July 27, 2015

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

Attention: CMS-2390-P – Filed via www.regulations.gov

Re: 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 (CMS-2390-P)

Dear Mr. Slavitt:

The Alliance of Community Health Plans (ACHP) is pleased to respond to the Proposed Rule referenced above, published in the *Federal Register* on June 1, 2015.

ACHP is a national leadership organization that brings together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care in their communities. Member plans provide coverage for more than 18 million Americans in the commercial market and for Medicare, Medicaid, and federal, state, and local public employees. Members also provide administrative services for self-insured employers. The community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, patient-centered medical homes, accountable health care delivery, information technology use, and other innovations to improve affordability and the quality of care that patients receive.

Introductory Comments

ACHP supports CMS' efforts to improve the alignment of rules, when applicable and reasonable, that apply to Medicaid plans with those that apply to Medicare Advantage (MA) plans and to other plans offered in the private market for health insurance. Better alignment of those rules will reduce

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inefficiencies in plan operations and improve transitions for people who move in and out of Medicaid and CHIP coverage or are dually eligible for Medicaid and Medicare coverage. Better alignment of rules will also help enrollees understand how to access processes such as grievances and appeals, because those processes are similar across the many types of health plans they may encounter. ACHP also supports aligning CHIP rules, when applicable and reasonable, with the proposed changes to Medicaid. We appreciate the thoughtful consideration of the many difficult issues addressed in the Proposed Rule and offer a number of recommendations for changes.

Note: ACHP's recommendations and concerns are highlighted in italics.

Rate Development Standards (§438.5)

ACHP generally supports the provisions of this section related to the development by the states of actuarially sound Medicaid capitation rates. It is in everyone's interest that the capitation rates be actuarially sound and sufficient to ensure access to the full range of services. The proposed standards would advance that objective. We have concerns, however, that the proposed transparency standards are not sufficiently far reaching and that certain provisions of the specific proposed standards are in need of greater clarity or modification.

Transparency of data and assumptions*.* We appreciate CMS' efforts in this proposed rule to provide for greater transparency in the rate setting process between the states and the federal government and between the states and managed care organizations (MCO) that contract with the states to provide Medicaid services. Requiring states to use standardized definitions and data components in their rate development process will help shed light on what is often a very non-transparent process and afford plans a better understanding of the actuarial assumptions factored into the capitation amounts. *ACHP recommends that the assumptions, data and methodology for determining the capitation rates should be complete and readily accessible to plans and other stakeholders*. Further, increased *transparency with respect to the calculation of administrative loads would be especially welcome* since this information historically has been difficult to obtain from some states. Greater transparency in the rate setting process will strengthen program integrity for all stakeholders, and CMS should ensure that all stakeholders have access to the information that determines actuarially sound capitation rates.

Definition of risk corridors*.* Under current regulations, a risk corridor is defined as a "risk sharing mechanism in which states and contractors share in both profits and losses under the contract outside of a predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the state contributes a portion toward any additional losses, and receives a portion of any additional profits." CMS notes in the proposed rule's preamble that because states apply risk corridors that apply to profits or losses, it is proposing to give states flexibility by modifying the definition of risk corridor at §438.6(a) to mean "a risk sharing mechanism in which states and contractors may share in profits or losses under the contract outside of a predetermined threshold amount." *ACHP opposes this proposed change and urges CMS to retain the existing language*. States should be encouraged to pursue a fair policy in the setting of risk corridors, balancing their constraints on plan profits with constraints on plan losses. A fair risk corridor policy should address both profits and losses in order to protect public funds

and beneficiaries' care, because while the corridor on plan profits safeguards taxpayer dollars, the corridor on plan losses ensures beneficiaries' access to needed care and services.

