COMMENTS FROM AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

ANCOR Comments
Medicaid Managed Care Regulations

July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2390-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: CMS-2390-P 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

Administrator Slavitt,

The American Network of Community Options and Resources (ANCOR) appreciates the opportunity to provide comments on the proposed regulations for Medicaid Managed Care. ANCOR is a national trade association representing more than 1,000 private providers of community living and employment services to more than half a million individuals with disabilities, and employing more than 400,000 direct support professionals and other staff.

On May 25, 2015, the Centers for Medicare and Medicaid Services (CMS) published a newly proposed rule that would change the way the agency regulates Medicaid managed care plans, the first regulation of its kind since 2002. The proposed rule seeks to address issues related to the healthcare experience of Medicaid and Children's Health Insurance Program beneficiaries, including quality of care and program administration, as well as improve program integrity, efficiency, and alignment. Specifically, the following areas are covered by the proposed rule:

- **Aligning With Other Health Coverage Programs** (including regulation of marketing, appeals and grievances, and medical loss ratio)
- **Standardizing Contract Provisions** (including provisions related to sound capitation rates, performance standards, categories of protected individuals, financial reporting, and outpatient drugs)
- **Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs**

• **Implementing Beneficiary Protections** (including enrollment and disenrollment process guidance and standardization, beneficiary access to support systems, continued benefits during appeals, coordination of care continuity, and advancement of health information exchanges)
• **Modernizing Regulatory Requirements** (including standards for network adequacy, and rating quality care)
• **Implementing Statutory Provisions**

ANCOR is pleased that the regulations seek to align with other preexisting regulations and policies and focus on proper oversight. There are still gaps, however in recognizing differences between managed long term services and supports (MLTSS) and medical procedures and recognizing unique areas where providers of disability services require protection. Please note that the final pages of the document are ANCOR's 2014 approved principles for MLTSS which we request are taken in account throughout the proposed regulations, with specific attention to #17 outlining that rates and payment methodologies must be actuarially sound, transparent and adequate to attract a retain a highly valued, stable and qualified workforce. Without a sustainable workforce, the MTLSS system cannot succeed. With these considerations in mind, ANCOR respectfully submits the following comments for consideration to provide further detail.

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Marketing – Section 438.104

- ANCOR advises amending the definition of "marketing" to specifically exclude communications from a qualified health plan to Medicaid beneficiaries even if the issuer of the QHP is also the entity providing Medicaid managed care and also amend the definition of "marketing materials."
- ANCOR further recommends the addition of a definition for "private insurance" to clarify that QHPs certified for participation in the FFM or an SBM are excluded from the term "private insurance" as it is used in the regulation.

Appeals and Grievances - Sections 438.400, 438.402, 438,404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.424, 431.200, 431.220 and 431.244

- Guardians are able to appeal decisions, but ANCOR seeks clarification as to whether or not providers can act on behalf of a beneficiary to appeal a decision with or without a guardian in place. There should be an explicit right for providers to appeal beyond being given the explicit right from a state provider or individual. This is critical because the administrative and logistics process can prolong the process further. If consumers are held harmless, there is little incentive to move along this process so necessary protections must be in place.
- ANCOR agrees that grievance procedures through electronic means should be improved and encouraged.
- In this section, as with others, ANCOR recognized that the language is still heavily medically focused and encourages an additional review to ensure that LTSS services are recognized.
- ANCOR feels it is essential for the rules to clarify that a provider who provides services in good faith should not be held liable for those services if an adverse determination is made. It will be important to clearly identify that payment for services will continue to the provider during the appeal process, noting that LTSS are very difficult to stop without a plan for service change, leaving the provider vulnerable to financial loss and the members at significant risk. This clarification also needs to clarify that LTSS is not a medical procedure.

Medical Loss Ratio – Sections 438.4, 438.5, 438.74

- ANCOR respectfully notes two issues in regards to medical loss ratio.
    - Firstly, ANCOR understands that a medical loss ratio is calculated across all programs in a state and is a tool to measure services. ANCOR appreciates the value that MLR plays for improving services, but would like to convey a potential concern that MCOs or states would utilize an MLR ratio for reimbursement to providers. This model would not be appropriate for such purposes so any requirements or regulatory language around MLR should acknowledge and protect continuity of managed long term services and supports. We do not oppose how it is currently proposed in the rule.
    - ANCOR requests clarification over the decision to reduce the calculation of MLR to 12 months. While we can see that the 12 month calculation could be advantageous as it could provide greater ability to respond to identified issues, it is possible that the calculation over a 3 year period would best reduce volatility and improve predictability. Therefore, ANCOR would like to request that CMS provide greater insight into the rational for the reduction of the duration considered in the calculation and how it would best serve LTSS services.

