to
ensure that no major population segment is overlooked in State comprehensive quality
strategies.

We also urge CMS to require states to include in their comprehensive quality strategy a
plan to assess, address and reduce health disparities in the state. The Affordable Care Act
(ACA) requires “any federally conducted or supported health care or public health
programs, activities or surveys” to collect and report data stratified by race, ethnicity, sex,
primary language, geography and disability status to the extent practicable. CMS has
moved to implement this mandate for national Medicaid population health surveys and to
incorporate it into Medicaid claims database upgrades. But quality measurement in
Medicaid managed care has barely addressed the issue of health disparities until recently.
Most performance data is reported in aggregate for each health plan and is not broken
down by key demographic factors. Stratifying quality data by the key factors called for in
the ACA would sharpen quality improvement interventions, identify groups that continue
to be left behind, and provide a status report on whether managed care is helping resolve
the longstanding inequities in our health care system.

Finally, we encourage additional language that would require flexible alignment with the
National Quality Strategy. Specifically, we recommend adding the following to the
§431.502(b) list of minimum requirements for the comprehensive quality strategies:
“elements that address the three broad aims, at least four of the six priorities, and four or
more of the nine levers (including public reporting, which is covered under (2) in this list) of
the National Quality Strategy.”

Part 433—State Fiscal Administration, Subpart A—General Provisions

§438.2 Definitions.

Under the §438.2 and §457.10 definition of “Comprehensive risk contract,” we encourage
adding “freestanding birth center services” to the list of possible services. We believe this is
warranted by the fact that Medicaid covered about 45 percent of the nation’s births in 2012,
Section 2301 of the ACA includes provisions for coverage of freestanding birth center
services, the number of available freestanding birth centers is rapidly increasing, and the
first-year evaluation of the Center for Medicare and Medicaid Innovation (CMMI)’s Strong
Start program included very favorable results for the birth center model (which reflect the
broader body of research about this model going back several decades). This model strongly
exemplifies the three aims of the National Quality Strategy.

We further support the addition of “doula and other community health worker agencies” to
the list of possible services under the definition of “Comprehensive risk contract.” There is
increasing recognition that community health workers have important roles to play among
Medicaid beneficiaries and in the health care system more broadly.2 Doulas warrant
mentioning due to their demonstrated effectiveness and favorable return on investment.
Pooled results of better-quality randomized controlled trials find that this model in
comparison with usual care decreases the likelihood of cesarean birth (by 28 percent), use of

any pain medications (9 percent), use of the “high-alert” synthetic oxytocin drug to speed up labor (31 percent), and negative ratings of the childbirth experience (34 percent). Notably, these studies have not identified any downsides to doula support. Studies in Minnesota, Oregon, and Wisconsin have found that Medicaid reimbursement of doula care has the potential to reduce Medicaid expenditures through healthy outcomes and reduction in overused cesareans and other procedures and services.

Further, the most recent national Listening to Mothers survey found that among women who knew about doula services and had not received them, underserved women were disproportionately interested in using such services: 35 percent of Medicaid beneficiaries compared to 21 percent of women with private insurance, and 39 percent of black non-Hispanic women and 30 percent of Hispanic women compared to 22 percent of white non-Hispanic women. Further, socially vulnerable women appear to benefit disproportionately from doula services. As just six percent of national survey participants had used a doula for their recent birth, the unmet demand and potential to bring exceptional benefits to childbearing women and newborns are great.

We strongly support enabling States to include as PCCMs physician assistants, nurse practitioners, and certified nurse-midwives (§438.2 and §457.10). Our enthusiasm reflects both the exceptionally strong evidence about the quality of care provided by these provider groups and the physician shortages in many areas of the country.

Finally, there is no statutory or regulatory definition of a Medicaid Accountable Care Organization (ACO), despite the fact that many states are providing services through these entities. We urge CMS to engage in further rulemaking to fully explain the differences between integrated care models that are and are not covered by managed care regulations.

Moreover, there is a growing need for a specific standard definition of an ACO. ACOs are becoming increasingly prevalent in state Medicaid programs. According to the Center for Health Care Strategies (CHCS), nine states have active Medicaid ACO programs and at least seven are actively pursuing them. Some of these ACOs are reporting promising results. It is likely, therefore, that these existing programs will expand and additional states will pursue their own ACO projects. Therefore, we encourage CMS to create a specific definition for Medicaid ACOs.

§438.3 Standard contract requirements.

We applaud CMS for the inclusion of Section 1557 of the Patient Protection and Affordable Care Act as one of the applicable federal laws for Medicaid managed care. Section 1557’s prohibition against discrimination on the grounds of race, national origin, sex, age, or disability in health programs or activities will provide women and their families with the legal protection they need to ensure and enforce their ability to receive equitable, timely

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access to a full range of health care services. A landmark provision, Section 1557 marks the first time that federal civil rights law has prohibited discrimination on the basis of sex in health programs or activities, thus significantly expanding the protections afforded to individuals seeking and receiving health care. It is clear that Section 1557 applies to Medicaid MCOs, PHPs, and all types of PCCMs, however, adding it to the regulations will help emphasize and publicize the new requirement.

Additionally, we strongly support the additional nondiscrimination provisions that are included in the proposed rule. Specifically, §438.3(d)(4) greatly expands the existing nondiscrimination standards in Medicaid managed care, ensuring that eligible beneficiaries will not be discriminated against on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability or use any policy or practice that has the effect of discriminating on those grounds. In particular, we commend HHS for adding sex, sexual orientation, and gender identity as protected categories. These protections are crucial because discrimination on these bases creates barriers to accessing medically necessary care—either by discriminatory plan practices (e.g., enrollment, through covered or excluded services, medical necessity definitions, or utilization controls), provider refusals, or treatment avoidance due to perceived discrimination in treatment.