Use of timely data for rate development. Under proposed §438.5(c), CMS would require states and their actuaries to use timely data in the rate development process. "Timely" is defined to mean the three most recent and complete years prior to the rating period. A state could seek an exception on the basis that it was unable to base its rates on such timely data. To qualify, a state would have to request approval for an exception indicating the reasons why an exception is needed. States that request an exception from the base data standards would have to have a corrective action plan to come into compliance with the base data standards no later than 2 years from the rating period for which the deficiency was identified. *ACHP believes that two years of historical data should be a sufficient starting point for rate setting and urges CMS to adopt that change in the final rule*.

Opportunities to appeal a state's rate setting process and/or methodology. *ACHP urges CMS to include in the final rule a provision establishing a process through which an MCO could request an appeal to CMS of the actuarial soundness of a state's MCO rate setting process and/or methodology*. The opportunity for such an appeal should be made available at the time of the initial establishment of the rate and during the rate period, as appropriate to the MCO's particular circumstances.

Special Contract Provisions Related to Payment (§438.6)

ACHP supports CMS' proposed modifications to current regulations under this section, including retaining the existing 105 percent limit of the certified capitation rate on incentive arrangements in §438.6(b)(2). *We also support the proposed addition in §438.6(b)(2)(v*) that incentive arrangements have to be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. This is consistent with our member plans' commitment to the goals of quality improvement and value based payment. We seek clarification though whether individual providers can receive more than 5 percent of the approved capitation as long as the overall 5 percent ceiling across all providers is met.

We are concerned, however, that CMS' proposed new standard related to withholds may allow for too much subjectivity in implementation and compliance. CMS would require in new (b)(3) that "Contracts that provide for a withhold arrangement ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PHIP's [prepaid inpatient health plan], or PHAP's [prepaid ambulatory health plan] financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves…." *We urge CMS to develop a standard for "reasonably achievable" that is less likely to lend itself to varying interpretations*. One approach would be for CMS to look to historical performance or to projected performance to establish what is within reason.

MLR Standards (§438.8)

ACHP appreciates that CMS has proposed to establish federal minimum standards related to Medicaid managed care plan Medical Loss Ratios (MLRs). *We support the proposed requirements on states that they ensure that each covered entity calculate and report an MLR* using the specific definitions of terms (such as those related to credibility) that are called for under the proposal. Having standardized definitions will facilitate plan compliance and assure stakeholders that the reported MLRs are reliable and comparable.

Treatment of Advanced Payment Models. With respect to the proposed methodology for calculating the MLR, *we urge CMS to provide more clarity on how advanced payment models (specifically, shared savings and losses under those models) should be treated in calculating both numerators and denominators*. We also recommend that the differences in how the Medicaid MLR is calculated versus how it must be calculated for other CMS-regulated products be compared and clarified.

Treatment of Community Benefits in the Calculation of the MLR. *ACHP supports CMS' proposal in paragraph (f)(3)(v) to allow Community Benefit Expenditures (CBEs), as defined in 45 CFR 158.162(c) (analogous to the definition in §422.2420(c)(2)(iv)(A)), to be deducted* up to the greater of 3 percent of earned premiums or the highest premium tax rate in the applicable state multiplied by the earned premium for the MCO, PIHP, or PAHP. We appreciate that CMS recognizes that tax-exempt MCOs would be put at a disadvantage if expenditures for community benefit (CB) activities, required under federal statute on tax-exempt status, were not deductible from premium revenue in the MLR denominator, in a manner that is similar to the deduction for taxes. We encourage CMS to retain in the final rule this important provision so as to ensure an even application of the MLR across the country, since the level of state premium taxes varies (sometimes even within a state) and some states do not impose premium taxes.

Treatment of Remittances. In those states that elect to implement remittances for MCOs that fail to the meet the minimum MLR, *we urge CMS to provide that the rules for calculation of the remittances are simple and clear and that they do not result in additional reporting burdens on the MCOs*.