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Standard Contract Provisions – Sections 438.3, 438.6

- ANCOR recommends adding language clarifying that the state is ultimately financially responsible to the beneficiaries and providers of the plan should the MCO fail to pay bills in a timely fashion or go out of business, leaving the state. The concern is under current practice in some states, when an MCO leaves a state, remuneration to providers goes unpaid. It is crucial that there is language protecting the providers of the plan naming the state fiscally liable in such instances.
- ANCOR is concerned that the proposed rules state that rates must be set to be adequate to pay for all services identified in the state plan but there is no guarantee that providers are included in this requirement. ANCOR requests clarification as to whether or not HCBS falls into the same requirement in that waiver services are not part of state plan services.
- ANCOR is concerned that not all states recognize personal care/attendant services as state plan services, but rather as optional services. Yet in LTSS some individuals rely on personal care services for essential tasks, for getting to and from work, for eating, etc. The cost of those services must also be included in the setting of an actuarially sound rate.
- ANCOR requests amendment of language to make it clear that "providers" are not MCOs, but are medical providers. "Providers" should be recognized to be a provider of HCBS or LTSS services as well.

Rate Cell Definition – Section 438.2

- ANCOR is concerned that in the new regulations, the use of the new "rate cells", are defined as: "Rate cells means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, and region or geographic area. Each enrollee should be categorized in one of the rate cells and no enrollee should be categorized in more than one rate cell." For the population of people with disabilities our providers serve, this system could result in people being pigeon-holed into one category that may not fully address their individual needs and that the rate cells would not be developed with enough variation to capture everyone in the population being served. Further, persons with complicated physical/medical long term needs are continuously moving from one "rate cell" to possibly another, so a person must be able to access services based on need and it should be a fluid system.

Actuarial Soundness – Section 438.4

- ANCOR is concerned that the review process may lack transparency. Data being used to determine rates should be made available for public review and an opportunity should exist for input by stakeholders. This is especially relevant with LTSS as there is currently no actuarial data available for individuals with intellectual and developmental disabilities. While there is claims data regarding acute and primary care, none exists for LTSS. Some states may assert they have their cost data paid to providers of those services, but in reality what they have is reimbursement data.
- Rates must be specific to the payment for each rate cell under the contract and not cross-subsidize any other payments (or be cross-subsidized). The goal is to ensure that there is no waste or duplication, but this may create the potential for too strict a definition leaving needed services without a rate to tie them to. Questions about whether oversight provisions will adequately ensure that individuals are receiving appropriate services, and

that appropriately authorized services are available for utilization (goes to network adequacy).

Modernize Regulatory Standards - Section 438.340

- ANCOR requests that CMS include language that addresses quality outcomes beyond medical ones, specifically Quality of Life outcomes. ANCOR recognizes that as managed care becomes more prevalent as a system model, states should start requiring and incentivizing states and providers of all types to focus on non-medical QOL outcomes.

Rate Development Standards - Section 438.5

- Under any willing provider, MCOs must negotiate with all providers but that does not mean that the rates presented by the MCO will be feasible for every provider, hence the potential downsizing of the network. ANCOR recommends that the regulations set a floor to the rates where they cannot be lower than what was established by the state under rate setting for a reasonable period of time.
- As MCOs become the norm for care delivery, the state may try to use the "provider payments" that the MCO pays physicians, PTs, etc. to set rates for service and treat disability "providers" as part of the MCO network forgetting that MCOs have other components of their rates such as the ability to build reserves, manage risks, employ care managers and other costs of doing business, plus a profit margin. The cost of care needs to be explored so that there is a rate methodology not solely based on medical care payments that makes sense and is not flawed from the beginning for LTSS.

Program Integrity Requirements under the Contract – Section 438.608

- The proposed rule requires states to develop compliance and oversight procedures, but ANCOR is concerned that there may not be enough federal oversight and enforcement to ensure that states properly enforce their procedures. The regulations should require states to assume full responsibility for the actions of the MCOs with which they contract. Therefore, if the MCOs are not complying with regulations and there is a pattern and practice of specific non-compliance, not only must the state address these practices but must ensure that corrective measures are taken to make consumers/providers on behalf of consumers whole. Without these protections, we have seen providers at risk of going out of business in states with managed care systems.

Sanctions - Sections 438.700 and 438.702

- ANCOR has overarching concern over the degree of discretion states have in imposing sanctions. Therefore, ANCOR recommends requiring financial sanctions against managed care organizations who did not comply with agreements with the reasoning that MCOs would be unlikely to lose an existing contract but would need an appropriate penalty to avoid noncompliance or to move forward with proper compliance in place.

Disenrollment Standards – Section 438.56

- ANCOR appreciates the new enrollment policy that a state must permit beneficiaries to disenroll or switch to another managed care plan when the termination of provider from the MLTSS network would result in a disruption in their residence or

employment. While allowing extended disenrollment can cause issues with service provision, this new policy allows for proper transition and continuity of services.

