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July 27, 2015

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U.S. Department of Health and Human Services
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7500 Security Boulevard
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Submitted electronically to http://www.regulations.gov

Re: CMS 2390-P

Dear Mr. Slavitt:

The National Association of States United for Aging and Disabilities (NASUAD) is pleased to offer comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule aimed at updating and modernizing the Medicaid managed care regulations at 42 CFR 438 (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) as published in the June 1, 2015 Federal Register, volume 80, number 104, pages 31098 to 31297.

Originally founded in 1964 under the name the National Association of State Units on Aging (NASUA), the organization changed its name to NASUAD in 2010 to formally recognize the work that the state agencies were undertaking in the field of disability policy and advocacy. Today, NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities. The Association's mission is "to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers."

While Medicaid directors have primary responsibility for managing managed care programs, our expertise lies in home and community based services and supports. As is widely known, the Medicaid consumers that we serve through HCBS waivers– older adults and persons with physical disabilities – are increasingly being enrolled in managed care plans. We, therefore, have reviewed the proposed rule

through the lens of long-term services and supports (LTSS), and our comments are primarily focused in that area.

We outline general comments first, and then provide specific comments on relevant regulatory provisions. Where possible, we have tried to provide recommendations for regulatory language to substitute or modify what has been proposed. Our modifications are noted in bold italics. Finally, we offer suggestions for technical corrections that would improve the readability of the regulation.

GENERAL COMMENTS

Incorporation of LTSS Elements – We appreciate CMS' efforts to recognize the increasing importance of managed care delivery systems in providing Medicaid services to older adults and persons with disabilities. While we have concerns about some of the new burdens that these requirements will place on our members, we recognize that setting minimum expectations for managed LTSS programs will serve the Medicaid program well.

Federal – State Partnership – Notwithstanding our comment above, in many other portions of the proposed rule, the federal government is taking a more authoritative approach to Medicaid managed care, creating a top-down model that does not reflect the reality that Medicaid is a state-federal partnership. CMS' approach in this NPRM removes the ability of states to fully leverage their managed care plans to improve outcomes for beneficiaries, or to tailor their system design to reflect the needs and expectations of their citizens. A truly modernized framework should ensure states continue to have the central role in operating a Medicaid managed care program, with strategic and thoughtful oversight from our federal partners.

Focus on Alignment - While NASUAD understands why CMS has made alignment across public programs a core feature of the managed care regulation rewrite, we have two significant concerns. First, the alignment efforts primarily benefit managed care plans, who operate in multiple markets. They do not generally benefit states – CMS' partner in Medicaid. In fact, some of the alignment proposals result in new requirements for states or will necessitate states changing their existing administrative processes and procedures.

Second, the focus on alignment – particularly in the quality area – has relegated LTSS to an after-thought. The increasing prevalence of managed care plans providing LTSS to Medicaid consumers – and the complexity of those services – should warrant careful consideration and inclusion of LTSS-relevant language. We have suggested a number of specific changes that will strike, where appropriate, the words "health" and "care" and replace them with broader and more inclusive terms like services and outcomes. We urge CMS to take a fresh look at the regulations and ensure that all opportunities to use broad and inclusive terms are acted upon.

Need for Staggered Implementation Time – The changes proposed in this rule are significant and will trigger multiple changes in state operations. We urge CMS to use a staggered timeline for implementation that reflects the complexity of the regulation and provide more time for state

compliance. Moreover, staggered implementation dates will give CMS time to develop the subregulatory guidance that will be critical for consistent national policy.

Use of Beneficiary Experience Surveys for Quality Improvement – CMS requested comment on the current use of such surveys and how they may best be used to improve the delivery of LTSS to beneficiaries and to improve their experience of care. **NASUAD believes that consumer quality of life/experience of care surveys are a critically important part of quality measurement and improvement.** Because there are so few ways to evaluate the impact of long-term services and supports on consumers' quality of life and ability to live independently and with dignity, consumer surveys fill that gap. NASUAD has developed, in collaboration with Human Services Research Institute (HSRI), the National Core Indicators-Aging and Disabilities (NCI-AD)©. NCI-AD© is a consumer experience survey that collects and maintains valid and reliable person-reported data about the impact that states' publicly-funded LTSS have on the quality of life and outcomes of consumers. Data for the project is gathered through yearly in-person consumer surveys administered by state agencies to a sample of at least 400 individuals, which includes older adults and individuals with physical disabilities accessing publicly-funded services through skilled nursing facilities, Medicaid waivers and state plans, and/or state-funded programs, as well as older adults served by Older Americans Act programs. The survey addresses the following domains of measurement as reported by beneficiaries:

Community Participation	Choice and Decision-making	Relationships
Access	Service and Care Coordination	Satisfaction
Self-Direction of Care	Work/Employment	Rights and Respect
Health, Safety, and Wellness	Everyday Living and Affordability	Planning for the Future
Functional Competence		

14 States have begun full-scale implementation of NCI-AD© in June, 2015. We expect that states will use the results from NCI-AD© in the same ways that states use National Core Indicators© results, which assess experience for individuals with intellectual and/or developmental disabilities. They include identifying issues states can flag for deeper analysis; comparing MCOs, AAAs, regions, and/or programs; and benchmarking and comparing data nationally. We urge CMS to include quality of life surveys to be included as a mandatory quality improvement activity.

SPECIFIC COMMENTS

Our specific comments are organized into the following broad areas: consumer protections, quality, state oversight, and contract and payment provisions.

CONSUMER PROTECTIONS

This section includes our comments on LTSS-specific issues as well as disenrollment, transition/coordination of care, coverage and authorization of services and information requirements.

1. Section 438.71 - Beneficiary support system.

While we are concerned about this new unfunded administrative burden, we do appreciate the flexibility that CMS has provided to states in structuring and delivering a beneficiary support system. Some states may choose to contract out portions – or all – of these functions, while others will provide them directly with state staff. From the regulatory language, it appears that all those approaches would be acceptable.

Subsubparagraph (e)(3)(i)

We have a number of concerns with this provision. First, it appears to be in the wrong place in this section. Since it addresses choice counseling, it is more appropriately placed under subparagraph (c). Notwithstanding, we oppose the flexibility provided herein that would permit an entity that receives non-Medicaid funding to represent beneficiaries at hearings may, subject to approval by CMS, establish firewalls to provide choice counseling as an independent function. Those organizations tend to have limited staff, so it is inevitable that individuals are cross-trained. The adversarial nature of state fair hearings or court proceedings when such an entity is representing a consumer against a managed care plan leads to strongly-formed opinions about the managed care plan. We believe that it is possible – even with firewalls – for such an advocacy group's opinions and interactions with those plans to cloud their impartiality and could result in inadvertent steering toward or away from a particular managed care plan.

If it was CMS' intent to permit entities that currently provide options counseling and information & referral assistance in the aging and disability networks to serve as choice counseling entities, we don't believe such a provision is necessary. ADRCs, AAAs and CILs do not provide legal representation to Medicaid consumers. Those entities would be required to meet the independence and conflict of interest requirements – which means no financial relationship to any managed care plan, but that is appropriate. The important role of unbiased and impartial choice counseling necessitates complete financial independence from any managed care plan. Any community based entity such as an AAA or CIL should not be permitted to have a financial relationship with a managed care plan and perform choice counseling.

Recommendation

Strike subparagraph (e)(3)(i) in its entirety.

2. Section 438.70 - Stakeholder engagement when LTSS is delivered through a managed care program.

We recognize the importance of stakeholder engagement in the successful design, planning, implementation and oversight of an MLTSS program, and strive to meaningful engage public input as practicable. We are concerned, however, about the vague language in this section and the opportunities for misinterpretation and potentially litigation. Specifically, this sentence "The composition of the stakeholder group and frequency of meetings *must be sufficient* (emphasis added) to ensure meaningful stakeholder engagement." is worrisome. Does CMS intend to set a standard for sufficiency? Are states expected to do so? We do not think it adds anything to the expectation already laid out in the first sentence of this section. We recommend deletion of this sentence.

> **Recommendation**
> The State must 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. ~~The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement.~~

3. Section 438.110 - Member advisory committee.

Paragraph (b) – Committee composition

We are supportive of the requirement for managed care plans having a member advisory committee (MAC); in fact that is a commonplace occurrence today across the country. We are concerned again with the vague language included in paragraph (b), namely "The committee required in paragraph (a) of this section must include at least a *reasonably representative sample* (emphasis added) of the LTSS populations covered under the contract with the MCO, PIHP, or PAHP." Similar to our concerns about the stakeholder engagement requirement, we find this language vague and open to misinterpretation. Does CMS intend to provide guidance on what a reasonably representative sample of LTSS populations is? Are states expected to do so?