We also strongly support the decision to add disability as a protected category. As stated in the preamble, beneficiaries with disabilities are increasingly enrolled in managed care and the protections for these enrollees reflect the challenges they often face, including lack of accessible information and services, discrimination in enrollment, and difficulty navigating managed care generally. Adding disability as a protected category provides an important broad protection for beneficiaries with disabilities that will cover discriminatory actions that many not be specifically covered by other provisions but still have a strong adverse effect. This could include instances such as when enrollees with disabilities who have high service needs are treated poorly by one managed care entity in an effort to get such individuals to switch to another managed care entity.

As managed care in Medicaid increasingly adopts alternative payment models, we encourage CMS to adopt additional language to ensure that the nondiscrimination provisions are specifically applied to beneficiaries enrolled in plans utilizing new payment and care delivery models. We recommend that CMS adopt the following language: “The managed care entity will not discriminate against individuals eligible to enroll, participate, or align in new payment or care models on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, health status or disability.”

§438.6 Special contract provisions related to payment.

We support the new provisions that allow for value-based purchasing, including pay for performance arrangements, bundled payments, and other service payment models intended to align reimbursement with value and quality rather than with volume of services. Further, we believe that the provision connecting value-based purchasing to the goals and objectives in the comprehensive quality strategy is critical to delivering on the Triple Aim of better care, better outcomes, and lower costs.
As Medicaid managed care entities look to adopt greater use of value-based purchasing, we encourage CMS to develop additional guidance that defines the principles of value-based payment models for Medicaid. We recommend, for example, that the following principles be incorporated:

- **Patient-Centered Care:** New payment models must demonstrate strong commitment to delivering patient-centered care by promoting partnership with patients at every level of care. Patient- and family-centered care criteria must be incorporated into clinical care model design, as well as into governance structures and accountability and compensation mechanisms. Patients should have timely access to care, including access to providers outside of regular business hours. Patient- and family-centered care criteria should be incorporated not only into model design, but also into hiring practices, job descriptions, performance reviews, and compensation.

- **Quality:** In all value-based payment models, quality performance data must be measured and tracked and be inclusive not only of clinical outcomes data, but also of the experience of patients and their caregivers and of patient reported outcomes. Measurement of and reporting on patient experience of care and patient-reported outcomes can help beneficiaries make wise decisions when choosing their health plans, providers, and care settings. Patient reported outcomes measures should robustly capture the patient’s views regarding the care they received. These high impact quality measures, which are meaningful to both beneficiaries and providers, can help alternative payment models drive quality improvement and value.

- **Use of Health Information Technology:** New payment models should accelerate the uptake of health information technology. To improve both care quality and health outcomes, it is critical that health information technology facilitate the safe and secure sharing of information, not just between providers, but also between providers and beneficiaries and with designated caregivers.

  Electronic Health Records (EHRs) can help providers facilitate communication, analyze trends in their patient populations, and offer care that is better tailored to patients’ unique needs. Giving beneficiaries the tools to access and manage their own health information electronically is foundational to patient engagement and ensuring that patients receive high quality care. Providers’ ability to track patients’ health statuses in real time using health information technology can improve provider-patient communication, help patients manage their care, and improve health outcomes.

- **Beneficiary Protections:** All models of care delivery and payment must include strong beneficiary protections. Strong quality measures can help to ensure that providers do not stint on care. However, as financial risk increases for providers, so does the opportunity to stint on care. Thus, as new models of payment are developed that push providers to take on increased risk, reward, and responsibility, it is important to ensure that the evolution and application of beneficiary protections are keeping pace. Beneficiary protections must be enhanced as the level of risk that providers may assume increases.
Beneficiary protections include, for example, choice in enrollment, provider selection, transparency regarding provider incentives, and a fair appeals process. Beneficiaries should be notified of providers’ and facilities’ participation in any new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities. Beneficiaries should be clearly informed of the opportunity to opt-out of new payment models. And, an external appeals process should be available to beneficiaries whose providers or care facilities are participating in a new payment model that offers providers/facilities the opportunity to profit from savings generated through the program.

Additional beneficiary protections include more complete notice requirements, greater emphasis on beneficiary outreach and education and adequate protections concerning alignment, attribution, and data sharing.

- **Data Collection and Monitoring**: Data on race, ethnicity, language and gender must be collected in order to address disparities in new payment models. This data should also be expanded over time to include geography and disability in order to gain more comprehensive information on health disparities. The impact and appropriateness of care for different patient populations must be monitored.

- **Community Supports and Social Determinants of Health**: To improve health outcomes meaningfully, alternative payment models must address the non-medical factors that contribute to health and wellbeing (e.g., housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices, and other environmental factors). Ensuring information sharing and automated connections between providers and community-based agencies is vital in order to connect patients to appropriate community supports and services.

- **Payment**: Any new payment model that creates new provider financial incentives should calculate rewards by weighing both quality measures and cost-savings. Models of care must also include risk-adjusted payment based on patient complexity and adequate payment for coordination, transition management and medication management. There must also be adequate payment for language services for individuals with limited English proficiency.

§438.6(c)(1)(ii)—Incentive for using certified EHR technology.

