December 22, 2020

Chiquita Brooks-LaSure, Team Lead
Biden-Harris Agency Review Team
Department of Health and Human Services

RE: ACAP Recommendations for Regulatory Changes to Medicaid, Medicare, and the Marketplaces to the Biden-Harris Agency Review Team for the Department of Health and Human Services

Dear Ms. Brooks-LaSure,

The Association for Community Affiliated Plans (ACAP) congratulates you and your colleagues on your appointment to the Biden-Harris Health and Human Services Agency Review Team. We look forward to working with you over the coming weeks to prepare for 2021 and beyond. ACAP is a national trade association representing 78 not-for-profit Safety Net Health Plans (SNHPs). Collectively, ACAP plans serve more than 20 million people through Medicaid, Medicare, the Marketplaces, and other publicly-supported coverage programs, including nearly one-third of all individuals covered in fully-capitated Medicaid managed care. Our mission is to support our member plans’ efforts to improve the health and well-being of people with low incomes and with significant health care needs.

ACAP has interacted frequently with the current and previous Administrations, responding to proposed rules in Medicaid, Medicare, and the Marketplaces, educating our member plans on federal guidance related to these programs, and articulating our priorities directly to Centers for Medicare and Medicaid Services (CMS) in hopes of representing the Safety Net Health Plan perspective and promoting high-quality health care coverage for all Americans. With this letter, we express our recommendations to the incoming Biden-Harris Administration for regulatory policy changes that we believe merit attention and amendments. With our recommended changes, we strive to:

- Expand access to meaningful coverage and care to as many people as possible.
- Promote affordability for all health care consumers, including people with low incomes and other vulnerable populations.
- Increase equity and quality in health care and coverage.
- Promote stability in the health care marketplace for all stakeholders, including states, health plans, providers, and consumers.
Department of Health and Human Services Cross-Program Rules and Policy

ACAP previously submitted these comments to the agencies expressing our concerns with the following policies.

- **Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule**, proposed by the Department of Health and Human Services (HHS) November 4, 2020. While HHS accepted public comments on the NPRM for 30 days for most regulations and 60 days for those addressing Medicare, ACAP believes that a 30- or 60-day 2 comment period is far too short considering the potential scope of the rule and complexity of the issues. HHS estimated that in the first two years of implementation, it would have to review over 2,400 rules; we recognize that this substantial increase of regulatory activity from the Department’s usual annual output would shift the priorities of any future Administration from new policies and programs, including any that are newly required by Congress. An automatic expiration date for unreviewed regulations would also create market volatility, threatening coverage and access for health care consumers.

  o ACAP urges HHS to withdraw the draft SUNSET rule.

- **Nondiscrimination in Health and Health Education Programs and Activities, Final Rule**, finalized by the HHS Office of Civil Rights (OCR) June 14, 2020. ACAP opposed the OCR’s regulation removing protections from discrimination based on gender identity and pregnancy status in regulations for section 1557, as well as Marketplace and Medicaid managed care regulations.

  o ACAP urges OCR to reverse the nondiscrimination rules finalized in June of this year.

**Medicaid Rules and Policy**

The following recommendations are primarily based on ACAP’s reactions to final regulations, or our comments previously submitted to CMS in response to proposed rules.

- **Reducing Provider and Patient Burden by Improving Prior Authorization Processes (prior authorization rule)**, proposed December 10, 2020. ACAP has yet to develop and submit comments to CMS, given its recent publication. We appreciate CMS’s goals to improve health information exchange, reduce administrative burden for providers, and ensure patients have access to their health information to make informed decisions.

  However, CMS intends to close the public comment period for this proposed rule on January 4, 2021, a mere 25 days after it was initially posted. ACAP questions whether CMS is in violation of the Administrative Procedure Act, which at section 553 requires a minimum 30-day comment period unless the rule grants or recognizes an exemption or
relieves a restriction, is an interpretative rule or statement of policy, or the agency otherwise publishes good cause, which CMS has not done. In any event, it is infeasible for states, providers, health plans, and other stakeholders to provide an adequate assessment of this rule, which represents complex changes to our systems and operational practices, in the timeframe provided. This is particularly true given the ongoing and extraordinary work required of all stakeholders to address the COVID-19 pandemic.

- ACAP asks CMS to extend the timeframe for commenting on this to at least 180 days.