Level of Aggregation. ACHP notes that proposed paragraph (i) related to the aggregation of data for purposes of calculating the MLR would require that the MCO, PIHP or PAHP aggregate data for all Medicaid eligibility groups covered under the contract with the state unless the state required separate calculation for specific populations. We appreciate the flexibility that this language implies for states to determine how their plans' MLR data are aggregated. However, *we encourage CMS to add a cautionary note for states in the final rule's preamble about the problems that may result from establishing an aggregation level that is too granular*, which may produce significant MLR anomalies for some plans, especially in their early years.

Information Requirements (§438.10)

ACHP supports CMS' efforts to clarify information standards and to update those standards to specifically recognize that current technology offers advances that can provide beneficiaries with improved access to plan information. Electronic communications enable plan information to be updated more quickly and provided to beneficiaries more timely and at a lower cost. ACHP appreciates that under this proposed rule, plan materials may be made available electronically and without specific requests from beneficiaries designating that the electronic format is preferred. To better align with Medicare plans, we encourage a similar flexibility be applied to MA plans so that beneficiaries who are dually eligible for both Medicaid and Medicare, and who are enrolled in special needs plans do not have to specifically request to receive information electronically.

ACHP also supports CMS' proposed requirement to ensure that plan materials are available in all prevalent non-English languages defined in §438.10(a) as those spoken by a significant number or percentage of enrollees and potential enrollees. CMS does not, however, propose to establish a specific threshold for the number or percentage of enrollees that would make a language "prevalent," thereby, leaving that standard to states to define. ACHP is concerned that each state will set different standards for the languages in which plan materials must be provided and those different standards would be especially difficult to achieve for plans that offer coverage for beneficiaries in multiple states. *ACHP recommends that CMS establish a single standard threshold for prevalent languages based on a percentage of the population*. CMS could look to existing rules applicable to Medicare MA plans and to private health insurance plans.

CMS proposes in §438.10(h)(3), timelines for updating provider directories. In that subparagraph, CMS proposes that paper provider directories must be updated at least monthly and electronic directories must be updated within 3 business days of receiving updated provider information. With respect to updating paper directories monthly, many plans no longer maintain a stock of paper materials that sit on a shelf and would, over time, become out of date as providers move in and out of its network. Those materials are maintained in a more up to date fashion online. As a result, *we recommend eliminating the requirement to produce updated written materials within 30 days*.

With respect to the proposed 3-day timeline for updating provider directories online, ACHP members are concerned that 3 days is an unreasonably short turnaround time and that meeting such a quick standard will not be possible. *We recommend increasing the timeline for updating electronic directories to within 5 to 7 business days*.

ACHP members are also concerned about proposed requirements in this section to post provider directories in a machine readable format. *We acknowledge and generally support CMS' proposals intended to increase transparency* and share its hope that making this information available will encourage the creation of innovative tools to make health plan information more accessible and useable for beneficiaries. *We encourage CMS to proceed with caution, however*. Designing a transparent system with useful data will depend on CMS making the submissions uniform across all types of plans, products, and payers, and making those submissions simple both for plans to submit as well as for end users to access and understand. In addition, protecting the security of plans' websites, and the privacy of providers and users of such data must be high priorities. Finally,

CMS must ensure that the integrity of the data is maintained so that the information that is made available cannot be altered by users.

Managed Care Enrollment (§438.54)

In new subparagraph 483.54(c)(1), CMS proposes changes to ensure that individuals, whether they voluntarily enroll in managed care plans or are required to do so, and whether they actively choose their plan or are passively enrolled by the state, have an opportunity to make an active choice. In the case of a passive system, the state would be required to provide a period of 14 days for potential enrollees to decline the plan selected for them and to select a different plan. In states where enrollees have a choice of plans or a choice between managed care and the fee-for-service (FFS) delivery system, they would be entitled to at least 14 days of FFS coverage while they exercise their election. Any default enrollment for beneficiaries not making a choice would take place after the end of the 14-day (or longer) choice period.