We greatly appreciate that CMS highlights that States may make available incentive payments for the use of technology that supports interoperable health information exchange by network providers that were not eligible for EHR incentive payments under the HITECH Act (for example, long-term/post-acute care, behavioral health, and home- and community-based providers). The Health Information Technology for Economic and Clinical Health (HITECH) Act leveraged the federal government’s role as the largest payor for health coverage to reach eligible hospitals and professionals across the nation with an incentive program to adopt EHRs and use them meaningfully to improve patient care. Here, CMS further leverages this role to expand the robust health information technology infrastructure that is necessary to support health care delivery system reform. Extending
EHR incentives to a wider range of health care programs and providers (including long-term/post-acute care, behavioral health, and home- and community-based providers) enable delivery of even more coordinated care and seamless information sharing across the health care continuum.

§438.8 Medical loss ratio (MLR) standards.

We commend CMS for including care coordination, case management, community integration activities, and other community benefits, in the Medical Loss Ratio (MLR) numerator. While we know that it will be challenging for CMS and states to distinguish genuine health care quality activities from administrative expenditures that may only be peripherally related to conducting health care quality activities, we agree that it is critical for CMS to ensure that there is no disincentive to conduct care coordination and related activities.

CMS’ proposed regulation relies on Marketplace regulation 45 C.F.R. §158.150 to define activities that improve health care quality. We believe CMS should re-evaluate that definition to ensure that no part of it could be used to block inclusion in the MLR numerator of care coordination, case management, community integration, or other services that improve the health of enrollees. We recommend that CMS should use more explicit language in the regulation to assure inclusion of the most important activities, or failing that, issue subregulatory guidance to this effect.

CMS must also evaluate if any essential “non-medical” quality activities might go unrecognized under the regulatory standards of §438.8(e)(3) (and 45 C.F.R. §158.150(b) and (c)), such as language services and non-emergent medical transportation. CMS should clarify that non-emergent medical transportation should be counted in the MLR numerator (whether as an incurred claim or activity improving health care quality) regardless of whether it is technically claimed as an administrative or service cost by the State, to ensure States do not have a disincentive to provide the services. Ultimately, we believe that more explicit standards will also help CMS draw the line between true health care quality activities and loosely related administrative activities.

It is our belief that, historically, health plan MLR calculations in the private market have been padded with administrative activities and that States have done a weak job enforcing the integrity of the MLR standard. Therefore, we also recommend that CMS take a proactive approach in monitoring the content of health care quality activities. CMS should prescribe how States should approve and audit plan calculations, and CMS should itself audit State criteria or data for a diverse sample of States every two years.

§438.10 Information requirements.

We appreciate CMS’s revised definitions of “prevalent” and “readily accessible”, which provide needed guidance on how to make electronic information genuinely accessible to the variety of beneficiaries across the nation. We fully support leveraging health information technology to provide better access to basic beneficiary materials by requiring that entities provide these resources based on preferred language. This requirement helps to ensure that every beneficiary can understand relevant information for better care and coverage.
Furthermore, making written materials available in the beneficiary’s preferred language is directly aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and the National Stakeholder Strategy for Achieving Health Equity.

We note, however, that both definitions refer generally to standards without specificity, leaving it to the entity to interpret or elect which standard to implement. Instead, the regulatory definitions should specify the standards they mean to incorporate so that MCOs, PIHPs, PAHPs and PCCMs, and all beneficiaries, both know what minimum standards to expect. In the case of “prevalent” languages, we recommend that the definition more specifically incorporate OCR’s “LEP Guidance.” Because Section 1557 of the Affordable Care Act also applies (proposed regulations are expected in the very near future), we also recommend specifically incorporating the relevant portion of those regulations. Likewise, we recommend that the actual definition of “readily accessible” incorporate the minimum standard stated in the preamble, namely the latest section 508 guidelines issued by the U.S. Access Board and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA.

Finally, we note that many people with limited incomes exclusively access the Internet with smartphones. In §438.10, we strongly encourage a requirement that all online materials be mobile enabled to maximize access. Further, we encourage an additional requirement that all materials posted on consumer websites be developed using fundamental principles for fostering health literacy, as presented in the DHHS/ODPHP Health Literacy Online guidelines.

§438.10(e) Information for potential enrollees.

We appreciate the requirement that covered entities provide information to current enrollees about Medicaid benefits not covered by the entity. This would include, for example, family planning services and supplies and abortion services not covered by a plan due to religious restrictions. We believe the same information should be provided to potential enrollees so they have sufficient information about what different plans do and do not cover. We suggest amending §438.10(e)(2)(v)(C) to include similar information.

§438.10(h) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities—Provider Directory.

We strongly recommend including an additional requirement in this section to ensure beneficiaries can find providers of maternity services. We urge CMS to require that directories identify providers of maternity care services, including obstetrician-gynecologists (ob-gyn), family physicians, and midwives. It is commonly assumed that the ob-gyn provider group fills this need. However, a major 2011 report from the American Congress of Obstetricians and Gynecologists, The Obstetrician-Gynecologist Workforce in the United States, identified severe existing and impending problems impacting women’s

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7 LEP Policy Guidance for HHS Recipients, August 8, 2003
ability to find and access maternity care. Indeed, in 2010, over half of U.S. counties lacked an ob-gyn, with a trend toward greatly increasing shortages over time. Further, on average, ob-gyns in 2009 stopped providing maternity services at age 48 (or age 44 for women, who increasingly make up the ob-gyn workforce).

Pregnant women may not think of family physicians as potential providers of maternity care. However, many family physicians do provide maternity care, and this professional group is an extremely important part of the maternity care workforce in many areas of the country. Finally, midwives have not been reliably included in provider directories, yet overall they provide exemplary maternal-newborn care and frequently practice in underserved areas and among vulnerable populations. When seeking maternity care providers, it is important for women to have clear information about available options. In addition to being a matter of consumer choice, this is also a matter of consumer safety: consumers need to understand the distances they may need to travel to receive care in less populated areas.