Because the member advisory committee is only a requirement if the managed care plan provides LTSS to enrollees, we expect the managed care plans to constitute the MAC with enrollees using LTSS or their representatives, and therefore the language is unnecessary. We recommend revised language.

> **Recommendation**
> (b)(1) The committee required in paragraph (a) of this section must include ***enrollees receiving LTSS or other individuals representing those enrollees.***

4. Section 438.56 - Disenrollment: Requirements and limitations.

Subsubparagraph (d)(2)(iv) – Cause for disenrollment

NASUAD strongly objects to the new 'for cause' reason added in this subparagraph regarding MLTSS services. The addition would permit an enrollee – at any time during their enrollment period – to disenroll from their managed care plan if the enrollee's residential, institutional or employment supports provider becomes an out-of-network provider.

We believe that CMS has added this new provision to prevent the disruptions in care that would result from an enrollee having to move from where they are currently living (whether a residential setting in the community or a nursing facility) or losing their access to employment. We agree that these are difficult transitions and should be minimized at all costs.

However, we are concerned that certain providers – already resistant to a managed care delivery system – will be incented to manipulate the system, either refusing to contract with managed care plans at all or bidding managed care plans against one another to get the most favorable contracting arrangements. This new provision also does not recognize or address the reason for a provider's change in network status, including poor quality performance or fraud. We believe that this new provision will give providers too much power in contract and rate negotiations with managed care plans, especially since managed care contracting with certain providers is already a difficult proposition in many states.

We recommend striking this new provision completely and creating a hardship process that would require the state to engage with the consumer and managed care plan to find alternatives short of disenrollment to address the disruption in care that would result from a residential or institutional provider termination from the managed care plan's network.

> **Recommendation**
> Strike subsubparagraph (d)(2)(iv) and renumber (v) to (iv). Renumber existing subparagraphs (3), (4), and (5), subparagraphs (4), (5) and (6) respectively, and insert a new subparagraph (3) as follows:
>
> (3) ***For enrollees that use LTSS services, if a provider's change in status from an in-network to an out-of-network provider with the MCO, PIHP or PAHP would result in an enrollee having to change their residential, institutional, or employment supports provider, a disenrollment request may be granted by the State if:***
> ***(i) the MCO, PIHP, or PAHP cannot reach a mutually agreeable agreement to maintain continuity of coverage on an out-of-network basis; and***
> ***(ii) a change in residential, institutional or employment supports provider would constitute a significant hardship to the enrollee.***

5. Section 438.62 – Continued services to enrollees.
Subsubparagraph (b)(1)(i)

Our members are supportive of this new requirement to ensure a continuity of care period for enrollees experiencing a transition from one delivery system to another or between managed care plans. However, we are concerned about the implicit expectation in this subparagraph that an enrollee must always retain their current provider, regardless of the interest or intention of the current provider to continue serving that enrollee after transition. Service provision is a two-way street, with both the enrollee and the provider willing to engage. It has been our experience that providers who are not in-network with the enrollee's new managed care plan are not always willing to deal with the new managed care plan. While we believe it is incumbent upon the new managed care plan to make accommodations for an out-of-network provider in this case, the provider should not be permitted to unilaterally set the conditions for ongoing cooperation. It is unreasonable to expect the new managed care plan to commit to such a continuity of care policy with an uncooperative provider.

We recommend modifying this paragraph to caveat this provision on the willingness of the current provider to cooperate with the new managed care plan.

