National
MLTSS
Health Plan Association

January 14, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care
CMS-2408-P

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the Centers for Medicare and Medicaid Services' proposed rule *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care.*

The National MLTSS Health Plan Association is an association of health plans that contract with states to provide managed long-term services and supports (MLTSS). Our members offer MLTSS plans in nearly all states with Medicaid MLTSS, and assist those states in delivering high quality services at the same or lower cost as the fee for service system with a particular focus on ensuring beneficiaries' quality of life and ability to live in the community instead of an institution. Responsibility for managing an LTSS benefit also extends to our members' offerings through dual-eligible special needs plans (D-SNPs) and Medicare-Medicaid Plans (MMPs). Member organizations include Aetna Inc., AmeriHealth Caritas, CareSource, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans Inc.

The proposed rule proposes changes to the Medicaid and CHIP Managed Care Final Rule that became effective July 2016, in an effort to achieve, as stated in the preamble, "…a better balance between appropriate federal oversight and state flexibility…" The proposed rule includes changes related to actuarial soundness standards, risk sharing and rate setting, network adequacy standards, state quality rating systems, grievances and appeals, and beneficiary information requirements.

The Association generally supports the additional flexibility CMS has granted states and health plans in operating managed care programs, especially as more states transition from a fee-for-service system to a managed care environment. The flexibilities to allow for pass-through payments during such transitions and a broader requirement for network adequacy standards are particularly helpful. However, we are concerned with the unintended consequences associated with some of the proposed changes – specifically:

> Changes to explicitly prohibit certain rate development practices that vary with federal financial participation, which may increase the risk of transitioning to a managed care environment and reduce access, and

Changes to allow for more state flexibility to establish an alternative state Quality Rating System (QRS), which may lead to an inability for stakeholders to meaningfully compare quality measure scores across states and managed care programs.

Below we offer more detailed comments on proposals as they appear within the rule.

Standard Contract Requirements (§ 438.3)

In the 2016 final rule, CMS required that all Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) who serve dual-eligible individuals must sign a coordination of benefits agreement (COBA) and participate in the automated crossover claims process through Medicare. However, CMS is now proposing to remove this requirement and replace it with a broader requirement that all managed care plan contracts must specify the process the state would use to ensure managed care plans receive all appropriate crossover claims they are responsible for.

As CMS and the general stakeholder community pursue a greater level of integration for dual-eligible beneficiaries (e.g. through the new standards of integration found in the *Bipartisan Budget Act of 2018*), we believe CMS should encourage free and timely access to all necessary clinical and administrative data to promote coordination among managed care plans. This should include a standardized process by which managed care organizations can receive timely claims and clinical data from both Medicaid and Medicare. CMS's proposed change to establishing a COBA may have the opposite effect as states begin to pursue divergent processes and fragment the administrative system for plans that operate in multiple states. We would like to further emphasize that a COBA only provides access to a member's Medicare FFS claims data, thus limiting full integration in instances where an MLTSS beneficiary is enrolled in an unaligned Medicare Advantage (MA) or dual-eligible special needs plan (D-SNP).

Actuarial Soundness Standards (§438.4)

Option to Develop and Certify a Rate Range (§438.4(c))

Under the final 2016 rule, CMS revised the capitated rate development process to require that states certify each rate cell paid to a managed care plan as actuarially sound based on documented data, assumptions, and methodologies. Before the final 2016 rule, CMS considered a capitated rate that fell within a range of certified rates to be actuarially sound. CMS is now proposing to allow states to develop and certify rate ranges, so long as they are for each individual rate cell and they comply with five specific requirements, including that both bounds of the rate range are certified as actuarially sound and that the upper bound of the rate range is not more than five percent higher than the lower bound.

We share CMS's concern that this proposed change could "reintroduce some of the risks that were identified in the 2016 fine rule related to the use of rate ranges" as it relates to the integrity and transparency of the rate setting process. We therefore urge CMS to closely monitor the impact of these changes on the viability of operating managed care programs and for CMS to encourage all parties involved in the rate setting process to provide all necessary and proper documentation.