Special provider directory consideration for maternity care is also warranted given that Medicaid covers nearly half of all births in the United States, and maternal and newborn care were the leading hospital conditions covered by Medicaid prior to Medicaid expansion (post-expansion data is not yet available). Further, maternity services are a population health issue, impacting individuals at the beginning of life as well as the 85 percent of women who give birth one or more times during their lifetimes. Also, through many frameworks, we increasingly understand that, for newborns, this period of human development involves windows of vulnerability that carry the potential for long-term adverse health impacts. These frameworks include: developmental origins of health and disease, life course health development, human microbiome, and hormonal physiology.

§438.12 Provider discrimination prohibited.

Medicaid enrollees should have access to comprehensive services from health providers, and providers participating in Medicaid managed care should be permitted to provide services according to the scope of their state licenses. We suggest that CMS further amend this section to make clear that Medicaid plans may not refuse to contract with providers because the provider offers services to which the health plan objects, or based on patient advocacy in which the provider is engaged.

Subpart B—State responsibilities

§438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities.

As proposed, §438.52(a) allows states to restrict individuals who are required to enroll in a primary care case management (PCCM) entity to a single entity. CMS notes that some states offer shared savings or other incentive payments to a PCCM entity and its participating providers, giving the PCCM entity “the same financial incentives as managed care plans.”

In pursuit of shared savings or other incentive payments, a PCCM entity may wish to limit enrollees to a particular network of providers and/or perform utilization review. If a PCCM
entity is permitted to perform these functions, however, the entity will more closely resemble an MCO than a traditional PCCM, particularly from the enrollees’ perspective. In those circumstances, Medicaid beneficiaries should have a choice of at least two PCCM entities for the same reasons that they have a choice of at least two MCOs. Enrollees need to have the ability to choose a managed care entity that will best meet their health needs. In short, if PCCM entities take on the majority of the characteristics of MCOs, CMS should treat them more like MCOs than like traditional PCCMs with respect to enrollee choice.

Additionally, managed care entities sometimes refuse to provide reproductive health services because they object to the services on moral or religious grounds. For example, in negotiating a managed care contract with a State, an MCO might request to have abortion services carved out of the contract, requiring enrollees to access those services outside of the MCO on a fee-for-service basis. Likewise, a PCCM that objects to abortion services could refuse to refer an enrollee to an ob-gyn for such care.

When Medicaid managed care entities refuse to provide reproductive health services, enrollees may encounter barriers to accessing these services in a timely manner. Many enrollees may not understand how to access services outside of the managed care entity and may have difficulty finding a provider to deliver these services. As a result, beneficiaries required to enroll in a managed care entity need the ability to choose a managed care entity that will meet all of their reproductive health needs. As proposed, §438.52 does not guarantee beneficiaries that ability. We suggest that CMS amend §438.52(a) and §438.52(b)(1) to require states to ensure that beneficiaries who must enroll in an MCO, PIHP, PAHP, PCCM, or PCCM entity have the ability to enroll in an entity that will provide the full range of reproductive health services covered under the state plan.

§438.68 Network adequacy standards.

We strongly support the addition of this new section on network adequacy. For too long, the Medicaid managed care program has lacked specific network adequacy standards aimed at ensuring that consumers can access comprehensive care from their Medicaid plans. These proposed provisions add significant detail to guide states and Medicaid plans in developing their networks to ensure adequate coverage and access.

We applaud CMS for requiring plans to publish their network adequacy standards in §438.68(e). We agree that this is an area where transparency is very important, and consumers, providers, advocates, and other stakeholders must have ready access to the standards to which plans are being held. We suggest that CMS also compile this information and publish it on Healthcare.gov or Medicaid.gov on an annual basis, since many stakeholders may look for this information on a federal government website rather than on the website for their state Medicaid program.

We strongly support CMS’ decision to consider a variety of existing network adequacy standards, including Medicare Advantage (MA) standards and the standards for qualified health plans (QHPs) in the Marketplaces, in deciding what approach to take for establishing network adequacy standards for Medicaid managed care. We appreciate that, in these proposed rules, CMS seeks to strike a balance between these two extremes, by setting forth specific areas for which States and plans must account, but not requiring a granular level of detail for every possible specialist type. We are concerned, however, that
CMS has erred too far on the side of broad standards and state discretion. By permitting each state to set its own time and distance standards without any outside limits set by CMS, we are concerned that standards will vary too widely from one State to another, and that oversight by CMS will continue to be fragmented. We suggest that CMS adopt specific minimum standards in the areas of geographic access, provider-patient ratios, and timely access to care.

We are pleased that §438.68(b)(1) will, for the first time, require states to employ specific measures of travel time and distance to determine whether the networks of their contracted plans are adequate. We commend CMS for delineating in this section the provider types for which states must develop geographic access standards. We applaud CMS for capturing key provider types that must form the foundation of a network for any comprehensive Medicaid managed care plan.

However, stronger standards are needed to ensure that women can access the full range of reproductive health care services. Freedom of choice, while a critical protection, is not a substitute for a network of providers that can meet the unique health needs of women enrollees. We accordingly support requiring that States establish separate network adequacy standards for access to ob-gyns, but urge CMS to broaden the rule. A plan’s provider network must be sufficient to ensure that women have meaningful access to all covered family planning and abortion services. CMS’ narrow focus on ob-gyns may fail to ensure the adequacy of a plan’s network in this regard. We therefore urge CMS to broaden the category currently titled “OB/GYN” to “providers of women’s health care services,” to capture a broader scope of practitioners who offer such services, which include prenatal care, family planning counseling and treatment, abortion services, and screening and treatment for vaginal infections and STIs.