> **Recommendation**
> (b)(1)(i) The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the MCO, PIHP or PAHP network, ***and the provider and the MCO, PIHP or PAHP can agree on mutually satisfactory payment terms and administrative processes.***

6. Section 438.208 – Coordination and continuity of care.

Subparagraph (b)(2)

CMS requested comment on whether it should include an additional standard relating to community or social support services in this subparagraph. CMS suggested that such coordination could include linking enrollees to services through organizations such as Protection and Advocacy organizations, Legal Aid, Aging and Disability Resources Centers, Centers for Independent Living, Area Agencies on Aging, or United Way 211 lines. NASUAD agrees that managed care plans generally do such coordination – either formally or informally – and that including a new requirement would acknowledge industry practice. However, given the critical importance of such linkages to enrollees using LTSS, we believe it is an appropriate addition to the managed care plans' expectations for care coordination. Care coordination is the linchpin to ensuring that enrollees receive the necessary supports to facilitate independence and inclusion. **We support the addition of this expectation in this section.**

7. Section 438.10 - Information requirements.

Subparagraph (c)(3) – Basic rules - website

We recognize the need for greater transparency in the management and operation of state MLTSS programs. In fact, most of our members do operate a website that provides – in various forms or another – much of the information that is required by this subparagraph.

This subparagraph will require States to include the following on its website:

- Enrollee handbook (438.10(g))
- Provider directory (438.10(h))
- Network adequacy standards (438.68(e))
- Annual EQR report (438.364(b)(2))
- Managed care plan contract (438.602(g)(1)
- Encounter data (438.604(a)(1))
- Data used to set actuarially sound rates, including managed care data (438.604(a)(2))
- MLR reports and data (438.604(a)(3))
- Managed care plan insolvency data (438.604(a)(4))
- Provider network documentation/files (438.604(a)(5))
- Ownership and control disclosures for plans and subcontracted providers (438.604(a)(6))
- Annual report of overpayment recoveries (438.604(a)(7))

We know that stakeholders and the general public will benefit from public disclosure of enrollee documents, as well as quality information. However, the most of the information in Section 438.608 is not appropriate for publication on a website. That section in fact specifically acknowledges that since it says that "the State must post on its Web site *or (emphasis added)* make available upon request the following documents and reports."

Encounter data is comprised of millions of individual, personally identifiable claim records; it is hardly appropriate for posting to the internet. Likewise, the data used for rate-setting may include proprietary financial information from each MCO and is also voluminous.

> **Recommendation**
> We recommend that CMS take the effort to specifically identify the types of information that they believe a State should make publicly available and call them out in this section. If CMS affirmatively decides that all the information in Section 438.608 is necessary and appropriate for public posting, we strongly urge modified language in 438.10(c)(3) that gives States the flexibility to post summaries of those data.

QUALITY

This section includes our comments on sections in Subpart E, including definitions, managed care quality program requirements and the quality rating system.

8. Section 438.320 – Definitions

External Quality Review

This definition includes the words "health care services." It does not reflect long-term services and supports and comes from a clinical point of view. As external quality review is one of the primary quality tools a state has for its managed care program, we believe it is a significant oversight to not reflect the broad scope of services that might be included in an EQR. We recommend striking the words "health care".

> **Recommendation**
> External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the ***covered*** services that an MCO, PIHP, or PAHP, or their contractors furnish to Medicaid beneficiaries.

Quality

Like the definition of external quality review, NASUAD believes that this definition is also focused almost exclusively on clinical health and does not have any clear references to long-term services and supports. The definition, in order to be broadly applicable to all services covered under a managed care contract, should reflect a broad understanding of health and well-being, including both quality of life and the ability to independently live and engage in community life. We recommend that descriptive adjectives that reflect solely health and clinical outcomes be struck from this definition.

> **Recommendation**
> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, or PAHP increases the likelihood of desired outcomes of its enrollees, ***which can include improvement in patient health, functional status, and quality of life,*** through:
> (1) Its structural and operational characteristics.
> (2) The provision of services that are consistent with current professional, evidenced-based knowledge.
> (3) Positive trends in performance measures and clinically significant results from interventions for performance improvement.

9. Section 438.330 - Quality assessment and performance improvement program

a. Subsubparagraph (a)(2)

NASUAD strongly supports the flexibility that CMS has provided in this subparagraph to permit States to both select their own performance measures (PMs) or performance improvement programs (PIPs), as well as request an exemption from Federally-mandated PMs or PIPs. Particularly in the LTSS arena, states are the innovators and leaders in quality measurement and performance improvement, while the federal government is just now turning its

attention to LTSS quality measurement. This language will allow states to continue to innovate as well as respond to the unique aspects of their LTSS systems.

b. Paragraph (b) - Basic elements of quality assessment and performance improvement programs.
We are pleased to see that subparagraph (5) addresses LTSS services specifically in a managed care plan's QA/PI system. This is important to ensure that quality programs do not continue to have a clinical focus. However, this entire paragraph is written from a medical/clinical focus, and seems to specify types of quality assessments a managed care plan must undertake. We recommend that those be struck, since states are in a much better position to provide guidance and/or requirements to managed care plans about their LTSS quality assessment mechanisms.