- Medicaid and Children’s Health Insurance Program (CHIP) Managed Care regulations, finalized November 13, 2020. ACAP has examined the entire Medicaid managed care regulation. While our plans are largely comfortable with the regulation, we continue to harbor concerns with CMS’ oversight of rate setting and actuarial soundness standards. ACAP has consistently urged CMS to increase oversight and transparency of state rate-setting practices to ensure that actuarial soundness standards are consistently met. Far from being a health plan-only issue, actuarial soundness standards when properly adhered to allow plans to pay fair provider rates, securing provider participation in plan networks and ensuring access to care for Medicaid enrollees.

- ACAP asks CMS to:
  - Require states to disclose in a timely manner sufficient information to permit plans to replicate the rate-setting methodology and underlying assumptions.
  - Establish an appeals process for plans related to actuarial soundness. Such a process would allow plans to request an additional review of the actuarial soundness of a state’s MCO rate setting process and/or methodology by the CMS actuary.
  - Develop a web page that lists the following information; this web page should be public-facing, or, at the least, accessible by Medicaid health plans and states:
    - The date CMS received each specific state’s contract and/or rates for review;
    - The date CMS began review of each state’s contract and/or rates;
    - A status indicator that defines stages of rate review and identifies which stage of the process the rate review is in; and
    - The date on which CMS rate review is concluded. CMS should develop a best practice toolkit for states on rate development transparency, highlighting state practices that encourage the
provision of historical costs, trends, and assumptions to Medicaid MCOs.

- **Interoperability and Patient Access**, finalized May 2020. ACAP supports and appreciates CMS’s initiatives to ease individuals’ access to and use of their health information. We fully support the necessary steps to implementing interoperability within health care systems and we appreciate the recent delay of enforcement deadlines in response to the COVID-19 pandemic. While we are continued supporters of this next phase in electronic health information exchange, we maintain our original views that these steps need to be carried out thoughtfully and with sufficient time to ensure that payers and providers are able to map and aggregate all patients’ data and establish private and secure data exchange pathways. The COVID-19 pandemic has required health plans to reallocate staff and resources to ensure a robust response during this crisis. In addition, the varied and continuous COVID-19 crisis and the complexity of implementing the interoperability rules create significant challenges.
  
  o As such, we strongly urge CMS to utilize discretion in enforcement and extend the compliance timeframe another six months.

- **Medicaid Fiscal Accountability Regulation**, informally withdrawn September 14, 2020. ACAP’s main concerns with CMS’ proposed Medicaid Fiscal Accountability Regulation focused on decreased state flexibility, decreased Medicaid funding, and impact on access to care; increased program oversight opaqueness; increased burden on states; and lack of data to determine overall effects of regulation. ACAP’s comment letter urged CMS to withdraw this rule, which CMS did temporarily and informally by way of twitter.
  
  o ACAP now urges the Biden-Harris Administration to:
    - Formally rescind the regulation.
    - Consult with appropriate stakeholders to explore how best to improve the financing and operation of state Medicaid programs.
    - Ensure that any future rulemaking to amend the federal Medicaid financing structure thoroughly assess the effects of proposed changes on Medicaid programs and enrollees.

- **Medicaid State Drug Utilization Review and Value-Based Purchasing for Drugs**, proposed June 2019. In our response to CMS, ACAP expressed our concerns that if finalized, the proposed rule could have the unintended consequence of allowing manufacturers to manipulate program rules to increase profit. We also articulated our concerns that CMS had not conducted a complete analysis on the effects of this rule. As such,
We recommend that the Biden-Harris Administration halt progress on the current proposed regulation until a thorough analysis of its impact on the Medicaid drug rebate program and broader health care system is conducted.

- We recommend CMS rewrite the proposed rule to clarify what is meant by “value-based purchasing arrangements.”
- We urge CMS to withdraw proposed changes to rules governing patient assistance programs.

- **Methods for Assuring Access to Covered Medicaid Services**, rescinded July 2019. ACAP commented on CMS’ rescission of the Access rule, indicating our support for CMS’s recognition of the growing importance of health plans in Medicaid coverage. We look forward to participating in efforts to ensure access to care for Medicaid enrollees going forward, and recommend that CMS:
  - Revive the effort to build a comprehensive access strategy.
  - Recognize the connection between access to health care services by Medicaid enrollees and adequate oversight of MCO rate setting and actuarial soundness standards.
  - Include representatives of Medicaid health plans in any technical expert panels and working groups established to advise on the access strategy.