Continued Services/Long Term Supports and Services – Section 438.208(c)

- ANCOR supports the proposal in the regulations to codify elements from the May 2013 guidance for managed LTSS programs under 1915b and 1115a waivers (please see the end of this document for ANCOR's managed care principles for LTSS for further consideration).
- ANCOR supports alignment of the new treatment of LTSS service programs to conform with person-centered planning standards as reflected in the CMS HCBS rule. ANCOR supports the spirt and goals of the HCBS rule and appreciates the regulations' attention to consistency across authorities.

Managed Long Term Services and Supports – Sections 438.10, 438.2

- This section references "Amending 438.10 to propose additional standards for enrollee and potential enrollee materials, including information on transition of care, who to contact for support and other standards for provider directories." ANCOR proposes that CMS stipulate states consider transition of care needs/timelines for states that may be changing Care Management structures that may change in the transition to managed care. CMS should also stipulate that in the case of people with I/DD that member materials be sent not only to the "member" but also to providers and guardians.

- ANCOR also recommends the following changes to elements that the regulation identifies as part of MLTSS:
  Element 2: Stakeholder Engagement - This section references "Educated stakeholders, including beneficiaries…" ANCOR encourages CMS to establish guidelines for "beneficiary" or "member" as well as provider representation on stakeholder advisory groups.
  Element 4: Alignment of Payment Structures and Goals – ANCOR requests that CMS stipulate that states consider payment structures for MCOs that take into account the varying rates for HCBS and facility-based services and that states in their contracting/rate setting establish rates that meet both provider and MCO needs to effectively and safely transition individuals who wish to transition to expanded community-based settings options.
  Element 5: Support for Beneficiaries – ANCOR requests that CMS include beneficiary education materials provided by an Ombudsman or other objective source, listing all available programs and services (the reasoning is that sometimes a provider or MCO may have a bias for or against a program/service). If a beneficiary is made aware of all types of services, even those that may not be currently available in their area, it gives them a sense of the options, and empowers them to self-advocate to access the service or push both their provider and the MCO to develop the service.

Advancing Health Information Exchange – Sections 438.62, 438.208

- ANCOR fully supports this section of the regulation supporting the coordination and enhancement of technology in providing improved services. ANCOR has been involved in formally sharing expertise with the Office of the National Coordinator for Health Information Technology (ONC) on their fiver year strategic plan. We have noticed in our work in the Health Information Exchange discussion that there is not a deep knowledge about health information technology in the LTSS space or the LTSS crossover and application of it into the medical sphere. Providers must be able to be

recognized and included in the HIE work so that the opportunity for technology and funding to improve efficiency and accessibility exists.

Stakeholder Engagement – Section 438.70

- This section adds a new section that would create a stakeholder group that would account for the perspectives of stakeholders, including providers. The standard is "sufficient" to quantify the amount of meetings and composition of the group. ANCOR urges the proposed rule should require the creation of the group and their input sought and used *before* a contract with an MCO is executed to ensure that input from stakeholders is accounted for from the outset of the process.

Network Adequacy Standards - Section 440.262

- Network adequacy standards are highly important to our providers and protecting LTSS. ANCOR emphasizes to CMS should highlight that absent having providers available within the prescribed geographic area/travel time that are accepting Medicaid managed care, it is clear that MCOs must cover costs associated with care provided by physicians and specialists outside of the network of providers. A simple example of this would be that for an individual who uses a wheelchair and needs dental care, that individual should not have to travel unreasonably far to a covered provider who provides that care in an accessible chair and office. Rather, if a provider outside the network can provide accessible care within the geographic region, that care should be covered.

- There are numerous loopholes that can distort the adequacy of the network and can exclude providers from the networks. ANCOR highly recommends that CMS require that a survey is conducted by the MCO to determine the status of their provider networks and to add an external quality review of the network. MCOs should also maintain a listing of their provider network on their website, note when it was last verified, and note changes to the network separately. Furthermore, the regulations must incentivize outcomes and allow for a period of reasonable transition so that service disruption is minimized to the maximum extent possible. ANCOR also encourages this section to include a nondiscrimination provision to ensure that consumers will have access to appropriate services.

Other issues not related to specific regulations: ANCOR has received several inquiries as to how the final rule will impact states that are currently undergoing transition into a managed care system. Releasing guidance and information as the final rule is being developed will be tremendously helpful.