Additionally, timely access standards should include all levels of maternal care, as defined by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine’s, “Obstetric Care Consensus: Levels of Maternal Care.” An increasing number of Medicaid-financed births occur in managed care. It is critical that pregnant women enrolled in Medicaid managed care have access to the most appropriate level of maternity care, including routine prenatal care and/or specialty case as needed, ensure healthy birth outcomes healthy babies.

We appreciate that CMS will continue to require plans to meet standards for timely access to care in §438.68. However, we urge CMS to go further and amend §438.68(b)(1) to specify that network adequacy standards must incorporate waiting times for initial appointments for time-sensitive services, specifically family planning services and supplies, prenatal care and abortion services. Women must be able to find an in-network provider who can deliver these services within, at most, five business days – or, in the case of pregnant women who are in their second trimester of pregnancy or later, within one business day. Timely access to appointments is critical for all of these services. Delayed access to initial appointments could result in an unintended pregnancy, poorer birth outcomes related to delayed access to prenatal care, or – particularly given the mandatory delay requirements many states impose upon women seeking abortion services – more complex procedures.

We also recommend that CMS consider requiring plans to provide a 24-hour telephone line to provide triage or screening services. These telephone lines are commonly used in the
private insurance market and studies have found that they are associated with reductions in inappropriate use of emergency services. We believe that by requiring plans to use some kind of telephonic screening system that is available 24/7, CMS can improve access to care by helping enrollees to quickly determine what level of care they need.

Further, we urge CMS to adopt standards for in-office wait times. Too often, Medicaid managed care enrollees schedule a needed appointment, arrange necessary transportation and childcare and take time off of work in order to attend it, and then wait hours after their scheduled appointment time before they see a provider. These long in-office wait times can seriously disrupt the fragile arrangements that the enrollee has made in order to attend the appointment. In some cases the enrollee will not be able to wait any longer for an appointment and must reschedule the appointment, further delaying care.

Finally, we also encourage CMS to set standards for and require States to monitor calls to Medicaid plans customer service lines. Too often, enrollees who cannot find a provider, need assistance with transportation, or who wish to file a grievance languish on hold with their plan’s telephone line, or are unable to get through on the line at all. CMS should set minimum standards to ensure that telephone wait times are reasonable so that enrollees’ can address problems with their plans.

§438.71 Beneficiary support system.

Medicaid managed care has proven to be a difficult system to navigate for many beneficiaries, and enrollees often encounter problems in connection with enrollment and disenrollment, service denials, enrollee rights, and provider network limitations. Therefore, we strongly support the creation of a mandatory beneficiary support system (BSS) to help beneficiaries choose the most appropriate managed care entity 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. As much as we support having a BSS, we are concerned, however, that as written, the BSS may not provide the services needed by enrollees and may raise in enrollees a false expectation of assistance. We therefore urge that the BSS requirements be revised to ensure that it will truly meet the needs of enrollees in Medicaid managed care.

As proposed, the BSS would only serve current and potential enrollees. We believe this is too limiting and suggest that caregivers be included, as many beneficiaries have others helping them when making decisions regarding managed care selection or are seeking information to resolve a problem. For example, this may be because they are ill and require help accessing care or managing treatment, because they use a type of supported decision-making, or because they generally use help in their lives for such matters. In previous guidance regarding managed long-term services and support (MLTSS), and managed care, CMS included caregivers in the description of essential support for beneficiaries. We recommend the addition of caregivers to the general requirement of whom the BSS will serve. Broadening to whom the BSS can provide services aligns with recent regulations about person-centered care and collaborative shared decision-making and care planning.

§438.100 Enrollee rights.
The right to participate in one’s own health care decision-making is a fundamental right in any health care situation, given the personal nature of such decisions. This is true regardless of whether or not the person has a guardian or legal representative. In some cases of substituted decision-making, the representative may not have the same cultural considerations or beliefs as the individual for whom they are making decisions. It is therefore important that individual beneficiaries be able to drive their own health care decisions. In order to be better aligned with the current movement toward greater recognition of person-centered care and self-determination, we strongly believe there should be recognition in the enrollee rights section that, to the extent possible, individual beneficiaries should be empowered to drive their health care decisions. This concept is already reflected elsewhere in Medicaid, such as in the home and community based services regulations, and should be reflected in these regulations. This change would also help meet CMS’s stated goal of modernizing the Medicaid managed care regulations to reflect current norms.

§438.110 Member advisory committee.

We strongly support CMS’ proposal to require States to develop plan-level LTSS stakeholder advisory committees, recognizing that enrollees and other stakeholders can play a critical role in the success of a MLTSS program. However, we strongly disagree with CMS’ proposal to allow State and plans flexibility in the design and implementation of LTSS stakeholder groups. The proposed rule is too broad and too vague to allow for meaningful and sustained stakeholder engagement. State agencies and managed care plans have a poor track record engaging consumers and other stakeholders in program in planning, implementation, and oversight. Accordingly, we recommend that CMS establish detailed requirements for State LTSS stakeholder groups, with clear requirements for membership, operations, responsibilities, and transparency, aligning requirements for the LTSS stakeholder groups with the State-established Medical Care Advisory Committee (MCAC) and LTSS stakeholder group.