- **Healthy Adult Opportunity (HAO) initiative**, published January 2020. While ACAP supported elements of the HAO initiative, including the option for states to offer 12-month continuous eligibility for enrollees and requirement that states measure quality of care using the adult core measures set, we strongly opposed the program’s reliance on capped Medicaid and permission for states to opt out of various managed care rules, including actuarial soundness standards in MCO rate setting.
  - ACAP asks that CMS cease the HAO initiative.

- **TennCare II – Amendment 42: Block Grant**, proposed November 2019. ACAP typically does not comment on proposed state waivers and we do not have a member plan in Tennessee. We made an exception for the TennCare II amendment out of concern about the national precedent it would set if approved. In particular, we were concerned with the proposed waiver of actuarial soundness requirements and the proposed block grant or per capita caps on enrollment, both of which threatened access to services and benefits for Medicaid enrollees.
  - ACAP recommends CMS deny Amendment 42 to the TennCare II demonstration.
Medicare Rules and Policy

ACAP previously submitted comment letters to CMS expressing our concerns with the following Medicare policies. Unfortunately, none if these issues were addressed in the CY 2022 Advance Notice. **It is our sincere hope CMS re-issues the 2022 Advance Notice to address these issues and/or addresses them via the CY 2022 MA-PD Proposed Rule, or another regulatory vehicle.**

- **COVID-19 Hold Harmless Policies for SNPs and MMPs.** COVID-19 has impacted Medicare utilization and patterns of care for all Medicare beneficiaries, including those enrolled in SNPs and MMPs. ACAP plans request clarity and hold harmless policies as they prepare their CY 2022 bids and work with providers to obtain accurate and comprehensive data for risk scores and Star Ratings. In September, we asked CMS to enact the following hold harmless policies for SNPs and MMPs. Unfortunately, these concerns were not addressed in the CY 2022 Advance Notice:
  - **Plan risk scores**
    - CMS should add additional sweeps for closing out payments for 2019 and 2020 dates-of-service, and for future years affected by COVID.
    - CMS should evaluate implementing a 2-year risk score for Plan Year 2020 and for all future payment years affected by COVID.
  - **Risk-adjustment**
    - Allow audio-only telehealth encounters to count towards risk-adjusted payments.
    - Apply a “COVID adjuster” to the CMS-HCC model.
  - **Plan bids**
    - CMS should develop a hold harmless COVID adjustment for plans for their 2022 plan bids, and possibly also for future years depending on the ongoing course of the pandemic.
  - **RADV**
    - CMS should suspend all RADV audits for the duration of the COVID pandemic.
  - **LTSS**
    - CMS should continue working with states to identify and allow flexibilities with the provision of LTSS.

- **Lower the threshold for identifying D-SNP look-alikes.** In response to CMS’ D-SNP look alike proposal in the CY 2021 Advance Notice, ACAP commented that the 80 percent threshold CMS is using to identify D-SNP look-alikes is too high. The threshold should be 50 percent. D-SNP look-alikes are causing dually eligible beneficiaries to not enroll in integrated care programs (e.g. Medicare-Medicaid Plans or integrated D-SNPs), and they are not subject to the same oversight and care management requirements as integrated care programs.
Marketplace Rules and Policy
ACAP has submitted comments to a variety of regulatory and subregulatory proposals impacting the individual market, and believes that much can be done to improve the stability of the marketplaces as well as coverage options available to consumers. We detail these recommendations below.

- **Short-Term, Limited-Duration Insurance (STLDI),** expanded in 2018 to a 364 day term, renewable up to 3 years. ACAP, along with 6 coplaintiffs and numerous amici, has since led the lawsuit, ACAP vs. Treasury, to rescind the 2018 rule. STLDI plans do not meet minimum essential coverage requirements and are permitted to engage in the very practices the ACA protects consumers against: underwriting, rescissions, gender rating, annual and lifetime coverage limits, and discrimination based on pre-existing medical conditions. STLDI plans that dodge the ACA’s consumer protections are appealing to healthy consumers: they typically cost far less than QHPs, which must provide comprehensive coverage and cannot discriminate against people on the basis of their health history. As a result, STLDI plans draw healthy risk from the single risk pool established in the ACA, raising premiums for the remaining consumers. We urge the incoming Biden Administration to restore the 2016 rule, ensuring that STLDI products are not used as alternatives to comprehensive coverage but instead serve their intended purpose as short-term stopgap coverage. We also urge improved data collection (see below) and to ensure that all policy terms end by Dec. 31 of the given policy year in order to better align consumers with open enrollment instead of a repeating cycle of purchasing STLDI coverage simply because it is the only option available mid-year, when a policy ends outside of open enrollment.
  - ACAP should rescind the 2018 rule on STLDIs and return to the policies established in 2016. Additionally, CMS should require that all STLDI plan terms end by December 31st of the given year.