Capitation Rate Development Practices that Increase Federal Costs and Vary with the Rate of Federal Financial Participation (FFP) (§438.4(b)(1) and (d))

In the 2016 final rule, CMS prohibited the practice of establishing different capitation rates based on the FFP associated with a particular population. CMS argued that this practice represents a form of cost-shifting from the state to the federal government and is not based on generally accepted actuarial principles and practices. In this proposed rule, CMS would add clarifying paragraphs to more explicitly describe the intent of its original policy set forth in the 2016 final rule. This clarification, along with a list of explicitly prohibited practices, would indicate that variation in the assumptions, methodologies, and factors used to develop rates must be tied to "actual cost differences" and not to any differences that increase federal costs and vary with the rate of FFP.

We appreciate CMS's concerns with some of these practices but are concerned with prohibitions that CMS proposes for other specific practices. We are particularly concerned about the requirement CMS would impose that "a state may not use a higher profit margin, operating margin, or risk margin when developing capitation rates for any covered population, or contract, than the profit margin, operating margin, or risk margin used to develop capitation rates for the covered population, or contract, with the lowest average rate of FFP." States should be allowed to account for the increased risk associated with creating or expanding an MLTSS program for a new population of complex care individuals. In addition, these proposed changes may have the unintended consequence of reducing access to LTSS, such as instances when states may wish to utilize the Community First Choice (CFC) state plan option, due to the increased FMAP, but would be restricted to providing historically low reimbursement rates which would discourage providers from participating in the CFC program.

Special Contract Provisions Related to Payment (§438.6)

Risk-Sharing Mechanism Basic requirements (§438.6(b))

In an effort to address certain instances when risk-sharing mechanisms are retroactively amended, CMS proposes to explicitly require that risk-sharing mechanisms be documented in the contract and rate certification documents prior to the start of a rating period and to explicitly prohibit retroactively adding or modifying risk-sharing mechanisms described in the contract or rate certification documents after the start of the rating period. These requirements would also apply to risk adjustment.

We are supportive of this change as we believe it would promote a more reliable and predictable method for risk-adjusted payments to managed care organizations. However, we would like to point out that there may be instances in which states may choose to retroactively change a risk-sharing mechanism to adjust for a previously unaccounted factor that would improve the validity of the risk-sharing mechanism. Therefore, we suggest that CMS allow for retroactive changes to a risk-sharing mechanism on the basis that the mechanism is improved by such a change and that the contracting parties agree to the change.

Pass-through payments under MCO, PIHP, and PAHP contracts (§438.6(d))

Through the 2016 final rule and the 2017 pass-through payment final rule, CMS limited state direction of payment (e.g., pass-through payments) due, in part, to the conclusion that "pass-through payments are not consistent with [CMS's] regulatory standards for actuarially sound rates because they do not tie provider payments with the provision of services."

However, CMS now proposes to provide additional flexibility to permit pass-through payments during transition periods from FFS to managed care to recognize the challenges associated with this process. A "transition" would either occur when a state expands the scope of its managed care program as it relates to: 1) services; or 2) populations. During these times, CMS proposes to allow states to require managed care plans to make pass-through payments for up to three years to network providers that are hospitals, nursing facilities, or physicians, provided that states and health plans meet certain requirements (e.g. services will be covered for the first time under a Medicaid managed care contract).

We support this proposed change as it removes the potential disincentive for states to transition to managed care environments in the absence of any pass-through payments. These transitions, including the creation of MLTSS programs, involve complex coordination among all stakeholders over a substantial period of time during the move away from a fee-for-service system. We appreciate the proposed length of three years for pass-through payments, would support a longer period (5 or more years) and encourage CMS, at a minimum, to work with states and health plans to address potential uncertainty that may arise after the end of the pass-through period.

Network Adequacy Standards (§438.68)

As explained in the preamble, CMS required through the 2016 final rule that states must establish time and distance network adequacy standards for certain provider types. However, it did not require states to adopt any specific form of LTSS network adequacy standards. Since then, CMS has been made aware of the challenges with uniformly adopting a time and distance network adequacy standard. Therefore, CMS now proposes to remove the requirements for states to set time and distance standards and replace them with a requirement that states set a "quantitative minimum access standard" for specified health care providers and LTSS providers (e.g., minimum provider-to-enrollee ratios).