ACHP requests that CMS clarify that under this proposal states, and not managed care plans, are responsible for the FFS payments for medical services used by beneficiaries who are in their choice periods. *We also urge CMS to allow states the flexibility to determine when and how individuals become enrollees*. Some states operating a State-Based Marketplace have a goal to streamline their processes and have their Marketplace system conduct Medicaid MCO enrollment. Assuming this Marketplace function works as intended, this would alleviate the need for a 14-day choice period, since enrollees would make their plan choice during the online decision process in which they are verifying their eligibility and comparing plans.

Readiness Reviews (§438.66(d))

CMS proposes in §438.66(d) to require states to conduct readiness reviews of managed care plans prior to the effective date of new or modified managed care programs. The reviews would be required to begin at least 3 months before enrollment begins or before enrollment of new groups begins or when the managed care organization is expanding coverage into new geographic areas and they would need to be submitted to CMS.

ACHP does not support these provisions as they raise a number of concerns for plans. Many state legislatures, when in session, routinely modify Medicaid managed care requirements. This can mean that minor modifications for most or many of a state's Medicaid managed care plans are an annual or semi-annual event. ACHP urges CMS to take this kind of activity into account to clarify that *minor modifications should not trigger a need for a readiness review*. Without such a clarification, the routine changes that result from state legislative activity could result in disruption for beneficiaries' delivery systems, and consequently their care and services, each time a state legislature meets. In addition, *ACHP recommends that CMS clarify that when a review for a modification is required, the review is only for that change and does not re-open all plan characteristics, coverage, and features to a renewed readiness review*.

ACHP also recommends changes to timelines for readiness reviews. State legislatures often require that modifications to Medicaid managed care policies go into effect very quickly. This would make the requirement that readiness reviews begin at least 3 months prior to enrollment (or prior to

implementing the change in benefits) impossible in some cases. We recommend that the timeline for such reviews be made more flexible to account for such a situation.

Network Adequacy (§438.68)

ACHP recognizes the need for appropriate standards and review of network adequacy so that enrollees are assured of access to providers. We appreciate CMS' efforts to modernize the regulatory framework for network adequacy in Medicaid managed care while maintaining state flexibility. However, *ACHP is concerned that the proposed requirements for states to establish time and distance standards for a listed set of providers does not adequately take into account, and is not particularly relevant for the many health plans that offer integrated network designs*.

Time and distance standards are based on a fragmented fee-for-service system and a "bricks and mortar" approach that assumes access can be provided only by geographic proximity. These standards may require health plans to contract with providers that may not share the plan's goals for quality and value or be willing or able to participate in a more coordinated or integrated approach to care. Those providers also may not be willing or able to participate in a value-based model of payment that moves away from fee-for-service. ACHP member plans are able to provide high quality care by carefully choosing providers and continuously working with them to manage care and assure patient satisfaction. The emphasis on the physical location of a provider can impede the ability of these high value networks to continue to provide high quality, coordinated care. In addition, advancements in telehealth have significantly enhanced access to care and further illustrates that evaluating time and distance is an outmoded approach to determining network adequacy.

ACHP urges CMS to permit states the flexibility to select and define the type of measure for network adequacy of the different provider types specified by CMS in §438.68. Further, we urge CMS to leave to the states the primary responsibility for administrating and monitoring Medicaid managed care networks. We believe that states are best able to set standards that meet their state's specific needs and harness the unique capabilities of their local provider communities.

CMS proposes, in §438.207, that plans provide documentation to states to demonstrate their compliance with states' network adequacy standards and requires states to provide to CMS an assurance of compliance with those standards. That assurance would need to include an analysis supporting the assurance and CMS would have a right to inspect all related documents. ACHP respects CMS' efforts to strengthen its role in reviewing plans' networks but raises concerns about the level of complication and delay that an additional level of review could bring to states' and plans' Medicaid operations. *We recommend that the two existing levels of review -- by states and by accrediting organizations -- are sufficient and we oppose adding a third level review by federal officials*.