> **Recommendation**
> (5) Have in effect mechanisms to assess the quality and appropriateness of ***services*** furnished to enrollees using LTSS.

c. Subparagraph (d)(1) – Performance improvement projects
Like our comments on other paragraphs in this section, the language in this section continues to reflect language based in the clinical care arena. We offer suggestions below to make the language broader and relevant to LTSS programs.

> **Recommendation**
> **(1)** MCOs, PIHPs, and PAHPs must have an ongoing program of performance improvement projects that focuses on both clinical and nonclinical areas. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes, ***quality of life*** and enrollee satisfaction. Each project must include the following elements:
> (i) Measurement of performance using objective quality indicators.
> (ii) Implementation of interventions to achieve improvement in the access to and quality of care ***and services***.
> (iii) Evaluation of the effectiveness of the interventions.
> (iv) Planning and initiation of activities for increasing or sustaining improvement.

10. Section 438.334 - Medicaid managed care quality rating system
Subparagraph (a)(2) – components of quality rating system.
NASUAD has significant concerns about the elements included in this subparagraph. There is no significant recognition of LTSS, which is understandable since these elements were pulled from the Quality Rating System for Qualified Health Plans. While QHPs are required, as an essential benefit, habilitation services, it is widely understood that Medicaid is the primary payer of LTSS

services. It is not reasonable to expect that a commercial insurance measurement process would reflect that reality.

The three elements: (1) Clinical Quality Management; (2) Member Experience; and (3) Plan Efficiency, Affordability and Management will work for some managed care programs but not for others. We recommend striking "affordability" from the third element, since it is rarely relevant to Medicaid programs. We further recommend striking the word 'clinical' from the first element. We are pleased to see member experience as an element, as noted in our general comments about NASUAD's NCI-AD© member quality of life survey.

Recommendation

(a)(2) The quality rating system must be based on the following three components:

(i) Quality management ***for both clinical and nonclinical services;***
(ii) Member experience;
(iii) Plan efficiency and management.

STATE OVERSIGHT

This section includes our specific comments on network adequacy standards, readiness reviews, and managed care program reports.

11. Section 438.68 - Network adequacy standards.

Subparagraph (b)(2) – LTSS

Our members are sensitive to the access concerns of consumers that use LTSS services but object to the inclusion of time and distance standards for LTSS network providers. Network adequacy standards for long term care service providers are unique and different from other traditional types of service providers. In addition, they have significant variation internally, in that some long term care service providers conduct business in significantly different ways from other long term care service providers. As such, it is critical that states retain the primary role in developing network adequacy standards; states need flexibility to determine the appropriate standards that will hold managed care plans accountable for a robust network that is achievable given provider availability in each community. They feel strongly that time and distance standards – even for providers to which enrollees travel, such as adult day providers – is rigid and inflexible, and should not be imposed. In order for any standard to be meaningful, it must be responsive to different service/provider types and service setting/location. For example, many states offer participant-directed care, and the enrollee often chooses a friend or family member to provide attendant care services. States and MCOs that offer participant direction may not have a pool of providers to evaluate for network adequacy in traditional sense.

We recommend a more flexible approach that permits states to accommodate the realities of provider availability while balancing enrollee needs for reasonable access. CMS might assist in

helping to gather best practices across the country for such standards and provide technical assistance through the Medicaid Innovation Accelerator Program.

Recommendation

(2) LTSS. States with MCO, PIHP or PAHP contracts which cover LTSS must develop network adequacy standards ***that are cognizant of the existing provider community but that ensure appropriate and timely delivery of services.***

12. Section 438.66 - State monitoring requirements.

a. Paragraph (d) – Readiness reviews.

i. Subsubparagraph (1)(iv)

NASUAD is concerned that the requirement in subsubparagraph (1)(iv) to conduct a readiness review when a new benefit is added to the managed care contract is unnecessarily restrictive. There are minor changes in benefits that do not materially affect the ability of a managed care plan that is currently performing under its contract to provide new benefits. For example, adding certain LTSS benefits to an existing LTSS benefit package may not require any change in provider network or internal plan processes. We prefer that States be able to exercise their judgment on when a benefit change is significant enough to warrant a review of the managed care plan's ability to provide it.

