

July 27, 2015  
Mr. Andy Slavitt  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2390-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

***Re: AHCA/NCAL Response to 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 Federal Register, Vol. 80, No. 104, June 1, 2015 [CMS-2390-P]***

Dear Mr. Slavitt,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents more than 12,000 non-profit and proprietary skilled nursing facilities (SNFs), assisted living communities as well as homes for individuals with disabilities. Thus, we play a critical role in Medicaid-financed long term services and supports (LTSS) delivery and programmatic development, both fee-for-service (FFS) and managed care.

As states continue to transform the payment and delivery of LTSS by shifting these services to managed care programs, it is critical to ensure that states and plans are equipped and able to provide high quality and cost-effective care for complex patients with varying needs. The shift from FFS to managed care has revealed a myriad of challenges for LTSS providers and beneficiaries which have created barriers to beneficiary access and choice. With the increasing presence of managed care, beneficiary and provider protections are critical to the delivery of patient-centered and quality care.

We appreciate the opportunity to comment on the proposed Medicaid managed care regulations. In providing input, we first offer general comments on themes that are present throughout the rule, and then address specific proposals as applicable.

We look forward to our ongoing dialogue with the Centers for Medicare & Medicaid Services (CMS) about Medicaid managed care as it relates to LTSS. If you have questions about any of our comments, please contact Mike Cheek at [mcheek@ahca.org](mailto:mcheek@ahca.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Michael W. Cheek". The signature is fluid and cursive, with a long horizontal stroke at the end.

[Transmitted Electronically]

Michael W. Cheek  
Senior Vice President, Reimbursement & Legal Affairs

## **General Comments**

### **COST SHIFTING IN MEDICAID MANAGED CARE**

The proposed rule includes several provisions that would require notable changes in operations and infrastructure for states and plans. AHCA/NCAL is concerned that increased financial pressure on plans will result in further erosion of provider reimbursement rates, thereby compromising providers' ability to deliver care.

Nursing facilities (NFs) rely heavily on Medicaid to pay for the services they provide to most of their patients – approximately 65 percent to 70 percent of nursing home residents are covered by Medicaid. Currently, the rates paid by states for Medicaid-covered services do not adequately reimburse the actual costs incurred by providers, resulting in a major disconnect between payment levels and the needs of the patients. Already in Medicaid fee-for-service (FFS), provider rates are inadequate. In 2014, the national average projected nursing home shortfall was \$24.26 per patient per day.<sup>1</sup> Under managed care, plans often seek to reduce reimbursement rates to its providers in order to contain costs. Should managed care plans further reduce rates, providers will be unable to adequately deliver needed services. AHCA/NCAL encourages CMS to specify that plans would be prohibited from shifting costs resulting from adherence to the proposed regulations to providers.

### **MANAGED CARE AUTHORITY**

AHCA/NCAL is encouraged by CMS's acknowledgement that the Medicaid managed care regulations should apply to all Medicaid managed programs regardless of authority, and not only those authorized under section 1932 of the Social Security Act. However, as written, it is unclear whether select provisions do not apply to all managed care programs. Specifically, CMS explicitly states that the proposed requirements apply in some sections, explicitly states that proposed requirements do not apply to all programs in others, and remaining sections do not indicate which program authorities the requirements address.

In order to reduce stakeholder confusion and ensure state and plan compliance with federal regulations, AHCA/NCAL requests that CMS clarify that all provisions apply to all Medicaid managed care program authorities, and to include language that exempts plans operating under certain authorities only in those sections that do not apply to all managed care program authorities. CMS may consider supplying a table indicating which provisions apply to which program authorities to provide additional clarification.

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<sup>1</sup> Eljay LLC and Hansen Hunter & Company. A Report on Shortfalls in Medicaid Funding for Nursing Center Care. March 2015.

AHCA/NCAL believes that standardized requirements across managed care authorities will better ensure that managed care programs operating under various authorities include beneficiary and provider protections to mitigate any unnecessary administrative and/or financial burden and reduce potential disruptions in care.

#### **ALIGNMENT WITH MA AND COMMERCIAL MARKET**

CMS indicates that the overarching goal of the proposed rule is to further align Medicaid managed care requirements with those of Medicare Advantage (MA) and the Affordable Care Act (ACA) Health Insurance Marketplace qualified health plans (QHPs). AHCA/NCAL appreciates CMS's intent to promote consistency and to coordinate the delivery of health care services across product lines, however, it is important to acknowledge that the needs of individuals served in Medicaid managed care, and particularly managed long term services and supports (MLTSS), are vastly different than the needs of the populations served by MA and the commercial market. In addition, the ability of many Medicaid beneficiaries to understand and navigate the complexities of managed care vary greatly from those served in the commercial market or MA.

While MA and QHP requirements can provide a basis for CMS to build upon, AHCA/NCAL urges CMS to instill tailored requirements to address the needs of beneficiaries receiving long term services and supports (LTSS) and the providers that serve them.