Stakeholder engagement (§438.70) and Beneficiary Support Systems (§438.71)

CMS proposes a requirement that states ensure the views of stakeholders are solicited and addressed during the design, implementation, and oversight of a state's managed long-term services and supports (LTSS) program and specifically includes beneficiaries and providers as two

groups of stakeholders whose views must be sought. *We recommend that CMS specify in final rules that managed care plans also be included as stakeholders* whose views are included as part of the stakeholder engagement requirements. MCOs have considerable experience providing LTSS services and can bring a realistic perspective on the design, implementation, and oversight of those programs. Likewise, *we recommend that states be required to seek comment from managed care plans in the development of beneficiary support systems*. Including managed care plans will help prevent states and MCOs from establishing duplicative or redundant beneficiary support activities.

Marketing (§438.104)

ACHP supports CMS' proposed changes to permit communications to Medicaid beneficiaries from the issuer of a qualified health plan. That change will improve continuity of coverage for Medicaid beneficiaries as family income often fluctuates and many beneficiaries experience transitions between Medicaid and qualified health plan (QHP) eligibility. Under existing rules that limit health plan communications to Medicaid enrollees, issuers offering QHPs as well as Medicaid managed care plans are prevented from reaching out to those beneficiaries to help eliminate coverage gaps and reduce the impact of churning between markets.

Health Risk Assessment and Care Coordination between Settings (§438.208)

In §438.208(b), CMS proposes that managed care plans must have procedures in place to coordinate the services that the managed care plan delivers to an enrollee "between settings of care including appropriate discharge planning." *We find this language to be confusing and request additional clarification about what is meant by services provided between settings of care and what exactly is meant by coordinating those services*.

Paragraph (b) also would require that, within 90 days of the effective date of enrollment, plans make "a best effort" to conduct an initial assessment of each enrollee's needs including making subsequent attempts if the initial attempt to contact the enrollee is unsuccessful. ACHP notes that after initial enrollment, it is generally difficult for plans to obtain a risk assessment from enrollees. Completing such assessments is voluntary for enrollees and historically the response to efforts to reach out are unsuccessful. *We urge CMS to take such consideration into account in interpreting what comprises a plan's "best effort" and we recommend eliminating the requirement for "subsequent attempts."*

ACHP requests that CMS clarify the proposed requirement in §438.208(c)(3)(ii) that treatment plans for enrollees needing LTSS or who have special health care needs (in states that require such treatment plans) be developed by a person trained in person-centered planning. Will states and plans that already utilize person-centered planning processes be grandfathered in as meeting the new requirement in §438.208(c)(3)(ii)? For plans that need to come into compliance with the rule, who will be responsible for providing such training or paying for the training costs? Would training costs be reimbursable as a Medicaid expense?

Quality Measurement and Improvement and External Quality Review (§438.310-§438.370)

Quality assessment and performance improvement program. As part of a state's quality assessment and performance improvement program, CMS proposes that states include mechanisms to assess the quality and appropriateness of care to enrollees using LTSS, including assessment of care between care settings, and a comparison of services received with those in the enrollee's treatment plan. *ACHP supports advancing quality and performance measurement for MLTSS programs but recommends that CMS delay implementation of these requirements until quality measures in those areas have been developed, tested, and shown to be reliable measures* of LTSS quality of care and performance. Comprehensive LTSS quality measures and performance tools in this area are not well-developed and, as a result, plans are not likely to be able to meet the proposed standards.

Medicaid managed care quality rating system. *ACHP supports CMS' efforts to better align, where appropriate, Medicaid's (and CHIP) quality standards with those of MA and Marketplace plans*. We agree that the use of a quality rating system in Medicaid managed care that is consistent in format and scope with those in MA and the Marketplaces would make it easier for beneficiaries, especially those transitioning among these programs, to understand the quality ratings of their health plan options. *ACHP fully supports CMS' intention to have a robust public notice and comment process* for stakeholders to provide feedback during the development of the standardized set of measures that states' quality rating systems will have to measure and report on. We also support CMS' proposal to allow states to adopt additional measures that may better serve the needs of their population.

