July 27, 2015 ***Submitted Electronically***

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

Re: File Code CMS-2390-P

Dear Mr. Slavitt:

LeadingAge appreciates the opportunity to comment on the Proposed Rule, **42 CFR Parts 431, 433, 438, 440, 457 and 495 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 LeadingAge Community includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations and foundations. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, and nursing homes, as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

Dedicated to expanding the world of possibilities for aging, we advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age.

LeadingAge supports the goals of the proposed rule and many of the specific changes. We agree that, to the extent practical and possible, Medicaid Managed Care should be aligned with other health coverage programs. The resulting reduction in administrative burden and provider and beneficiary confusion are strong arguments for alignment. However, it is critical that alignment among programs be balanced with the unique challenges and characteristics of a more vulnerable and complex population as those who require long term services and supports (LTSS). Effectiveness in the financing and delivery of services for the LTSS population should not be forgone by the desire for efficiency.

Our comments include numerous areas where we support the changes CMS has proposed. We also include recommendations that may clarify and strengthen the rule to meet the stated goals.

§ 438.2. Definitions

Long-term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility or other institutional setting.

Recommendation:

1. Include specific language that includes those with cognitive impairments
2. Include language that expands the purpose of LTSS beyond the ability to live or work in the setting of their choice and references the person centered care plan

Amend to read: *Long-term services and supports (LTSS)* means services and supports provided to beneficiaries of all ages who have functional and/or chronic illness **and/or cognitive impairments** that have the primary purpose of supporting **an individual's goals as outlined in the person centered care plan** and includes the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility or other institutional setting.

§ 438.3. Standard contract requirements

§ 438.3 (a) CMS Review

We support CMS' ability to set forth procedural rules related to timeframes and detailed processes for the submission of state contracts for review and approval. We believe this supports a more uniform and rigorous approach to oversight ensuring that the basic processes and principles in the final rule are adhered to.

Further, considering the complexity and variation within and between state Medicaid programs allowing CMS adequate time to review proposed contracts is critical. It is our concern that managed care programs are implemented without ample time for providers, beneficiaries and health plans to comprehend and master the processes necessary to ensure continuity of care and therefore success.

Recommendation:

1. States be required to submit final contracts for review no later than 180 days before the planned effective date of the contract
2. Readiness reviews timeframes be a minimum of 180 days prior to implementation

§ 438.3 (t) Requirements for MCOs, PIHPs or PAHPs responsible for coordinating benefits for dually eligible individuals

We strongly support the CMS' revision related to requiring MCOs, PIHPs or PAHPs to enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process. This provision will result in significant reduction in administrative burden to providers and facilitate uniformity with current program processes.

§ 438.6 (c) Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts

We strongly support the flexibility the CMS is providing states in encouraging/requiring health plan participation in delivery system and payment reform. LeadingAge providers are eager to develop meaningful partnerships with payers to support improved population health and better care at lower cost. This includes opportunities to **accept accountability for outcomes** and **share in resulting savings.**

In the discussion CMS indicates that "*capitation rates to health plans could reflect an amount for incentive payments to providers for meeting performance targets, however the health plans retain control over the amount and frequency of payment"*. Additionally, the CMS stipulates that these funds associated with delivery system or performance initiatives*, " if unspent are to remain with the health plan".*

The ability to retain unspent funds could act as a disincentive for plans to develop meaningful performance based partnerships with providers. Funds provided by the state for this purpose should be passed through to providers meeting challenging yet achievable performance standards.

We commend CMS for providing states the flexibility to set a minimum fee schedule for and a uniform dollar or percentage increase for providers with the goal of ensuring beneficiary access to care. Too often provider contracting is viewed as a cost cutting measure with proposed rates that do not align payment with quality and severely undercut rates that already inadequately compensate for care. This strategy undermines a provider's ability to invest in the technology and clinical expertise that is necessary for delivery reform. Additionally, it forces reliance on other payer sources to compensate. Quality is not supported with these contracting tactics and the resulting cost shifting should no longer be accepted.

Recommendation

1. Any unspent funds should not remain with the MCO, PIHP or PAHP. Unspent funds should be reinvested with high quality providers or returned to the state Medicaid program.

2. Performance targets and payments to providers related to state funded provider initiatives should be reviewed and approved by the state

§ 438.8 Medical loss ratio (MLR) standards

We support the CMS' understanding that more complex Medicaid populations require services that are not necessarily considered a traditional medical expense. These services, however, are critical to maintaining health, reducing and avoiding more costly acute episodes.

While incorporating the definition of activities that improve health care quality in 45 CFR 158.150 is more comprehensive than traditional methodology we believe the activities alluded to in the definition should be specifically stated in the rule.