We support this broader definition for developing network adequacy standards and we agree with the concerns that "time and distance may not be the most effective type of standard for determining network adequacy," especially as it relates to the community of individuals who access LTSS and the unique set of providers of LTSS, as compared to the traditional concept of a medical provider. We suggest that CMS convene a technical expert panel to allow for the stakeholder community to develop suggested guidelines around what constitutes "network adequacy" and which measures of network adequacy are effective, especially as they relate to populations that access LTSS provided in the home.

Medicaid Managed Care Quality Rating System (QRS) (§438.334)

CMS proposes to revise the requirement in the 2016 final rule that an alternative state QRS must produce "substantially comparable information to that yielded by the CMS-developed QRS" to require that the information yielded be "substantially comparable *to the extent feasible* [emphasis added] to enable meaningful comparison across states, taking into account differences in state programs that complicate achieving comparability." This change is made in response to the "technical and methodological complexities of producing substantially comparable information to enable meaningful comparisons between plans across states." However, CMS proposes to also identify a set of mandatory performance measures that a state alternative QRS must include, with the opportunity for stakeholders to provide public comment on such mandatory measures.

The National MLTSS Health Plan Association has worked with quality measurement stakeholder organizations, LTSS recipient and caregiver advocates, and CMS since the issuance of the 2016 final rule

on opportunities to align and standardize the quality measures reported by Association members. Our intent in these efforts is to encourage more widespread adoption of person-centered quality measures for MLTSS and greater consistency among states in what is measured and publicly reported. We will continue to engage with CMS and other stakeholders to work toward a set of standardized, person-centered LTSS quality measures based on our April 2017 "Model LTSS Performance Measurement and Network Adequacy Standards for States."

As an Association of health plans that operate across multiple states we understand the complexities of operating programs and comparing results across states. We strongly believe that the priority in the implementation of Medicaid QRS should be to facilitate meaningful cross-plan and cross-state comparisons based on a set of agreed-upon quality measures. We, therefore, urge CMS to do whatever is possible in its review and approval of states' alternative versions of the Medicaid QRS to encourage states to adopt standardized measures.

In addition, in order to maximize comparability of quality measurement across states while minimizing the administrative burden of measurement on MLTSS plans, we recommend that CMS include standardized measure specifications for MLTSS plan measures, such as those published by CMS in partnership with NCQA[1], in its proposed list of mandatory quality measures. We also recommend that all quality measures required or recommended by CMS for MLTSS plans should go through the National Quality Forum (NQF) measure endorsement process in order to ensure their validity, reliability, and consistency if a state chooses to include them in their QRS.

Managed Care State Quality Strategy (§438.340)

Due to its concern that the current definition of "disability status" may be "unintentionally narrow", CMS proposes to remove the current definition for the purposes of states identifying demographic information for each Medicaid enrollee and providing it to the managed care plan at the time of enrollment. CMS further encourages states to use and provide more current sources of information for an individual's disability status, if available.

We support this change and encourage states to consistently adopt a definition of "disability status" that will allow MLTSS plans to identify individuals who may need LTSS and, separately, will allow MCOs to identify individuals with disabilities that may need reasonable accommodations regardless of their need for LTSS (e.g. an enrollee who is deaf and may need a sign language interpreter at an appointment). Additionally, as states work to operationalize this proposed change, we encourage CMS to distribute guidance on the benefits and limitations of using certain forms of data to determine disability status under a potentially broader definition (e.g. self-reported data vs. administrative claims data vs. clinical data).

Institutions for Mental Disease (IMD) (§438.6(e))

IMDs are institutions with more than 16 beds that primarily provide psychiatric care. According to the 2010 decennial census, there were 42,000 people in the U.S. living in IMDs. Medicaid prohibits federal financial participation (FFP) for IMDs due to a desire to reduce institutional lengths of stay for people with behavioral health needs. The 2016 final rule allows FFP for a full monthly MCO capitation payment for an

[1] *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*. Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services. September 2018. <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf>

IMD stay of no more than 15 days. All substance use treatment facilities with more than 16 beds are IMDs, and certain treatments (such as SUD detox and rehab) often require long stays.