Recommendation

(1)(iv) When any MCO, PIHP, PAHP or PCCM entity currently contracting with the State will provide benefits ***that require new types of providers or new plan policies and procedures*** to current or new eligibility groups; or

ii. Subsubparagraph (2)

NASUAD is also concerned about the timeframes for completion of and submission to CMS of readiness reviews in subsubparagraph (2). The specificity of the timeframes in this section are inflexible and do not permit states to conduct readiness reviews consistent with their resources. In addition, contract negotiations and signatures for some events in subparagraph 1 may not be completed 3 months prior to implementation date; readiness reviews can't be conducted until contracts are signed. Moreover, it appears from this language – although it is oblique – that CMS will use this information to determine approvability of contracts. We vigorously object to this new requirement, as it will add another administrative hurdle to implementation of a program modification. If the language remains – which we do not support - CMS should clarify here its meaning. If CMS intends to weigh in on the acceptability of a readiness review report with contracts possibly being held up, such intentions should be made explicit.

Recommendation

(2) The State must conduct a readiness review of each MCO, PIHP, PAHP, or PCCM entity ***in a timely manner so that there is sufficient*** time to ensure smooth implementation of an event described in paragraph (d)(1) of this section.

b. Paragraph (e) – Managed care program report

NASUAD objects to the new administrative burden imposed by the requirement in subparagraph (e)(1), and respectfully requests that CMS use other existing sources of data to procure the information sought in this report, rather than requiring another new report. If this requirement remains in the final rule, states should have more than 4 months after the end of the contract period to complete and submit it to CMS. Encounter data lags alone would necessitate a longer preparation and submission timeframe.

We recommend striking this new provision completely, or in the alternative, modifying it to provide a longer period of time for submission to CMS.

Recommendation for modified language

(1) The State must submit to CMS no later than ***eight months after the end of each contract year***, a report on each managed care program administered by the State, regardless of the authority under which the program operates. For States that operate their managed care program under section 1115 of the Act authority, submission of an annual report that may be required by the Special Terms and Conditions of the demonstration program will be deemed to satisfy the requirement of this paragraph provided that the report includes the information specified in paragraph (e)(2) of this section.

CONTRACTING AND PAYMENT ISSUES

This section includes comments on medical-loss ratio calculation, LTSS definitions and contract requirements, the IMD provision, provider payment initiatives and FFP for the beneficiary support system.

13. Section 438.8 - Medical loss ratio (MLR) standards.

Subparagraph (e)(3) – Activities that include health care quality

While we appreciate CMS' efforts to maintain consistency with Medicare Advantage and Marketplace standards for a MLR, we remain concerned about the cross reference in this subparagraph to the Marketplace requirements for quality activities that may be included in the numerator of a MLR calculation. As with most specifications in the Marketplace rules, it is heavily medically focused and outlines typical 'insurer' activities, including:

- Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives;

- Preventing hospital readmissions;
- Improving patient safety, reducing medical errors, and lowering infection and mortality rates;
- Wellness and health activities;
- Enhancing the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology

As you are aware, plans providing MLTSS spend money on all types of activities that are not medical in nature yet contribute to quality of life and improved outcomes for consumers. For example, would activities that are undertaken for consumers transitioning from a nursing facility, such as housing transition coordinators, or the costs of operating an electronic visit verification system for self-directed programs, be considered 'activities that include health care quality'?

They are not specifically called out in 45 CR 158.150(b), and are not applicable to subsubparagraphs (ii) and (iii) in this subparagraph. Moreover because this subparagraph also references exclusions in 45 CFR 158.150(c), States might be further disadvantaged since (c)(14) states that exclusions from activities that improve health quality are "Any function or activity *not expressly included in paragraph (a) or (b)* (emphasis added) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement."

If these activities were not included in the numerator, it will negatively impact a managed care plan providing LTSS services by lowering its MLR. That is counterproductive. CMS and the States do not want managed care plans to be disincentivized to undertake those activities that are not claim-based but that, in totality, allow the plans to deliver services consistent with a person-centered service plan and that lead to improved quality outcomes.