The Proposed Rule also provides for the inclusion of certain health information technology (health IT) expenses in the numerator of the medical loss ratio (MLR), provided they satisfy the requirements set forth in 45 CFR 158.151 for health IT expenditures by health insurers. To qualify for inclusion in the MLR numerator under section 158.151, expenditures related to the adoption and meaningful use of electronic health records (EHRs) must support "certified

electronic health records technologies." Several provider types, including LTPAC and behavioral health providers, have not been eligible for meaningful use incentive payments. As a result, certification bodies have been slow to develop certification program for LTPAC products. CCHIT Certification for Nursing Home and Home Health EHRs, the only LTPAC Certification program, which a few EHR vendors have attained, has expired in 2014 and CCHIT is no longer certifying EHRs. There are currently only a handful of EHR products certified for LTPAC providers. Accordingly, as currently drafted, the regulations may discourage managed care plans from making EHR-related payments to LTPAC and similarly situated providers, as they may lack access to certified EHRs. Since EHR adoption by these providers will be critical to the success of MLTSS and other delivery system transformation efforts, the regulations should, instead, encourage MLTSS plans to incentivize the adoption of EHRs by LTPAC providers.

Lastly, we support the CMS' application of a credibility adjustment and the degree to which it provides sustainability to small and new plans. We believe this will foster increased choice of health plans for beneficiaries.

Recommendations:

1. Specifically include activities related to service coordination and case management in the definition of Activities that improve health care quality.

Amend to read: **§ 438.8 (e)(3)(i)** An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150 (c). **To include activities related to service coordination, case management, and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS.**

2. Include in the MLR numerator expenditures related to the adoption and meaningful use of EHRs, whether or not those EHRs are certified. MCOs and PIHPs should have the discretion to decide whether or not to make expenditures on non-certified EHRs. If they make such expenditures, their investments should be recognized in the MLR calculation.

Amend to read: **§ 438.8 (e)(3)(iii)** Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151**, with the exception of investments in non-certified EHRs for LTPAC, LTSS and behavioral health providers,** and is not considered incurred claims as defined in paragraph (e)(2) of this section.

§ 438.8 (j) ***Remittance to the State if Specific MLR is not met.*** If required by the State, a MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section

Recommendation:

If the intent of a minimum medical loss ratio is to ensure that a specified portion of revenue is being invested in healthcare related services and not administrative overhead then any amounts falling below the MLR threshold should be **required** to be remitted to the State and reinvested in the Medicaid program.

Amend to read: **§ 438.8 (j)** *Remittance to the State if Specific MLR is not met.* ~~**If required by the State, a**~~ **An** MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section

§ 438.10 Information Requirements

Accurate and timely information are critical components for sound decision making. For beneficiaries to proactively evaluate and select a health plan that meets their needs they must first have the necessary information.

We commend the CMS for creating a more comprehensive and consistent approach to ensuring beneficiaries access to this information. Specifically we applaud the following revisions:

1. Increased focus on the provider directory inclusive of the additional required element on accessibility of the provider's office/facility to enrollees with physical disabilities including exam rooms and equipment.

2. Timeframes for updates to paper and electronic provider directories

Recommendations:

1. When an MCO notifies an enrollee that their provider is no longer with the network **the notification should include information on how to disenroll or choose a plan in which their provider is in network.** This would be consistent with any other notification of an event that triggers and opportunity to choose a new plan.

2. Requirement for the timeliness of MCOs providing enrollee handbooks should be aligned with Medicare Advantage and/or Medicare Medicaid Plan requirements.

§ 438.52 Choice of MCOs, PHIPs, PAHPs, PCCMs, and PCCM entities

The proposed rule changes the definition of a rural area fostering the state's ability to offer only one contracted MCO in the designated area. We strongly disagree with this approach and urge the CMS to reconsider.

Beneficiary choice of provider and plan is of paramount importance. While this change would align the rural designation with Medicare Advantage's county based classification system it does not apply the protections to beneficiary choice afforded by the full range of Medicare Advantage network adequacy standards.

Should this revision remain in the final rule we recommend, at the very least, that restrictions around mandatory and passive enrollment in these rural counties mirror the Capitated Financial Alignment Demonstration. **Beneficiaries in counties with fewer than two Medicare Medicaid Plans may not be passively enrolled but opt into the MCO or remain in the fee for service alternative.**

§ 438.54 Managed care enrollment

We applaud the CMS' efforts to ensure beneficiaries have sufficient time to make an informed choice of health plan. At the same time, we recognize that a seamless transition into managed care and continuity of care are vitally important. Multiple enrollments and disenrollments into various programs can lead to confusion and inhibit access to needed services. While opt out rates in traditional Medicaid managed care programs have been generally low, experience from the Financial Alignment Demonstration Medicare Medicaid Plans points to a very different experience with dual eligible and LTSS populations.