CMS considered allowing FFP for IMD stays longer than 15 days in the proposed rule, but decided against any changes at this time due to concerns regarding transfer of risk and cost-shifting by states (states are the primary payer for inpatient behavioral health services). In the proposed rule, CMS instead encourages states to apply for 1115(a) SUD demonstrations allowing FFP for longer lengths of IMD stays, and has already approved 15 waivers of the so-called "IMD exclusion." CMS requests comment and data sources on the topic.

The MLTSS Association is committed to federal and state efforts to rebalance LTSS with more integrated and cost-effective home-and-community based services, and to the implementation of the integration mandate in the Americans with Disabilities Act (ADA) and *Olmstead* Supreme Court decision. Any support for policies that increase institutionalization runs contrary to this commitment. Therefore, we recommend that CMS not allow FFP for IMD stays longer than 15 days, but instead pursue other policy solutions to the underlying problem, such as removing SUD treatment from the IMD definition.

Language and format (§438.10(d))

The 2016 final rule requires that states and MCOs include taglines in prevalent non-English languages and in large print (no smaller than 18 point font) on all written materials for potential enrollees and enrollees; and that MCOs include information in directories about whether a provider has completed cultural competency training.

The proposed rule requires taglines only on materials for potential enrollees that "are critical to obtaining services," deletes the current definition of large print and replaces it instead with the phrase "conspicuously visible," and eliminates the required provision of information about provider completion of cultural competence training in directories. Part of the rationale given for this change is that it "is beneficial to Medicaid managed care enrollees to align the requirements for Medicaid managed care with the FFS directories" (page 49).

The Association appreciates the value, particularly for plans, in reducing the volume of communication that must meet these standards. At the same, it is critical that important plan information be conveyed to all members in a way they can access and understand, in compliance with existing standards to ensure communication and access to services that are culturally, linguistically, and disability responsive. We are concerned that terminology in the proposed role that is not well defined, such as "conspicuously visible" and "significant documents," may result in communications that are ineffective and reduce access for some persons with disabilities. We recommend in refining this rule that CMS work with the Office for Civil Rights (OCR) to define these terms and create a definitive list of "significant documents" which ensures that beneficiaries with disabilities can fully engage with their health plan and are not excluded through failures to effectively communicate important plan information to them.

Resolution and Notification: Grievances and Appeals (§438.408)

The 2016 final rule revised the timeline for enrollees to request a state fair hearing to 120 calendar days, rather than the previous timeline of 90 calendar days. The change to 120 days was made so that enrollees would have more time to gather the necessary information, seek assistance for the state fair hearing process, and make the request for a state fair hearing. While this change was more protective of the

enrollee, it created an inconsistency in filing timeframes between Medicaid FFS and managed care, creating administrative burden for states and confusion for enrollees.

The proposed rule revises the state fair hearing request timeline language so it aligns with the Medicaid FFS timeline. The timeframe to request a state fair hearing "would be no less than 90 calendar days and no greater than 120 calendar days" from the date of the MCO's notice of resolution.

While the proposed rule would align managed care and FFS timelines, it would permit states to roll back their grievances and appeals timeline to 90 days, as was required prior to 2016. Such a change would deny beneficiaries the time they need to adequately prepare a state fair hearing request. Additionally, the proposed rule language is ambiguous, and may mislead beneficiaries into believing they may not submit a request prior to 90 calendar days. As such, the proposed rule may have the unintended consequence of discouraging beneficiaries from submitting appeals within the legal timeframe.

The MLTSS Association recommends that CMS not make this change, and instead work to revise the FFS timeline so it aligns with the managed time timeline, rather than the other way around. While this may create some administrative burden for states, it will maintain the more stringent beneficiary protections embedded in Medicaid managed care.

Conclusion

We appreciate the opportunity to provide comment on these proposed rule changes that would increase flexibility to enable states and plans to better serve the full spectrum of Medicaid beneficiaries. We welcome the opportunity to meet with you and your staff to discuss our comments or the efforts of the Association. If you have any questions, please contact me at latkins@mltss.org.

Sincerely,

G. Lawrence Atkins
Executive Director