States are best positioned to determine which of these non-medical services are functioning as quality improvement activities in their program and for the populations served. Therefore, the final regulatory language must explicitly allow states to define the quality improvement services that would be included in the numerator. Further, state flexibility to define this element of the MLR will also ensure that the program can account for future unforeseen innovations in non-medical services that serve as quality improvement activities.
To ensure clarity and remove any ambiguity about the allowability of activities in the definition, we recommend the addition of a new subsubparagraph to the existing list in this subparagraph. A new (ii) in this subparagraph with current (c)(3)(i)(ii) and (iii) being renumbered as (iii) and (iv), respectively would provide more specificity around those LTSS activities.

Recommendation:

(e)(3)(ii) An MCO, PIHP, or PAHP activity that the State determines supports beneficiaries' needs, goals and preferences for daily living consistent with a person-centered planning process.

14. Section 438.2 - Definitions

Long-Term Services and Supports (LTSS)

NASUAD commends CMS for attempting to define LTSS – a term which has no commonly accepted definition. We understand that CMS for the first time is using a set of benefits included in a managed care contract to trigger a set of unique requirements for a managed care program. However, precisely because the definition is going to be used to determine a State's regulatory compliance, it is critical that the definition be broad enough but not too broad. A too-broad definition – for example, encompassing home health services or short-term rehabilitative services delivered in a nursing facility – may inadvertently activate the LTSS provisions throughout the rule. The focus of the current definition on setting of choice does not reflect the person-centeredness philosophy that CMS has been pursuing. Finally, the definition does not seem to encompass other activities that support an individual that are not residential in nature, such as adult day services. Recommended revisions to the definition are below.

Recommendation:

LTSS means services and supports, provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses ***expected to continue for at least ninety days***, which have the primary purpose of ***supporting beneficiaries' needs, goals and preferences for daily living consistent with a person-centered planning process***.

15. Section 438.3 - Standard contract requirements.

a. Paragraph (o) – LTSS contract requirements

This paragraph requires that LTSS provided in a managed care contract comply with the HCBS settings requirement in 42 CFR 441.301(c)(4). While we understand that this cross-reference is intended to ensure that LTSS provided under authorities other than those that are implicated by this regulation still comply with that regulation, we suggest that the approach needs modification. Section 441.301(c)(6) provides a transition period for HCBS programs to come into compliance with the provisions of (c)(4) – five years after the regulations' effective date. That has been interpreted by CMS to mean 2019. We fully expect that this rule will be finalized and effective sooner than that. Therefore, if this cross-reference stands without modification, states with MLTSS programs will effectively have less time to make the necessary changes to their provider system to become compliant with the settings rule than states that do not use a managed care delivery system. We can assume that CMS did not intend for that to happen. Our recommendation to fix this issue is below.

Recommendation:

(o) LTSS contract requirements. Any contract with an MCO, PIHP or PAHP that includes LTSS as a covered benefit must require that any services covered under the contract that could be authorized through a waiver under section 1915(c) of the Act or a State plan amendment authorized through sections 1915(i) or 1915(k) of the Act be delivered in settings consistent with § 441.301(c)(4)***-(6)*** of this chapter.

b. Paragraph (u) – Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease (IMD)

This paragraph permits States to explicitly provide payment to managed care plans for services delivered in an IMD. While a number of managed plans currently use IMDs to deliver services to enrollees, it has previously been done under the guise of services "in lieu of" covered contractual benefits. We support this shift in CMS policy as it provides more flexibility to managed care plans to provide services in the most cost-effective and efficient manner.

However, we object to the 15-day maximum stay included in this paragraph. While 15-days is preferable to the current situation, we are concerned that it will arbitrarily restrict care without regard to the patient or their individual treatment needs and is not patient-centered. Short-term stabilization for some illnesses can exceed 15 days, and such a limit imposes service authorization decisions that may not be in the enrollee's best interest. Understanding that the rationale for the exception is that the IMD services are part of a monthly capitation payment, we urge CMS to remove the 15-day maximum and instead require that the enrollee spend at least one day outside the IMD during the month when the capitation payment is made.