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ANCOR Principles of Managed Long Term Services and Supports (MLTSS)
September 5, 2014

The central organizing goal of system reform must be to assist people with disabilities to live full, healthy, participatory lives in their community. [1] Recognizing the many unique challenges involved, ANCOR recommends the following guiding principles are rigorously applied in designing and operating Medicaid managed long term services and supports (MLTSS) systems serving children and adults with chronic disabilities:

Core Values

1. Managed long term services and supports (MLTSS) systems must treat people with disabilities with dignity and respect.

2. Managed long term services and supports (MLTSS) systems must be designed to honor, support and implement person-centered practices and consumer choice. People with disabilities will be able to hire and fire providers; choose outcomes important to their lives; and change priorities as dictated by life events or as needed.

3. Delivery systems for MLTSS must be capable of addressing the diverse needs of all beneficiaries on an individualized basis.

4. All individuals should be able to access comprehensible information and usable communication technologies to promote self-determination and engage meaningfully in major aspects of life.

5. Beneficiaries in managed long term services and supports must have access to the durable medical equipment, assistive technology and technology enabled supports to function independently and live in the most appropriate integrated setting.

6. Primary and specialty health services must be effectively coordinated with any long-term services and supports an individual might require.

7. MLTSS must result in choice for the beneficiary in the most appropriate integrated setting.

[1] Gettings, Robert, Charles Moseley, and Nancy Thaler. *Medicaid Managed Care for People with Disabilities*. National Council on Disability, 18 Mar. 2013. Web. <http://www.ncd.gov/publications/2013/20130315/>.

8. MLTSS must plan to provide support over the lifespan in addition to a person's episodic needs.

9. Services and supports accessed through each managed care entity must be sufficiently robust and diverse to meet the contracted scope and needs of all beneficiaries with disabilities.

10. Beneficiaries must have a choice among Managed Care entities.

11. MLTSS must promote an Employment First philosophy. Working-age enrollees with disabilities must receive the supports necessary to secure and retain competitive employment or other meaningful daytime activity. For people who have not succeeded in being able to sustain employment with appropriate supports, there must be meaningful alternatives that meet that person's needs available during any period of unemployment.

12. All eligible individuals must be included in the transition, including those residing in state institutions. Resolving waitlists, including addressing the needs of individuals who are underserved, should be addressed in state plans, such as using any savings to reduce the waitlist.

Stakeholder Engagement

13. MLTSS must allow for multiple opportunities for meaningful stakeholder engagement throughout the process to include people with disabilities, families, providers of supports, state government and other individuals knowledgeable about integrated community settings and both medical and non-medical outcomes for people with disabilities. States should be required to identify stakeholder input to CMS; how they incorporated input into plans; or, why they chose not to do so.

14. The existing reservoir of disability-specific expertise, both within and outside of state government, should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system.

Health Information Technology (HIT) and Electronic Health Records (EHR)

15. MLTSS must design and implement health information technology and electronic health records prior to the implementation of the MLTSS system.

16. States should design, develop, and maintain state-of-the-art management information systems with the capabilities essential to operating an effective managed long term services and supports delivery system.

Assessment and Rate Setting Methodology

17. MLTSS rates and/or payment methodology and the provider rate-setting mechanisms must be actuarially sound, transparent, adequate to attract and retain a highly valued, stable, and qualified workforce; and, geared to achieve valued outcomes.

Implementation

18. MLTSS implementation must require states to complete a readiness assessment before enrolling people with disabilities.

Performance Measures and Metrics

19. Must include non-medical metrics focused on LTSS (in addition to acute and behavioral health into the RFP and contract). These metrics must incorporate equality of opportunity, independent living, economic self-sufficiency and full participation as defined in the Americans with Disabilities Act (ADA) and the integration mandate of the ADA and the Olmstead Supreme Court decision. Performance reports on these metrics will be shared with all stake

State Responsibility and Regulations

20. MLTSS implementation must be accompanied by regulations which encourage and support innovation; modified to reduce process burden in exchange for performance outcome measures as the accountability standard; and, allow provider creativity on how to meet the regulation.

21. MLTSS regulations must assure individuals are safe and secure without compromising an individual's civil rights, choice, informed decision making and dignity of risk.

22. States must assure transparency in the contract procurement process for MLTSS, monitoring, and quality assessment.

23. MLTSS contracts must define financial risk between the state and the MLTSS entities and providers.

24. States must require MLTSS systems for people with disabilities to cover the full range of services and supports needed to address the diverse needs of people with disabilities on an individualized basis across the life span.

25. Benefit package should build upon existing services and supports needed by beneficiaries to live in the community, including services for acquiring, restoring, maintaining and preventing deterioration of function or acquisition of secondary disabilities.

Appeals and Grievances

26. MLTSS must safeguard individual rights and all applicable federal (e.g. ADA/Olmstead) and state statutes.

27. Enrollees with disabilities should be fully informed of their rights and obligations under the plan, as well as the steps necessary to access needed services in accordance with the requirements of the Social Security Act.

28. Grievance and appeal procedures must be established that take into account physical, intellectual, behavioral, and sensory barriers to safeguarding individual rights.