We recommend that when LTSS are covered under a risk contract between a State and an MCO, PIHP, or PAHP the contract must provide that each MCO, PIHP or PAHP or PCCM entity establish and maintain a member advisory committee. The member advisory committee must include at least 50 percent representation from consumers, consumer representatives, and caregivers who are a reasonably representative sample of the LTSS populations covered under the contract with the MCO, PIHP, or PAHP; members of legal services providers; consumers’ groups; and consumer organizations such as labor unions, cooperatives, coalitions, and others. The member advisory committee must also include the MCO, PIHP, or PAHP’s medical director or director of LTSS services who is responsible for services authorization and utilization management.

Subpart D—MCO, PIHP, and PAHP Standards

§438.206 Availability of Services.

We commend CMS for continuing to require plans to provide direct access to women’s health specialists at §438.206(b)(2).
However, we strongly support women’s access to choice among multiple providers of women’s health services and recognize that they may wish to choose a different provider for certain women’s health services even if their primary care provider offers such services. We thus have concerns about the current language specifying providing access to “a” women’s health provider “if [the designated source of primary care] is not a women’s health specialist.” We also ask that CMS remove the qualifying phrase “routine and preventive” from the phrase “women’s health care services.” We are concerned that limiting direct access to “routine and preventive” services may encourage plans to establish barriers that will impede enrollee access to women’s health specialists. Female enrollees require access to women’s health specialists for a wide range of women’s health services that may not neatly fit into a definition of “routine and preventive” care, including counseling and treatment for irregular or painful menstrual cycles, abortions, follow-up care after an irregular pap test or mammogram, colposcopies, diagnosis and treatment for premenstrual syndrome, diagnosis and treatment of perinatal or postpartum depression, treatment for symptoms associated with menopause, and treatment of vaginal and urinary tract infections and sexually transmitted diseases. We strongly suggest that CMS require direct access for all women’s health care services, not only those that can be classified as “routine and preventive.”

Additionally, we suggest that CMS specify that adolescent female enrollees should be provided with direct access to women’s health specialists. We are aware of plans that have interpreted the phrase “women’s health specialist” to exclude enrollees under age 18, even when those enrollees need the services provided by women’s health specialists such as diagnosis and treatment for irregular or painful menstrual cycles, family planning counseling, treatment for premenstrual syndrome, screening and treatment for sexually transmitted infections, and prenatal care. We do not believe CMS’ intends adolescents to be excluded from the group of female enrollees who can have direct access to a specialist for these services, and we suggest that it say so explicitly to avoid any further confusion.

§438.208(b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees.

We strongly support CMS’s proposal to strengthen care coordination. Specifically, we support defining care coordination as “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.” As stated in the proposed rule, this would align Medicaid managed care definitions with the Agency for Healthcare Research & Quality (AHRQ) definition of care coordination, which is already integrated into the Medicare Advantage program and in Marketplace regulations.

We also support the requirement that each enrollee be ensured an ongoing source of care appropriate to his/her needs and a person or entity responsible for coordinating care. We further support requiring coordination between settings of care, inclusive of appropriate discharge planning, coordination among services received from other MCOs, PIHPs, and PAHPs, and encouraging an initial assessment of each enrollee’s needs when beneficiaries change plans.
For care coordination to be effective, patients, their family caregivers must also be integrated into the care team. To accomplish patient and family integration into the care team, we recommend managed care entities adopt the following practices:

- Patients and families receive timely, complete, and accurate information in order to effectively participate in care planning and decision-making. Family are not treated as simply “visitors” but encouraged to be actively involved in care and decision-making.

- Patients, families, and providers work together to develop care plans that aim to reach clinical and personal health goals. Shared decision-making processes are routinely implemented. Care plans are thought of as shared care plans, which are jointly maintained and updated by patients, family caregivers, and members of their care team.

- Care settings robustly utilize health information technology and health information exchange to communicate with patients and family caregivers.

Finally, we strongly support expanding standards to include community or social support services. Care for vulnerable populations will be better coordinated if there are stronger linkages with the community, reimbursement for wraparound services, and delivery models in place that take a multi-disciplinary approach to health. Indeed, managed care entities in Medicaid should be required to integrate community resources – including community-based organizations, community health workers, mental health peer wellness specialists and non-clinical social supports – into their networks and care coordination teams. These services are particularly important for the most vulnerable Medicaid beneficiaries, including older adults, and individuals with disabilities.

§438.208(c) Additional services for enrollees with special health care needs or who need LTSS.

As described earlier, we strongly support CMS’s continued efforts to support partnerships with beneficiaries, patients, and families at every level, including design and governance. Specifically, we support CMS’s proposal to require States to create a structure for engaging stakeholders including beneficiaries and advocacy groups regularly in the ongoing monitoring and oversight of the MLTSS program. As CMS notes, beneficiaries and consumer organizations “inform decisions as to what works and what does not in the managed care system, allowing the state to design systems that are responsive to the needs of stakeholders and to address any implementation issues discovered early in the process.”

We support requiring States to ensure the views of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation and oversight of a State’s managed LTSS program. We also support new requirements for MCOs, PIHPs, and PAHPs to establish a regular process to solicit direct input on the enrollees’ experiences, including through a member advisory committee.

CMS proposes significant flexibility for States in demonstrating the stakeholder process is sufficiently ensuring meaningful participation, specifically regarding composition of the stakeholder group and the frequency of meanings. While we understand the need for
flexibility, we urge CMS to provide guidance to states around what “meaningful engagement” entails. We define “meaningful engagement” to mean:

- **Proportionate representation.** Proportionate representation requires having more than just one patient, family caregiver, or consumer representative on decision-making entities and balanced representation with other stakeholders.

- **Consumer representatives are “true” consumers.** The primary interest of “true” consumers is the needs and interests of consumers, patients, and families. Consumers have no direct financial stake in the health care system.