#### **PRESERVATION OF BENEFICIARY ACCESS AND CHOICE**

Throughout the preamble, CMS indicates that states with MLTSS programs would need to include standards that favor use of home and community based services. Specifically, the rule encourages states and plans to promote community integration in its sections on medical loss ratio (MLR), performance measurement, and beneficiary support services. While AHCA/NCAL understands CMS's intention of providing beneficiaries with an alternative to traditional LTSS, we are concerned that improperly incentivizing use of home and community based services may deter states and plans from ensuring that beneficiaries who are most appropriately served in a NF setting are able to access this level of care. AHCA/NCAL recommends that CMS promote incentives for states and plans to provide needed services in the most appropriate setting desired by the beneficiary.

## Detailed Comments by Section/Topic

### **LONG TERM SERVICES AND SUPPORTS DEFINITION (§ 438.2)**

AHCA/NCAL supports the inclusion of a definition for LTSS as it applies to managed long term care programs, and is defined as “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.”

### **CODIFICATION OF MANAGED LONG-TERM SERVICES AND SUPPORTS GUIDANCE (§ 438.2, § 438.3, § 438.70, § 438.71, § 438.214)**

AHCA/NCAL generally supports the codifying of MLTSS Guidance and adherence to the 10 elements CMS identified in the 2013 guidance and proposed regulation. However, we encourage CMS to consider that NFs are held to rigorous Requirements of Participation (RoPs) and several of the 10 elements described in detail in the preamble and incorporated into the proposed regulations are already addressed by the RoPs. We strongly encourage CMS to defer to the RoPs and the Nursing Facility Survey and Certification process, where relevant, rather than create a parallel system resulting in additional administrative burden to states and to NFs.

Following are examples of RoPs that address the 10 elements.

- Element 6: Person Centered Process: §438.02(c)

CMS currently requires all residents/patients of NFs to be assessed using a standardized assessment instrument (the Minimum Data Set or MDS) and a person-centered plan of care must be developed based on the MDS. The MDS must be updated on a regular basis as well as when there is a change in the resident’s/patient’s condition and the person-centered care plan adjusted as necessary. Continued use of this tool in the NF setting is appropriate and preferred to a new or additional process.

- Element 8: Qualified Providers §438.214(b)(1)

CMS currently certifies all NFs and conducts annual surveys to ensure compliance with the RoPs. We strongly encourage CMS to defer to the CMS certification for NFs in lieu of each state establishing a new credentialing and re-credentialing policy.

- Elements 9 and 10: Participant Protections and Quality §438.330(b)(5); §438.330(b)(6)

There are numerous protections for residents/patients of NFs within the RoPs. Facilities must report accidents/incidents to the State Survey Agency, which must then investigate each to assess the situation and determine if the facility addressed the issue appropriately and actions are consistent with RoPs. CMS may impose remedies (including civil money penalties) when it determines these are warranted.

There are also other protections for NF residents/patients contained in the Resident's Rights sections of the Social Security Act (§1819(c) and §1919(c)) and the RoPs (§483.10, §483.12, §483.13, and §483.15). AHCA/NCAL strongly encourages CMS to defer to these statutes and regulations that are currently monitored and assessed by CMS.

CMS is currently developing a proposed rule to advance the provision in the Affordable Care Act that requires each NF to develop and implement a Quality Assurance and Performance Improvement (QAPI) program. We strongly encourage CMS to defer to this QAPI program for NFs that participate in a Medicaid managed care program.

### **COVERAGE AND AUTHORIZATION OF SERVICES (§ 438.210)**

AHCA/NCAL applauds CMS's acknowledgement that the current regulations reflect an acute care model of health delivery and do not address medical management of individuals with ongoing or chronic conditions, including LTSS. AHCA/NCAL supports CMS's proposal to require that states must ensure that service authorization standards are appropriate for and do not disadvantage those individuals with ongoing chronic conditions or requiring LTSS. Appropriate utilization controls will help ensure that beneficiaries do not encounter barriers to access to needed services.

### **STANDARD CONTRACT REQUIREMENTS (§ 438.3)**

AHCA/NCAL firmly supports CMS's proposed provision to require that, in states that enter into a Coordination of Benefits Agreement (COBA) with Medicare for FFS, managed care plans enter into a COBA with Medicare and participate in the automated claims crossover process. Currently, providers that contract with Medicaid managed care plans that do not have COBAs with Medicare must submit separate claims for cost-sharing to the plans, creating significant administrative and financial burdens. In order to facilitate compliance with this requirement, CMS may consider allowing plans to use the State's COBA as a template rather than requiring states to negotiate new agreements.