Recommendation:

(u) Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease. The State may make a monthly capitation payment to an MCO or PIHP for an enrollee receiving inpatient treatment in an Institution for Mental Diseases, as defined in § 435.1010 of this chapter, so long as the facility is an inpatient hospital facility or a sub-acute facility providing crisis residential services, and ***the enrollee does not reside in the Institution for Mental Disease for the entire month for which a capitation payment is made.***

16. Section 438.6 – Special contract provisions related to payment.

Subsubparagraph (c)(1)(iii) – Delivery system and provider payment initiatives

While this subsubparagraph suggests two permissible methods for the State to dictate payment parameters for the managed care plans' providers, our members have identified an additional method that is quite frequently used in MLTSS programs. In order to ensure contracting relationships between certain LTSS providers and managed care plans, and to minimize gaming and 'bidding up' payment rates, states are simply telling the managed care plans what they can

pay a certain type of provider. It is not a minimum, because that sets expectations that the managed care plans will pay above the state-set floor; it is simply the state's rate transferred to the managed care plans. We believe that this arrangement doesn't comport with either of the methods, and suggest adding language to permit such activity. While it certainly most used in MLTSS programs, it is a method that might be attractive for acute and primary care managed care programs for unique or 'captive market' providers who can demand exorbitant payment rates in exchange for managed care plan network participation.

Recommendation

(c)(1)(iii) The State may require the MCO, PIHP or PAHP to:

(A) Adopt ***specific payment rates for all providers that provide a particular service under the contract;***

(B) Adopt a minimum fee schedule for all providers that provide a particular service under the contract; or

(B) Provide a uniform dollar or percentage increase for all providers that provide a particular service under the contract.

17. Section 438.816 - Expenditures for independent consumer support services for enrollees using LTSS.

Since CMS is imposing a new requirement for a beneficiary support system with specific features for enrollees using LTSS, NASUAD appreciates CMS' clarification in this section that Federal financial participation (FFP) is available for the cost of that system. We request clarification that the FFP available is at the administrative match rate, rather than the service match rate.

TECHNICAL CORRECTIONS

Section 438.4(b) – recommend striking "do all of the following" so that list that follows can be read properly as complete sentences.

Section 438.6(c)(2)(F) – recommend striking "not to" and replace with "may not" so that the phrase makes a complete sentence when paired with the lead-in phrase.

Section 438.10(c)(3):

- recommend inserting after "§438.68(e)," "438.66(e)(2)," so that the requirement in §438.66(e)(3)(i) that the annual managed care program report be posted on the State website is reflected in the section where website content is specified.
- recommend inserting before "§438.364(b)(2)" "438.332(c)," so that the requirement in §438.332(c) that the final approval status for each managed care plan be posted on the State website is reflected in the section where website content is specified.

Section 438.56(d)(2)(iv) – recommend striking "MLTSS" and replacing with "LTSS", since MLTSS is not a defined term in this subpart.

Section 438.66(d)(1)(v) - recommend striking the word "contacting" and replacing it with "contracting", to correct the typographical error.

Section 438.66(d)(2)(iii) - recommend adding "(a)" after "438.3", since it is 438.3(a) that references CMS' approval of managed care contracts. The reference to the entire section is otherwise too broad and confusing.

Section 438.71(c)(1) – recommend striking "and" and replacing with ", as well as" to clarify that they are two separate groups that would receive choice counseling at different times and for different reasons.

Section 438.334(a)(3) – strike "(a)(1)" and replace with "(a)(2)" since the subparagraph refers to the quality rating system components in (a)(2).

Section 438.816 – recommend striking "independent consumer support services" in the section title and replacing with "beneficiary support system", so that the cross-reference to §438.71(e) uses the same terminology.

On behalf of NASUAD, thank you for the opportunity to comment on this proposed rule. While the recommendations provided above have been developed collectively by our members, we remind CMS that the many new requirements in the proposed rule will impact states in very different and dynamic ways. Therefore, we urge CMS to carefully consider the comments submitted by individual state agencies; they may provide more granular information on concerns and impacts.

We look forward to continuing to work with CMS on these issues throughout this rulemaking process and beyond. If you have any questions or concerns about these submitted comments, please do not hesitate to contact Camille Dobson, NAUSAD's Deputy Executive Director at cdobson@nasuad.org.

Sincerely,

Martha Roherty
Executive Director