- **Representatives include both consumer advocates and beneficiary representatives.** While consumer advocates include, for example, non-profit organizations or faith-based groups, beneficiary representatives, on the other hand, are patients and/or family caregivers. Both bring unique and valuable perspectives to the table. We strongly support the rule’s proposal to include both beneficiaries and consumer advocacy organizations in this process.

- **Representatives are meaningfully involved in decision-making.** All representatives, including patients, families, consumers, and providers, have an equal seat at the table and an opportunity to share their perspectives as decisions are made.

Finally, we commend CMS for the inclusion of **Element 6: Person-Centered Process** in codified LTSS guidelines and agree that “[e]nsuring that ‘beneficiaries’ medical and non-medical needs are met and that they have the quality of life and level of independence they desire within a MLTSS program starts with person-centered processes including comprehensive needs assessments and service planning policies.” We encourage CMS to modify the statement slightly to say “person- and family-centered processes.”

**§438.210 Coverage and authorization of services.**

We appreciate that CMS has consistently confirmed that Medicaid enrollees are entitled to freedom of choice for family planning, and applaud CMS for reaffirming this commitment in the proposed rules by prohibiting utilization controls that are inconsistent with the enrollee’s freedom to choose their method of family planning, articulated at §441.20. These rules require that each beneficiary be “free from coercion or mental pressure and free to choose the method of family planning to be used.”

The personal nature of family planning care necessitates each individual being able to access the birth control product she or he needs, taking into account the individual’s medical history, lifestyle, and personal preference. An individual may require a certain birth control method and coercion may occur if an enrollee does not have equal access to all covered birth control methods. Permitting utilization controls, such as step therapy and prior authorization, on family planning methods contravenes the regulations, as free choice is impossible unless an enrollee has unimpeded access to all covered methods.

Similarly, medical necessity criteria for family planning services and supplies that exceed an assessment that the beneficiary is of child-bearing age and desires family planning.

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10 The Medicaid Act guarantees that family planning services must be “furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies.” 42 U.S.C. §1396d(a)(4)(C). States must ensure that “each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used.” 42 C.F.R. §441.20.
services could restrict enrollees’ access to the birth control method of their choice. CMS should therefore amend §438.210(a)(4)(i) to limit the use of medical necessity criteria to ensure that the managed care entity provides family planning services and supplies consistent with §441.20.

§438.214 Provider selection.

We strongly support the addition to subsection §438.214 (b)(1) that provides more specificity about what the credentialing and recredentialing policies must address. We agree with the inclusion of acute, primary, behavioral, substance use disorder, and LTSS providers. We believe this list must also include reproductive health providers because such policies would help in identifying women’s health care providers who refuse to provide certain services for religious reasons. For example, while a plan’s network may include several ob-gyns, if they all work within religiously affiliated hospitals, critical covered services may not be available. Information acquired during the credentialing process could help ensure that the managed care entity has full knowledge of the provider network’s actual provision of services (as opposed only to types of providers) and can therefore address any gaps in services where necessary and refer women to alternate providers if services have been refused.

§438.236 Practice Guidelines.

We urge CMS to require a higher bar in the standards for practice guidelines at §438.236(b)(1). It is well known that expert opinion and expert consensus often prove fallible when held up to best available scientific research. We strongly support practice standards that reflect best current evidence whenever available and rely on professional consensus only in the absence of the needed evidence. This is consistent with recommendations in the Institute of Medicine’s Clinical Practice Guidelines We Can Trust (and its companion report, Finding What Works in Health Care). We recommend the following language to strengthen this requirement: “(1) Are based on valid and reliable clinical evidence whenever available, and otherwise on a consensus of health care professionals in the particular field.” This is also consistent with the definition of quality at §438.320(2).

Subpart E—Quality Measurement and Improvement; External Quality Review

§438.330 Quality assessment and performance improvement program.

This section includes language at §438.330(a)(2) that would permit CMS to specify a set of performance metrics each State must collect from its participating management care plans and report to CMS. Currently, States are not required to do this, although the State response on a voluntary basis to the recommended core sets of child and adult measures established by CMS, pursuant to CHIPRA and the ACA, has been very good. In 2013, 15 States reported scores on at least 17 of the 26 adult measures, and 41 of the States plus D.C. reported on at least one of the 26 child measures for both their Medicaid and CHIP populations.
Under current policy, it has proved difficult to build national benchmark scores for some recommended measures, as the States are able to select which measures to report scores. For example, only 16 states elected to report scores on the adult patient experience of care measure (CAHPS health plan survey 5.0H) in 2013, and only 25 chose the child obesity prevention measure (BMI assessment of children and adolescents). Both of these are important quality indicators for patients and families. Requiring all States to report on a common core of measures will help establish national quality benchmarks.

In implementing this new provision, however, it will be important that the common set of measures be parsimonious and meaningful to both providers and patients. As with the new comprehensive State quality improvement plan required by §531.502, extensive and robust involvement of the patients themselves and their families will be needed to achieve that goal. Establishing a quality task force that includes balanced and meaningful representation from various advocates, Medicaid beneficiaries, and their families would help increase awareness and expertise for future revisions of and additions to the core measures set. This could also be achieved through regular required consultations with State MCACs and, as applicable, LTSS stakeholder advisory groups.