### **CHOICE OF MCOs, PIHPs, PAHPs, PCCMs, AND PCCM ENTITIES (§ 438.52)**

AHCA/NCAL is concerned about CMS's proposal to change the definition of a rural area for purposes of the state option to contract with one managed care plan under mandatory Medicaid managed care programs. As CMS notes, this proposal would expand the number of areas that would be considered "rural," increasing the number of geographic areas that could limit enrollee access to a single managed care plan in those areas. AHCA/NCAL believes that this could result in a significant loss of beneficiary choice, access, and consumer protections. If this change is finalized, AHCA/NCAL urges CMS to also include the requirements outlined in the

January 13, 2014 guidance to Medicare-Medicaid plans (MMPs) participating in the Financial Alignment Initiative which states that, in service areas where only one MMP passes readiness review, CMS will not permit passive enrollment in that service area.<sup>2</sup> Additionally, beneficiaries in these areas should be permitted to continue receiving covered services through FFS if they do not elect to enroll in the plan.

### **SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT (§ 438.6)**

AHCA/NCAL supports CMS's proposals to allow states to require that plans adopt value-based purchasing models or participate in delivery system reform in order to incentivize plans *and* providers to collaborate on quality improvement activities. We agree that these models must use a common set of performance measures across all payers and providers to ensure comparability. In order to ensure that LTSS providers are prepared and able to perform well under these initiatives, AHCA/NCAL seeks clarity from CMS on the structure and design of the types of arrangements that would qualify for federal approval. AHCA/NCAL is in the process of developing guiding principles to aid CMS, payers, and providers in the advancement of value-based purchasing (VBP) strategies and methodologies for post-acute care and LTSS. Once finalized, we would be happy to share these principles with CMS to help inform VBP program design and management.

AHCA/NCAL also agrees that capitated payments to plans should account for incentive programs for providers. However, AHCA/NCAL strongly opposes CMS's proposal to allow plans to retain unspent funds designated for provider incentives, as this would discourage plans from allocating these funds to providers in order to increase plan revenue. This proposal, paired with CMS's proposed MLR provisions which would allow plans to retain funds in excess of the MLR threshold (discussed below), would create perverse incentives. The benefit of retaining unspent capitated funds, if not controlled by sufficient checks and balances on plans, could result in such plans being able to engineer incentive programs that are designed to disburse lesser amounts to providers, creating an unintended windfall. We do not think CMS intends to, nor is it appropriate to, reward plans for withholding payments intended for quality and outcome improvements. Earlier in the proposed rule, CMS states that plans would have control over the amount and frequency of incentive payments. This indicates that plans would have the autonomy to implement payment incentive arrangements that ensure that these funds are allocated to providers in a method that promotes quality and efficiency. In order to prevent inappropriate use of Medicaid funds, AHCA/NCAL recommends that CMS remove the provision that would prohibit the State from recouping any unspent funds allocated for these arrangements, and instead requires that the states and plans employ a methodology for the provider incentive allocation that ensures that

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<sup>2</sup> Centers for Medicare & Medicaid Services. CY 2015 Capitated Financial Alignment Demonstration Timeline. January 13, 2014.

all funds intended for provider incentive programs are disbursed to network providers.

In addition, AHCA/NCAL strongly urges CMS to require that the innovative payment methodologies implemented by states do not allow plans to reimburse providers at levels below the Medicaid FFS rate. Federal Medicaid statute requires that states set provider payment levels that are consistent with efficiency, economy and quality of care and sufficient to ensure that the beneficiaries have access to needed services.<sup>3</sup> As stated above, rates paid by states for Medicaid-covered services do not adequately reimburse the actual costs incurred by providers. Further reduction of these rates would compromise providers' ability to deliver quality care. Accordingly, AHCA/NCAL also encourages CMS to remove the requirement that the Agency must approve minimum provider payment fee schedules; as mentioned above, states are already required to meet federal requirements in the state plan to promote efficiency, access and quality.

AHCA/NCAL is also concerned that CMS's proposal would compromise states' ability to use provider assessments and other federally approved mechanisms to finance their Medicaid programs. Any such provision would be in direct conflict with CMS's intent to improve access and quality for beneficiaries enrolled in Medicaid managed care programs. Provider assessments have been used to expand coverage, offer additional benefits, and increase reimbursement rates, alleviating gaps in patient access caused by insufficient reimbursement. States have become increasingly reliant on provider assessments as a source of revenue for the Medicaid program. Without this source of funding, states that are already struggling to finance Medicaid and other programs would need to reduce other budget items to levels that may threaten the integrity of other state-funded programs.

Additionally, AHCA/NCAL urges CMS to include a provision which would minimize delays and disruptions to provider reimbursement during changes in enrollment that occur when LTSS is carved out of the Medicaid managed care program. For example, in states with managed care programs that cover only primary, acute, and post-acute care services, enrollees may receive coverage for a short-term skilled nursing stay (less than 100 days) through the Medicaid managed care plan, however, if the beneficiary needs to receive LTSS following the post-acute care stay, those benefits are covered through FFS. Delays in obtaining, processing, and confirming eligibility create significant disruptions to payment, leaving the facility to assume the costs of providing needed care. CMS, even within the context of managed care, should ensure states strictly adhere to existing Medicaid eligibility processing timelines already in law and regulation, for example at 42 U.S.C. 1396a(a)(8) and 42 C.F.R. §435, Subpart J.