ACHP expects that alignment will be furthered through the important flexibilities that CMS is proposing in §438.330 and §438.334 by allowing states to use the MA quality improvement projects and quality rating system for plans that serve individuals who are dually eligible for both Medicare and Medicaid. Aligning quality standards across plans will increase the operational efficiency for plans that participate in both programs and will avoid duplication of effort.

External Quality Review (§438.358 and §457.1250)

ACHP opposes CMS' proposal, in §438.358, to add validation of network adequacy as a mandatory activity for external quality reviews. The requirement is redundant and duplicative of the existing efforts that states have in effect already to review and validate networks.

Grievance and Appeals (§438.400-§438.424)

CMS proposes changes to several timelines related to filing or responding to grievances and appeals that are mostly consistent with CMS' broad effort to improve alignment and uniformity between rules for Medicaid managed care and those applicable to MA plans. One of those changes, however, raises some concerns for our members. *ACHP is concerned that an open timeframe for filing a grievance will lead to confusion and missed deadlines* for beneficiaries who wish to appeal plan decisions since many people are confused about what types of beneficiary denials or concerns must go through a grievance process versus an appeals process. Further, allowing grievances to be filed at any time could raise the level of difficulty and complexity for plans responding to those grievances because staff could be required to research grievances related to care provided on a long-past date, making information gathering and documentation related to it significantly harder

to retrieve. This could work to a beneficiary's disadvantage as well. *ACHP requests clarification as to how eliminating a timeframe for filing grievances would be a benefit for the beneficiary*.

CMS requests feedback on the extent to which states and managed care plans are using an online system that can be accessed by enrollees for filing and checking the status of active grievances and appeals. At this time, *feedback from our members suggests that online tracking systems are not generally in use*. If such a requirement were to be established, our members would need to either build new systems or purchase systems.

Program Integrity – State Responsibilities (§438.602)

CMS proposes in §438.602(b) to require that states screen and enroll all network providers of managed care plans that are not otherwise enrolled with the state to provide FFS care under Medicaid. ACHP recognizes that these changes are intended to strengthen Medicaid against fraud and to identify conflicts of interest and at the same time to improve efficiencies so that each managed care plan is not undertaking duplicative screening and enrolling processes. Those provisions, however, raise a number of questions that are not answered in the regulatory text or in the preamble. *We request that CMS provide additional information clarifying how this requirement will work before implementing it*.

More specifically, the process raises the following questions:

- What timelines will states need to adhere to in conducting provider screening and enrollment processes?
- If states are unable to adhere to those timelines, what will be the consequences?
- If plans have contracts with a provider who is not cleared through the state's process, what are the consequences for plans?

Data, Information, and Documentation (§438.602 and §438.604)

In general, ACHP supports increased transparency as a way to encourage that health care information is available and can be used to improve decision making and ultimately improve outcomes. However, *ACHP opposes the overly expansive reporting and transparency provisions established in §438.602 and §438.604*. Section 438.602 would require states to post on its website a large amount of information, including financial information collected from plans under §438.604. The types of information included, such as data used for certifying capitation rates and calculating medical loss ratios, and "any other data, documentation, or information" as required by the Secretary is overly broad, and raises major concerns about trade secrets for plans as well as privacy for beneficiaries.

Source, Content, and Timing of Certification (§438.606)

Under this section, managed care plans' executive officers would be required to certify that they have conducted a "reasonably diligent review" of the data or documents and attest that the data are "accurate, complete, and truthful." *ACHP requests that CMS clarify what is meant by a*

"reasonably diligent review," as provider data are difficult to verify as accurate without costly chart reviews.

Thank you for your consideration of ACHP's comments. If there are any questions or a need for additional information, please contact me at hshapiro@achp.org.

Sincerely,

Howard B. Shapiro

Howard B. Shapiro, Ph.D.
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Alliance of Community Health Plans