We are concerned that there is significant need for public reporting of standardized meaningful performance measures that are comparable across competing plans, to provide enrollees and prospective enrollees with comparative quality information to help choose among available plans, and to encourage plans to continuously improve on quality. Section 438.330(a)(2) states that CMS “may specify performance measures for collection in accordance with paragraph (c) of this section,” and §438.330(c)(1) says that “States may select their own performance improvement project topics and performance measures.” We encourage CMS to issue further direction to ensure that States “will select” performance measures that enable meaningful quality comparisons across plans within the State, meaningful transparency, and meaningful consumer choice. Additionally, a shared set of metrics used by plans across the State will be needed to roll up results required for the State comprehensive quality strategy proposed in this rule.

Meaningful, accessible, user-friendly public reporting should go hand in hand with comparative quality metrics. Because Medicaid beneficiaries incur little or no out-of-pocket expense for their care, quality metrics likely provide the most important basis for comparing available plans. In addition to fostering beneficiary choice, full public disclosure has also been associated with greater quality improvement. We are concerned that only requiring plans to make the “findings on access and quality of care” available on request to interested parties, including enrollees/prospective enrollees, participating providers, and beneficiary advocacy groups does not provide adequate transparency. Likewise, the requirement that findings be posted somewhere on the State’s website is necessary, but not sufficient. It does not provide consumers with the information they need to make informed choices, nor does it sufficiently spur improvement within and across plans.11 Section 438.10(c)(3) requires States to operate a website and include specified content; we recommend adding public reporting of comparative quality information as a required information on State websites. In addition to enrollee handbooks and provider directories, the websites should provide access to the most recent comparative quality data for plans in the State in a user-friendly format, and following established practices for health literacy.

11 See §438.364(a) and §438.364(b)(2) of the proposed rule.
§438.334 Medicaid managed care quality rating system.

This section would require each State contracting with managed care plans to establish a quality rating system for those plans. The system would have three components: clinical quality management, member experience, and plan efficiency, affordability, and management. The system would have to include measuring and reporting on the core measures identified by CMS under §438.330(a)(2), but the State could, with CMS approval, deviate from that requirement to use an alternative system. The State could also, pursuant to §438.334(d) opt to use the Medicare Advantage rating system for Medicaid plans serving only dual eligibles. We support this provision. But note that CMS should define “affordability” to refer to an individual’s ability to meet out-of-pocket expenses – and not to overall costs to the Medicaid program. If CMS intends to use the latter definition of “affordability” – overall costs to the Medicaid program – we urge CMS to strike this component from the star rating system. While this may be an important goal for the State agency, it is not strictly relevant to the quality of care offered by a health plan, and may in fact run counter to the aims of a quality rating system intended for consumer use.

In the preamble to this regulation, CMS states that it expects to spend three to five years working with stakeholders to develop the Medicaid plan rating system. We believe that is the correct approach. Choosing the health plan in which to enroll is a hard decision, whether you are Medicaid-, Medicare- or commercially insured. Rating systems that cluster a host of information into four or five domains – such as access or clinical outcome – can be very helpful. How those domains are labeled, however, is also critical. The Michigan Medicaid agency’s annual health plan guide for beneficiaries, for example, groups performance data into five categories described as follows: Dr. Communication and Service; Getting Care; Keeping Kids Healthy; Living with Illness; and Taking Care of Women. The agency then rates each plan from two stars (below average) to four stars (above average) in each category. The Michigan report has proved effective in aiding beneficiaries to make their selections in an informed manner.

We strongly encourage CMS to continuously test the language used to display quality ratings for user comprehension. Medicaid enrollees have varied levels of education and literacy and it is important that language, definitions, and scoring of the rating system be easily understood. We encourage CMS to use simple, straightforward language, to evaluate chosen terminology rigorously, and to refine it with user groups prior to implementation.

Equally critical is how each domain is weighted within the system, and which measures are selected to undergird it. Medicaid populations can differ significantly from state to state, and so can the health status of the population of each state. Reducing its infant mortality rate may have a high priority for the leadership of State A, while control of diabetes will have a much higher priority in State B. Health care costs may have escalated dramatically in State C, but not in State D. Beneficiaries may care much more about the importance attached to access to care – such as access to particular specialists – than they do to preventive care measures. It will be important to take the time for the thoughtful discussion and collaboration of all stakeholders in this process in order to achieve an effective and equitable system.
In addition, any effective star rating system must include a transparent process for addressing health differences between covered populations for different plans. On the one hand, if a plan does a particularly good job with care management for chronic conditions and attracts more individuals with chronic conditions, its performance on health outcome measures may actually go down relative to another plan that serves a healthier population. On the other hand, if a plan knows its quality outcomes will be risk adjusted to account for sicker members, it may have less incentive to focus on improving outcomes for those individuals. In either case, a clear and transparent process for addressing risk adjustment is an essential part of any Medicaid quality rating system. This will be particularly important should a State (or CMS) decide to implement or apply a similar system to its fee-for-service populations.

Additional Comments

Advancing health information exchange

We support strongly the rule’s principle that all individuals and their families should have timely access to their health information and be able to securely exchange it with their providers and others involved in their care. We commend the rule’s encouragement for all entities to utilize certified health information technology. As the Office of the National Coordinator for Health Information Technology’s (ONC) Interoperability Roadmap makes clear, to improve both care quality and health outcomes it is absolutely critical that health information exchange emphasize interoperability and the safe and secure sharing of information not just between providers, but also with patients, families, and other designated caregivers.

Giving patients the tools to access and manage their own health information electronically is also fundamental for effective patient engagement and high quality care. The National Partnership’s comprehensive national survey, released in December 2014, found that patients report that online access has a positive impact on their knowledge of their health, the quality of their care, and their desire to do something to improve their health. 12

For these reasons, we support the rule’s encouragement for all entities to utilize certified health information technology and health information exchange.

Conclusion

Thank you for this opportunity to submit comments on the proposed rule for 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.

If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.