Providing time to understand a managed care program and the benefits and services provided through the individual managed care entities has the potential to reduce the disruption that is caused by churn. We believe, in time and with accurate information, the opt out rates for the dual eligible and LTSS populations will decrease. Beneficiaries will more clearly understand the benefits of coordinated care and be more confident in the choice to join a health plan. To achieve that end we believe it is absolutely necessary that dual eligible and LTSS populations have sufficient time to understand managed care and evaluate their options.

Recommendation:

To promote informed decision making and continuity of care we recommend that the enrollment process for dual eligibles and individuals requiring LTSS align with the Capitated Financial Alignment model. The process requires notifying dually eligible individuals that they can select a Medicare-Medicaid plan 2 months prior to their enrollment. If no choice is made enrollment into a plan using an intelligent assignment algorithm which takes into account a beneficiaries' primary care and/or LTSS provider could be implemented.

§ 438.56 Disenrollment: Requirements and limitations

We commend the CMS for acknowledging the critical relationship between enrollees and their residential, institutional or employment supports provider. We strongly support an enrollee's ability to disenroll from a plan where their LTSS provider is no longer in network.

To support an enrollee's ability to remain independent in the community it is also important to protect the enrollee and home and community based services provider relationship. For example, Adult Day Program providers establish strong trusting relationships with enrollees and their caregivers. Often they are the key support that allows caregivers needed respite to work and continue to assist them in keeping their loved one at home. Disruption to that relationship can result in an enrollee's inability to remain at home.

Recommendation:

Include home and community based service provider's network status as a cause for choosing a new plan or disenrolling.

Amend to read **§ 438.56 (d)(2)(iv)** For enrollees that use MLTSS services, the enrollee would have to change their residential, institutional, **home and community based services** or

employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO, PIHP or PAHP.

§ 438.66 State monitoring requirements

As a state moves to Medicaid Managed Care their role in monitoring and oversight becomes an ever more critical one. The success of the program can hinge on a state's ability to effectively manage the readiness review and implementation process. As states move more vulnerable populations into managed care programs the intricacy of service provision and payment become increasingly complex. Health plans need time to ensure they understand and can successfully execute the vital processes required to support the population. Missteps in this area can result in delays to the provision of critical beneficiary support and untimely, inaccurate claims payment to providers that are heavily dependent on consistent cash flow.

Recent experience from the Capitated Financial Alignment Demonstration supports the need for adequate readiness review periods. Pervasive issues with untimely and inaccurate claims payment to LTSS providers coupled with the implementation of critical health plan subcontractor relationships post readiness review have led to significant confusion and strain on the provision of services.

Recommendation:

1. The CMS require states begin the readiness review process at least 6 months prior to implementation of Medicaid managed care programs for complex populations such as dual eligibles and those receiving LTSS.

2. Claims testing between health plans and LTSS providers should be added to readiness review requirements.

3. Implementation and readiness review testing of major health plan subcontractors must be completed <u>prior to program commencement</u>.

4. Health plans that have not successfully completed readiness review prior to program start date should have a delayed start date.

<u>*Amend to read*</u> **§ 438.56 (2) (i)** Started at least ~~**3**~~ **6 months** prior to the effective date of the events described in paragraph (d)(1) of this section

Amend to read **§ 438.56 (2) (ii)** Completed in sufficient time to ensure smooth implementation of an event described in paragraph (d)(1) of this section. **Health plans that have not successfully completed readiness review prior to program start date should have a delayed start date.**

Amend to read **§ 438.56 (4)(iv)(A)** Claims management **inclusive of claims testing with non-traditional provider types such as LTSS**

Amend to read **§ 438.56 (4)(v) Subcontractors- implementation of the delegation of any primary function must be concluded and reviewed**

§ 438.68 Network adequacy standards

We commend the CMS for including requirements for standards specific to LTSS providers. Choice is paramount when considering a LTSS provider and the development of adequacy standards can be complex. Often the proximity of a provider to the caregiver can be the priority making distance from the enrollee standards inadequate.

A health plan's network is dynamic. Thousands of changes can take place throughout a benefit year making it even more difficult to assess adequacy. Frequent network reviews are necessary to ensure sufficient coverage. Reviews should occur at least biannually. Significant changes that include a plan's membership size or provider consolidation should also trigger a review.

Considering the complexity and immaturity of the development of these standards we recommend during the initial commencement of an MLTSS program that an "any willing provider" provision be adopted. This will illuminate patterns of care and inform the development of effective network standards.