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<sup>3</sup> (42 U.S.C. § 1396a (a) (30) (A))



Lastly, AHCA/NCAL encourages CMS to reevaluate current policies and procedures concerning patient-pay liability. Under FFS, NFs are required to collect the patient-pay (when applicable) as calculated by the state, county and/or other local authorities. This process creates a significant administrative burden for providers, as NFs are required to follow the various requirements to report patient-pay amounts and related details to each entity. These issues are intensified when an additional party is added under managed care arrangements, and resource amounts and related details are not processed by the managed care plans in time for proper determination of payments to the providers. This creates an additional administrative burden and often results in delays to accurate reimbursements. AHCA/NCAL encourages CMS to require that states hold the responsibility for collection of patient resources; providers would then be able to receive payments from the plans in accordance with terms of their contracts.

#### **MEDICAID MANAGED CARE QUALITY RATING SYSTEM (§ 438.334)**

In general, AHCA/NCAL supports implementation of a five star quality rating system for Medicaid managed care plans that seeks to assess plan performance in the categories of clinical quality management, member experience, and plan efficiency, affordability, and management. We also support CMS's proposal to, through a public notice and comment process, identify the performance measures to be required by states in contracts with managed care plans. We agree that obtaining consumer and provider input on selected measures is critical to ensuring that the quality rating system will inform beneficiary choice and provider quality improvement efforts.

AHCA/NCAL also supports CMS's proposal to require states to display the quality ratings of each plan to enhance transparency and consumer awareness. AHCA/NCAL encourages CMS to display the managed care plan quality ratings on the Agency's website in order to provide a resource for beneficiaries and providers in states with new or expanding managed care programs. The CMS-managed site would allow beneficiaries and providers to research plan performance in other states, and make educated enrollment and contracting decisions regarding plans that are new to the state.

However, while we support flexibility granted to states to pick their own performance measures, AHCA/NCAL disagrees with CMS's proposal to provide states with the option to select their own performance measures. Inconsistency in measures across states will create an additional burden and confusion for plans and providers that may operate in multiple geographic areas. In addition, inconsistency would create difficulties in data reporting and collection for purposes of comparing and evaluating state programs. If a state disagrees with the nationally identified measures, we believe that the state should be required to demonstrate why and how the performance measures they seek to adopt are superior to those identified in CMS's measure selection process.

In addition, AHCA/NCAL encourages CMS to revise the language in the proposed rule which encourages states to adopt the quality and performance measures used in the MA program for Medicaid managed care plans serving dual-eligibles. As CMS indicated in the 2016 Rate Announcement and Call Letter, researchers and the Agency continue to evaluate the relationship between dual-eligible status of a plan's enrollees and a plan's ability to achieve high star ratings and seek to identify the driving factors for the difference that has been observed in the preliminary research.<sup>4</sup> AHCA/NCAL believes that plans that serve dual-eligibles must be evaluated against distinct quality and performance measures related to the needs and characteristics of this population. Although dual-eligibles comprise only 14 percent of the Medicaid beneficiaries, this population accounts for approximately 40 percent of Medicaid spending.<sup>5</sup> Given the historically greater levels of utilization, higher per capita medical care costs and self-reported poorer health status than nondual-eligible beneficiaries, it is critical for federal and state policy makers to understand plan performance as it relates to the unique traits of the dual-eligible population.

In addition, AHCA/NCAL disagrees with CMS's proposal to allow states to apply for an exemption from certain performance improvement projects (PIPs) or metrics after achieving performance scores above the 90<sup>th</sup> percentile for three consecutive years. Failure to collect this data would affect the validity of the data and could compromise CMS's ability to accurately monitor and effectively monitor and evaluate program performance. We encourage CMS to continue to require data collection and reporting for those metrics so that national-level analyses of Medicaid managed care programs include this data.

AHCA/NCAL strongly believes that a Medicaid managed care quality rating system should not be based on a ranking methodology. Some states may have only a few plans and rankings may suggest differences that do not exist or may suggest that the top performing plans are doing well, when in fact their performance on the measures is poor. Rather, we recommend that CMS consider setting performance targets for each measure that are then used to determine a plan's overall performance. Using this methodology, all plans could receive a five-star rating or all plans could receive a one-star rating, and the rating would have significance relative to meaningful quality benchmarks. This approach would ensure that the ratings are meaningful to consumers and that plans are incentivized to achieve performance levels that have clinical meaning rather than statistical meaning.

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<sup>4</sup> Centers for Medicare & Medicaid Services. 2016 Rate Announcement and Call Letter. April 6, 2015.