- **Non-ACA-Compliant Plans,** offered as “alternatives” to ACA-compliant coverage, have proliferated through a variety of rulemaking. ACAP urges CMS to reevaluate whether any such rulemaking on Association Health Plans (AHPs), Health Care Sharing Ministries (HCSMs), Grandfathered plans violates the letter and spirit of the ACA. Additionally, we urge CMS to institute robust data collection efforts for all types of non-compliant plans. A recent report by the GAO investigated a variety of deceptive practices in which brokers are enrolling consumers into non-compliant plans, even if they have pre-existing conditions that will not be covered. However, it is unknown the extent to which consumers are enrolling in fixed indemnity or many of the other non-compliant plans. For example, STLDI plans are often marketed through AHPs, thereby evading the NAIC’s limited reporting requirements. And in response to a Senate request, the CBO recently stated that it needs additional data in order to reconsider its 2019 decision to include
many STLDI plans in its definition of insurance, rather than continuing to count consumers with SLTDI plans as uninsured. However, such data does not exist. Or, in the case of Grandfathered plans, which were supposed to be phased out under the ACA, CMS recently issued rulemaking instead giving them additional flexibilities in order to remain in the market. Accordingly, we urge CMS to consider necessary regulatory changes in keeping with the goals of the ACA and to institute additional rulemaking to better track enrollment data of all non-ACA-compliant health insurance type offerings.

- CMS should develop robust data collection and reporting requirements for all types of non-ACA-compliant plans.

- As of this writing, the 2022 Notice of Benefit and Payment Parameters (NBPP) has not been finalized, however, we expect that it may be by the time President-Elect Biden takes office in 2021. Accordingly, our highest priority suggestions are based on the proposed rule and may need to be adjusted slightly pending the final guidance. However, within this rule, we urge a rescission of the language codifying the 2018 guidance loosening section 1332 state innovation waiver rules, as discussed below. We also urge reversal of the policy that would permit states to eliminate usage of healthcare.gov or another state-based Exchange website as the primary consumer-shopping platform for qualified health plans in favor of third-party direct enrollment platforms operated by web-brokers. Finally, we urge a return to the premium adjustment percentage methodology previously in place, in order to improve affordability and lower cost-sharing maximums for consumers.

  - CMS should rescind the proposal to permit states to eliminate use of an Exchange in favor of third-party direct enrollment platforms.
  - CMS should return to the previous premium adjustment percentage methodology in order to improve consumer affordability.

- 1332 State Innovation Waiver Guidance, published in 2018 and which CMS now proposes to codify in the 2022 NBPP. ACAP believes that the 2018 guidance itself violates the guardrails set out in the ACA and opposes the expanded interpretation. We urge CMS to rescind the 2018 subregulatory guidance, which sidestepped the appropriate notice-and-comment rulemaking and does not contain appropriate consumer or market protections, and revert to the previous guidance published in the Federal Register in 2015.

  - CMS should rescind the 2018 guidance on 1332 state innovation waivers in favor of the guardrails set out in 2015.
Meaningful Difference Standards, eliminated in the 2019 NBPP. ACAP urges CMS to consider reinstituting meaningful difference standards for QHP products offered on healthcare.gov and the State-Based-Marketplaces. However, ACAP has instead long urged CMS to strengthen meaningful difference standards in order to prevent issuers from dominating the market with numerous products that offer little variation and instead serve to increase consumer confusion. While CMS states that eliminating the meaningful difference standard would encourage innovation, we do not believe that slight variations in benefits equate to innovation. Additionally, research has shown that if there are too many options to choose from, consumers actually will not make any choice at all. In addition, we are concerned that issuers may be crowding the market at the lower-ends of the price spectrum—offering multiple products with just a few cents or dollars difference in premium and no discernable difference to consumers—in order to gain market share and ensure that they have the benchmark plan for advance premium tax credit (APTC) calculations—and ultimately lowering the APTC accordingly. We urge CMS to review whether this is the case and, if so, reinstitute appropriate meaningful difference standards and/or establish that the second-lowest silver plan must be the second-lowest silver plan offered by a different issuer than the lowest priced plan in order to ensure that the APTC amounts available to consumers better reflect the breadth of offerings in their area.