Recommendations:

1. Require an initial period at program implementation where any willing provider may contract with a health plan

   Amend to read **§ 438.68 (b)(2)(iii) Include an initial period at program implementation that requires health plans contract with any willing provider**

2. Network submission and reviews should occur at least biannually

3. Significant changes such as in a health plan's number of enrollees, provider consolidation should also trigger a review

§ 438.70 Stakeholder engagement when LTSS is delivered through a managed care program

We applaud the CMS' efforts to ensure that meaningful stakeholder engagement is inclusive of LTSS providers and beneficiaries. Many states have demonstrated competency with stakeholder engagement activities. We encourage CMS to provide specific examples of effective stakeholder engagement for states to emulate.

For example, Virginia involved LTSS stakeholders through varying events and mediums to engage in thoughtful discussion and development prior to implementation and throughout the Capitated Financial Alignment Demonstration program. Regular stakeholder committee meetings were held to inform the community of the program's progress. Informational calls and specific workgroup meetings were held for individual provider types to engage with health plans and the state in troubleshooting and problem solving. This resulted in the early identification of potential issues, facilitation of solutions and administrative efficiencies.

Recommendations:
Specific types of stakeholder engagement should be required and more clearly defined. The CMS should develop examples of effective stakeholder engagement from which States must choose.

§ 438.71 Beneficiary support system

LeadingAge supports the development of a beneficiary support system. We encourage the adoption of models such as the Ombudsman and State Health Insurance Counseling Program. The system should leverage the expertise and infrastructure that currently exists within the aforementioned models to avoid duplication of efforts, increased costs and beneficiary confusion.

§ 438.208 Subcontractual relationships and delegation

As health plans enroll complex populations we are witnessing significant delegation of services to large specialty subcontractors. For example, health plans are delegating the management of behavioral health, case management and LTSS to organizations specializing in those areas.

Often these are newly formed relationships where the processes and communication channels are not yet perfected. With compressed managed Medicaid and managed MLTSS program implementation timelines the delegation of these large and critical functions can result in a chaotic, less than optimal outcome for providers and enrollees.

Many times the delegation agreement is not executed prior to provider contracting and program implementation. Significant changes in critical processes such as authorizations and claims payment can result in providers receiving inadequate advance notice and training. This type of significant change jeopardizes a provider's ability to deliver care.

Recommendation:

We strongly recommend that rigorous requirements and oversight be outlined for the delegation of these agreements. <u>This should include but not be limited to the following</u>:

1. Sufficient timeframes for implementation, readiness review and oversight by the state,
2. Mandatory provider training and beneficiary notification and education.
3. Beneficiary handbooks and provider manuals should include revisions related to the grievances and appeals processes
4. Provider manuals should be revised to include new processes related to grievances/appeals, authorizations and claims payment
5. Provider directories should be updated to reflect resulting network changes

§ 438.330 Quality assessment and performance improvement program

We support quality assessment of managed Medicaid programs and, specifically, LTSS services. <u>However, we strongly recommend that assessment of LTSS services be aligned with current quality measurement innovation</u> resulting from new and ongoing initiatives including skilled nursing facility value based purchasing and the IMPACT Act.

Many quality measures for LTSS are still in development and testing phases. We encourage CMS to delay the implementation of LTSS quality measurement to align with the progress that is currently underway and avoid duplication of efforts.

Subpart F – Grievance System

§ 438.402 General requirements

We support the alignment of grievance and appeals processes between healthcare coverage programs. We encourage the use of the timeframes and processes that are the most supportive of the most vulnerable subpopulation of beneficiaries.

To that end we support:

1. One level of health plan appeal
2. Expedited appeals decisions within 72 hours
3. Standard appeal decisions within 30 calendar days
4. Removal of the requirement for an enrollee's written consent for a provider to file an appeal
5. Elimination of the option for the state to allow providers and enrollees less than 60 days to file an appeal

Recommendations:

Retain the option for the enrollee to request a SFH prior to the completion of the health plan internal appeal

Amend to read § 438.402 (c)(1)(i) An enrollee may file a grievance and an appeal with the MCO, PHIP, or PAHP. An enrollee may request a State Fair Hearing ~~**after**~~ **prior to** receiving notice under § 438.408 that the adverse benefit determination is upheld.

§ 438.410 Expedited resolution of appeals

Recommendation:

Include language related to an enrollees' residential setting being at risk if standard appeal timeframes are applied

Amend to read § 438.410 (a) General rule. Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum functioning **or remain in the residential setting of their choice**.

Again, LeadingAge appreciates the opportunity to comment on the CMS Proposed Rule, 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. We hope our comments will be helpful to you.

Please do not hesitate to contact us if you have any questions or would like further discussion. We look forward to our continued work with you on this and related issues.

Sincerely,

Cheryl Phillips, MD

Cheryl Phillips M.D.
Senior Vice President, Advocacy
LeadingAge