<sup>5</sup> Kaiser Family Foundation. Issue Brief: Medicaid Moving Forward. March 2015.

### **ENCOUNTER DATA (§ 438.2, § 438.242, § 438.818)**

AHCA/NCAL strongly supports CMS's proposals to strengthen requirements and incentives for state submission of accurate and timely encounter data for purposes of program oversight and evaluation. Data consistency and comparability are essential as the presence of managed care continues to grow; researchers and policymakers will benefit from the ability to evaluate program performance.

However, AHCA/NCAL is concerned that CMS's proposed approach to defer or disallow payment only for those enrollees whose data are non-compliant, may not help CMS achieve intended goals. Specifically, AHCA/NCAL believes that this "sliding scale" of data penalties will cause contributors of data to choose a lower threshold for their data quality than CMS needs for its objectives. AHCA/NCAL believes that CMS should instead have a fixed data validity standard that data contributors must meet, or else they receive a fixed percent payment decrease. For example, if a state were to submit data found to be less than 95 percent valid then the state would receive a pre-determined across-the-board disallowance of payment. This would instantly remedy data quality problems and time delays. AHCA/NCAL urges CMS to revise the incentive mechanism to optimize data collection and reporting.

In addition, AHCA/NCAL believes that CMS should publish the encounter data in order to provide researchers and policymakers with the appropriate financial and clinical data to evaluate managed care programs and compare costs and outcomes with those in traditional Medicaid FFS. This is particularly important because the current pool of available literature does not provide conclusive findings about the impact of Medicaid managed care on costs, access or quality.<sup>6</sup> It is particularly important to ensure that researchers and policymakers have access to data that can be categorized by different Medicaid sub-populations in order to inform needed policy changes for dual-eligibles, the adult disabled population, etc. By modifying requirements in this way, and by using the best incentive mechanism available to incent data quality and timeliness, both CMS and the research community will be able to understand and inform future policymaking.

### **MEDICAL LOSS RATIO (§ 438.8)**

AHCA/NCAL strongly supports CMS's proposal to impose a federal minimum MLR in order to ensure that an adequate proportion of health plan funds are allocated to beneficiary care and quality improvement activities. We also applaud CMS's efforts to establish uniform definitions and standardized methodologies to calculate MLRs, as this will provide greater transparency to beneficiaries, providers, and policymakers assessing compliance with MLR requirements. However, due to the unique nature of LTSS and the vast difference between LTSS and services covered

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<sup>6</sup> Sparer, M. Robert Wood Johnson Foundation. Medicaid Managed Care: Costs, Access, and Quality of Care. September 2012.

under traditional MA plans and QHPs, AHCA/NCAL encourages CMS to reevaluate current definitions of services that qualify for expenditures on activities that improve health care quality for plans providing MLTSS. We agree that service coordination, case management, and community integration activities are important for all beneficiaries, including those receiving LTSS, however, we believe that there must be exact definitions for these activities to ensure clarity and reduce plan, provider and beneficiary confusion. AHCA/NCAL would welcome the opportunity to work with CMS and other stakeholders in the development of definitions for these and other services that may qualify for expenditures on activities that improve health care quality.

In addition, AHCA/NCAL is concerned that the proposed provisions would not require states to collect remittances from plans that are unable to satisfy the MLR requirement. Although CMS indicates that these states would need to take into account past MLRs in future rate development, exempting states and plans from this requirement may hinder CMS's intent to improve and standardize accountability procedures across markets. AHCA/NCAL encourages CMS to revise the current proposed language to require that plans in violation of MLR requirements remit excess funds to the state.

#### **NETWORK ADEQUACY STANDARDS (§ 438.68)**

AHCA/NCAL appreciates CMS's proposal to set threshold standards for the establishment of network adequacy measures to ensure beneficiary access and provider availability. As highlighted in recent Office of Inspector General (OIG) report, *"Access to Care: Provider Availability in Medicaid Managed Care,"* time and distance standards are not adequate indicators of access.<sup>7</sup> We support CMS's inclusion of standards beyond time and distance standards, such as the ability of health care professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities, to ensure access for all Medicaid beneficiaries.

AHCA/NCAL also appreciates CMS's recognition of the need for specialized network adequacy standards for LTSS providers. However, due to the complex and varying needs of populations requiring LTSS, AHCA/NCAL believes that these beneficiaries would be best served by states employing an "any willing provider" approach, which would allow beneficiaries, along with their families and caregivers, to select services from any LTSS provider that satisfies the state's RoP criteria. Most states have adopted Certificate of Need (CON) programs to regulate the number of NFs in a designated area and ensure that NF availability is based on the needs of the population. As a result, states have already determined the appropriate number of NFs needed to comprise an adequate network. AHCA/NCAL strongly encourages

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<sup>7</sup> Office of Inspector General. *Access to Care: Provider Availability in Medicaid Managed Care*. December 2014.

CMS to include an “any willing provider” provision for LTSS providers in the final rule, as this approach increases continuity of care and preserves existing beneficiary/provider relationships.<sup>8</sup>

### **MONITORING AND OVERSIGHT (§ 438.66)**

AHCA/NCAL applauds CMS’s efforts to enhance state monitoring and oversight capabilities, particularly as recent analyses by the Office of Inspector General (OIG) indicate that additional oversight is needed to ensure compliance with federal regulations.<sup>9,10</sup> AHCA/NCAL strongly supports CMS’s proposal to require that states provide an annual program assessment report no later than 150 days after the end of the managed care plan’s period of performance. We also agree that the annual assessment should be posted publicly so that all stakeholders, researchers, and policymakers are able to review and assess the information collected.

In addition, AHCA/NCAL strongly supports CMS’s proposal to strengthen readiness review standards. Although states currently require plans to meet certain criteria prior to implementation, current requirements do not address the state’s processes for verification and validation. Providers in several states have reported that, despite having met readiness review requirements, plans were unprepared for program implementation, leading to major disruptions in vital processes – particularly in claims processing and payment, and enrollment verification. Some providers went unpaid for months as plans learned to process their bills. AHCA/NCAL/NCAL believes that more specific requirements for readiness review would forestall these problems and avert service interruptions.

To further ensure plan readiness, AHCA/NCAL encourages CMS to expand the readiness review period from three months as proposed to six months. This modification will allow plans to formalize and/or revise their provider agreements, hire new staff, conduct training, test their systems, etc., well before implementation or expansion of the managed care program.

### **GRIEVANCES AND APPEALS (§ 438.4)**

AHCA/NCAL applauds CMS’s efforts to improve beneficiary protections related to plan grievances and appeals processes. Specifically, AHCA/NCAL agrees with CMS’s proposals to align the Medicaid managed care grievances and appeals process with those of MA and QHPS with respect to limiting the internal plan appeal process to only one level of appeal, allowing a provider to request an appeal on behalf of a

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<sup>8</sup> Center for Health Care Strategies. Technical Assistance Brief. Developing Provider Networks for Medicaid Managed Long-Term Services and Supports Programs: Considerations for States. July 2013.

<sup>9</sup> Office of Inspector General. Not All States Reported Medicaid Managed Care Encounter Data as Required. July 2015.

<sup>10</sup> Office of Inspector General. State and CMS Oversight of the Medicaid Managed Care Credentialing Process. November 2013.

beneficiary without the beneficiary's written authorization; and allowing the beneficiary to file a grievance at any time. AHCA/NCAL also supports CMS's proposals to shorten the time frames required for plan appeal determinations.

In addition, AHCA/NCAL agrees with CMS's proposal to allow beneficiaries receiving services from non-emergency medical transportation (NEMT) prepaid ambulatory health plans (PAHPs) to continue to have direct access to the state fair hearing process to appeal adverse benefit determinations, as many LTSS beneficiaries depend on these services to obtain access to needed care. The timeliness of these services are critical to beneficiary quality of life and well-being.

In accordance with our support for beneficiary access to the state fair hearing process, AHCA/NCAL urges CMS to remove the proposed provision that would permit beneficiaries enrolled in other types of managed care plans (MCOs, PAHPs, PIHPs, PCCMs, PCCM entities)<sup>11</sup> to request a state fair hearing only after exhausting the plan's single level of appeal. Many states currently allow beneficiaries access to a state fair hearing upon an initial adverse benefit decision, which affords beneficiaries with immediate independent review of an adverse decision. Denying immediate access to this route of appeal could have significant implications for beneficiary access to services.

In addition, AHCA/NCAL is concerned about CMS's proposed provisions which would allow plans to recoup payments from beneficiaries for services furnished during the appeal or state fair hearing processes. Beneficiaries served under Medicaid managed care are typically medically and socially vulnerable, and this provision, if adopted, could deter beneficiaries from seeking an appeal and/or obtaining needed services. AHCA/NCAL urges CMS to revise these provisions to prohibit plans from collecting recoupments in the event of an adverse benefit determination that is upheld after an appeal or state hearing process.

We are also concerned that the current provisions regarding expedited appeals do not include living arrangement disruption as an indicator warranting an expedited appeal resolution. For beneficiaries in LTSS, this disturbance could create stress and harm to beneficiaries and their families. Therefore, we recommend that CMS require that expedited appeals be made available in cases that include potential loss or disruption of residence.

AHCA/NCAL observed that there is no mention of appeals and/or grievance processes for network providers. Currently, any appeals and/or grievance processes (if included) are defined by the health plans in contracts with providers, leaving providers with no avenue to voice and/or address concerns in instances where the plans internal processes fail. In addition, providers have indicated that

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<sup>11</sup> Managed care organizations, prepaid ambulatory health plans, prepaid inpatient health plans, primary care case management, primary care case management entities

there is a broad-reaching fear that any appeal or grievance action will result in termination of contract or loss of preferred network status. We strongly urge CMS to require that states develop standards for appeals and grievance processes for providers to ensure that there are sufficient opportunities for providers to raise issues that must be addressed by the state and/or CMS with respect to plan performance and compliance. At a minimum, a state's Medicaid FFS provider grievance and appeals processes should apply to Medicaid managed care.

### **MANAGED CARE ENROLLMENT (§ 438.54, § 438.56)**

AHCA/NCAL supports CMS's proposal to implement minimum standards for mandatory managed care enrollment, and agrees that states should be required to allow enrollees to continue coverage under FFS during the plan selection process. However, AHCA/NCAL encourages CMS to expand the proposed 14-day FFS period to 60 days, which aligns with the time period allowed under open enrollment in MA. For beneficiaries receiving LTSS, an extended period is even more critical to ensuring beneficiary understanding and choice, particularly if the individual is disabled or cognitively impaired.

In addition, in proposed 438.54(c)(2)(i) and 438.54(c)(2)(ii) CMS proposes that, under voluntary managed care arrangements, beneficiaries that do not select a plan during the designated time period would be enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity using the state's "default process" or a passive enrollment process. This provision appears to be contradictory to the intent of a voluntary managed care program. The transition to managed care already creates uncertainty, confusion, and concern for many beneficiaries, and can be especially challenging for individuals with low health literacy and/or cognitive impairments. If adopted as written, this provision would create significant confusion in beneficiaries' understanding of their coverage options in a voluntary managed care program. In addition, if a certain provider or providers are not included in the plan network, this would result in disruptions to care. In order to ensure alignment with the definition, AHCA/NCAL strongly encourages CMS to revise this language to require that beneficiaries remain in fee-for-service if they do not select a managed care plan.

In addition, CMS proposes that under both voluntary and mandatory managed care programs, passive enrollment processes must seek to preserve existing provider-beneficiary relationships based on data from the previous year, and suggests that states may consider additional criteria. AHCA/NCAL urges CMS to revise this provision for MLTSS programs to require states to include LTSS beneficiaries' current needs in passive enrollment criteria. For beneficiaries just transitioning to LTSS settings, this will mitigate unnecessary disruptions to care.

AHCA/NCAL commends CMS's proposal and associated rationale to allow beneficiaries to disenroll from a plan if the beneficiary would be required to change their residential, institutional, or employment supports provider based on the

provider's change in status from an in-network to an out-of-network provider. Many beneficiaries receiving LTSS rely on their providers for services beyond medical care; this provision would reduce potential disruptions in housing and employment.

However, AHCA/NCAL is concerned about CMS's proposal to allow beneficiaries to disenroll from a managed care plan without cause during the initial 90 days of enrollment. Plan switching creates a significant level of confusion regarding coverage and service authorization for both beneficiaries and providers. We understand that there are valid circumstances for switching plans (e.g., change in institutional or residential provider network status), but we respectfully request that CMS specify these circumstances in lieu of permitting beneficiaries to disenroll without cause.

### **HEALTH INFORMATION EXCHANGE (HIE) (§ 438.242)**

AHCA/NCAL agrees with CMS's statements on the importance of meaningful adoption of health IT and health information exchange in NFs and the role it plays in the access to and sharing of important health information across settings of care. AHCA/NCAL would support any efforts to provide states the flexibility to develop incentive programs for LTSS providers in the adoption of health IT.

AHCA/NCAL also agrees that uniform standards around health information exchange and health IT interoperability must be agreed upon and widely adopted by all stakeholders in order to be effective. In the preamble of the proposed regulation, CMS recommends that states employ "best available standards" from the Office of the National Coordinator's (ONC's) 2015 Interoperability Standards Advisory document, and alludes to potential future guidance that may address state adoption of these standards. However, AHCA/NCAL is concerned that these "best available standards" have been designed to align with the requirements for Meaningful-use incentives, LTSS providers may lack the resources and/or infrastructure to meet these standards. Because NFs were excluded from these incentive programs, there have never been strong incentives to build or conform these systems to meet the functionality standards around health IT and health information exchange that are characteristic of Meaningful Use-eligible providers.

CMS should recognize that many LTSS providers already have invested considerable resources into adopting certain health IT systems and then customizing them to meet their needs, which are often different from the needs of hospitals and physician practices who participate in the Meaningful Use program. Many of these systems are home-grown. If, in future rulemaking or subregulatory guidance, CMS were to enforce requirements or design incentive programs based on compliance with criteria that is tied to the Meaningful Use program, it would place a tremendous financial and administrative burden on these providers, with a



disproportionate amount of that burden falling on smaller and independently operated facilities.

### **SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION (§ 438.230)**

AHCA/NCAL supports CMS's proposal to codify standards to address the ambiguity pertaining to delegation of health plan responsibilities to subcontractors and other parties. Due to the prevalence of these relationships, it is imperative that plans maintain accountability for complying with all terms of contracts with the state. However, AHCA/NCAL strongly recommends that CMS reevaluate the proposal to adopt the standards applied to MA plans and first tier, downstream, and related entities.

Under MA, beneficiaries and providers are often unaware of the contractual relationships between plans and subcontracted entities, creating significant confusion and unnecessary inconvenience. Beneficiaries and providers often experience difficulty reaching or communicating with plan subcontractors, resulting in significant delays and/or inappropriate denials for authorization and/or payment for needed services. In several instances, providers have also received information from subcontracted entities that was in direct conflict with language contained in the contract between the provider and the MA plan. AHCA/NCAL is also concerned that MA plans are increasingly delegating clinical decision-making authority to entities with a limited understanding of the needs of the enrolled populations.

To address these issues and to mitigate delays and disruptions to care in Medicaid managed care, AHCA/NCAL urges CMS to apply standards above those required in the MA program. Specifically, CMS should require that plans disclose all subcontractual relationships, and the responsibilities delegated to those entities, to CMS, the state, providers and enrollees in writing prior to provider contracting and beneficiary enrollment. Additionally, to ensure operational consistency and compliance with provider contract terms as well as state and federal statutes plans should be prohibited from entering into these relationships during the plan year.

In addition, AHCA/NCAL encourages CMS to apply MLR requirements to subcontractual relationships and delegated entities for purposes of MLR calculations. Otherwise, plans may be incentivized to enter into subcontractual relationships with other entities to ensure that these expenditures are reported entirely in incurred claims, even if some portion of the expenditure has an administrative nature and/or relieves the plan of administrative expenses it would incur on its own. Managed care plans could employ this strategy to increase the amount of total revenue allocated to administrative expenses, negating the intent of the MLR requirement.

**COMPREHENSIVE STATE QUALITY STRATEGY (§ 431.500, § 431.502, § 431.504, § 431.506, AND § 438.340)**

AHCA/NCAL supports CMS's proposal to require that states develop a comprehensive quality strategy to address and support efforts to strengthen quality in Medicaid managed care, and that the quality strategy must include MLTSS when applicable. Further, AHCA/NCAL strongly supports the proposed addition of a State Medical Care Advisory Committee to the existing list of persons and entities from which the state would obtain input when developing the comprehensive quality strategy.

As managed care programs evolve, states and plans will need to address unanticipated events resulting from changes in health care utilization, market composition, and the regulatory environment. All stakeholders will undoubtedly benefit from working collaboratively with beneficiaries, stakeholders and other interested parties through sharing of knowledge, expertise, and unique perspectives.

Due to the unique nature of LTSS and the populations that use these services, AHCA/NCAL encourages CMS to require inclusion of long term care providers in stakeholder representation on the Advisory Committee and other relevant entities. Effective management and planning of LTSS is critical to support the needs of beneficiaries. Long term care providers can serve as an excellent resource and have wealth of knowledge, expertise and perspectives with regard to the delivery of Medicaid services. This-on-the-ground knowledge is invaluable to partake in identifying quality improvement goals and selecting the best approach to achieve better health outcomes.

In addition, we urge CMS to require states to consider the needs of dual-eligible beneficiaries in the development, evaluation, and revision of comprehensive quality strategies. Specifically, the quality strategy should include discussion of efforts to further alignment between Medicare and Medicaid services in order to enhance quality and coordination across programs.

**BENEFICIARY SUPPORT SYSTEM (§ 438.71)**

AHCA/NCAL commends CMS for proposing that states create and implement a beneficiary support system and specifying that beneficiaries requiring LTSS will need services beyond those of other managed care enrollees. We support CMS' efforts to improve coordination of care for beneficiaries as well as steps which support beneficiary choice among LTSS settings and provide an emphasis upon person-centered planning.

AHCA/NCAL particularly appreciates CMS's reference to the need for "ombudsman services." Several states, including California and Minnesota, have created Ombudsman offices for managed care that serve as a resource to resolve issues

between managed care enrollees and their health plans. AHCA/NCAL would support requirement for an Ombudsman office in each state that is dedicated to serving as an objective source for addressing managed care issues

CMS's proposed language for choice counseling for MLTSS also indicates that this service will be provided by an enrollment broker or other staff serving in this function. AHCA/NCAL supports CMS's efforts to ensure that qualified individuals are serving as choice counselors, and encourages CMS to include additional language to ensure that these individuals have qualifications above those of traditional enrollment brokers and demonstrate a sufficient understanding of the needs and issues that are prominent among the LTSS population. For example, individuals providing choice counseling services for LTSS beneficiaries should possess a deep understanding of how to navigate Medicare and Medicaid systems for dual-eligibles as well as extensive knowledge about the full array of services and providers included in LTSS.