- CMS should evaluate the breadth of plan offerings and consider reinstituting meaningful difference standards.

Actuarial value calculator & de minimis variations, updated annually. ACAP urges CMS to thoroughly evaluate the de minimis variations permitted to the actuarial value calculator for product tier metal levels in order to ensure robustness of plan benefits and ensure some value for consumers pre-deductible. Some consumers may prefer to have lower-deductibles, even at the expense of a less pre-deductible coverage, for example. We urge CMS to evaluate the AV calculator to ensure adequate variation in cost-sharing, particularly at lower metal tiers where deductibles tend to be quite high.

- CMS should evaluate the AV calculator moving forward to make it easier for issuers to offer products with lower deductibles.

Exchange Program Integrity Rule, published in January 2019, changed longstanding interpretation on the segregation of premium funds for the payment of non-Hyde abortion coverage. Our full comments on the rule detail the numerous operational and financial challenges associated with compliance, along with our concerns on the legality of the interpretation. We were pleased by the District Court ruling that halted the rollout of this onerous and illegal policy. We urge CMS to rescind the provisions in full
and clarify that generally accepted accounting requirements would permit one single bill outlining the separate charges for any covered non-Hyde abortion services.

- CMS should issue guidance clarifying that issuers who provide non-Hyde abortions are not required to send separate bills to and require separate payments from their enrollees.

**Regulations and Policy Issued by Other Agencies**

The following regulations and policies fall under the jurisdiction of agencies outside of the Department of Health and Human Services, but they either strongly impact or have the potential to impact the programs that our health plans serve. We urge CMS to coordinate with these agencies on the following policies.

- **Department of Homeland Security “public charge” rule**, finalized August 2019. ACAP has consistently and forcefully opposed changes to the public charge rule that would allow the federal government to consider an individual’s enrollment at any time in Medicaid when making decisions related to immigration status.

  - ACAP urges the Department of Homeland Security to rescind the changes to the public charge finalized in August 2019.

- **Office of Management and Budget (OMB) Request for Comment on the Consumer Inflation Measures Produced by Federal Statistical Agencies**, proposed May 2019. In response to the OMB’s request for comment, ACAP recognized the value of periodically evaluating poverty measures, but indicated our belief that the official poverty measure currently in use may be too low. We articulated our concerns that the changes contemplated by OMB would result in further inaccuracies, potentially reducing health coverage among people with low incomes.

  - ACAP strongly opposes any measures that would undermine eligibility for Medicaid, Medicare, and the Marketplaces, and urges OMB not to move forward with changes to Census poverty thresholds that would impact poverty guidelines.

- **Federal Communications Commission (FCC) Telephone Consumer Protection Act (TCPA)**, proposed October 2020. The TCPA restricts unsolicited health care phone calls and text messages from health care entities to consumers to prevent excessive and unwanted marketing. Currently, however, the TCPA exempts calls by Health Insurance Portability and Accountability Act (HIPAA)-covered entities and business associates as long as they deliver a health care message to consumers. Unfortunately, HIPAA rules do not define “health care message.” ACAP seeks an additional exemption to cover calls
and text messages that are not considered marketing as defined by HIPAA. To be effective, this exemption must apply to wireless numbers. Health care education and communications are always key to good health, and particularly during the current COVID-19 pandemic, phone calls and text messages are critical tools to encouraging safe behaviors, access to preventive care, and receipt of COVID testing, care, and vaccines.

- ACAP urges the FCC to exempt calls (including to wireless numbers) and text messages from TCPA restrictions on unsolicited communications.

**Conclusion**

ACAP thanks the Transition Team for your willingness to consider these recommendations. ACAP’s published comments on proposed regulations can be found on our web site [here](#) and our full slate of policy recommendations for 2021 can be found [here](#). If we can provide any further information, please do not hesitate to contact me at mmurray@communityplans.net.

Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer