Comments to the Centers for Medicare & Medicaid Services
Re: Medicaid and CHIP Managed Care Notice of Proposed Rulemaking
(CMS 2390-P)
Submitted by Community Catalyst
July 27, 2015

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed regulations released May 26, 2015 regarding various updates applicable to managed care in Medicaid and CHIP.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We have been working to improve Medicaid managed care for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders. These tools include "Strengthening Long-Term Services and Supports"[1] and "Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities."[2] We also conceptualized and produced key data, including sanctions against MCOs, for the Medicaid Managed Care Market Tracker[3] that is housed on the website of the Kaiser Family Foundation.

We appreciate the opportunity to provide comments on this significant update to the Medicaid managed care regulations. States are shifting more Medicaid enrollees onto managed care and expanding it to new and vulnerable populations. In light of uneven performance, it is important

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[1] Community Catalyst. Strengthening Long-Term Services and Supports. Retrieved from http://www.communitycatalyst.org/resources/tools/mmltss

[2] Community Catalyst. Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities. Retrieved from http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement

[3] Kaiser Family Foundation. Medicaid Managed Care Market Tracker. Retrieved from http://kff.org/data-collection/medicaid-managed-care-market-tracker/

to strengthen the ability of Medicaid managed care[4] to deliver on the promise of achieving improved access to care, higher quality of care and cost savings to the state.[5]

We have included our detailed section-by-section comments below, but want to highlight here the three areas we find most significant:

- **Transparency**. We applaud CMS for strengthening transparency throughout Medicaid managed care by requiring states to make vital consumer information, including enrollee handbooks, provider directories and drug formularies available online in an accessible manner. We believe that the rule can be further strengthened by requiring more critical information to be made available publicly for consumers and consumer advocates alike, such as MLR reports, rate certification documents, and enrollment and plan information. Also, we would like CMS to pursue greater transparency in stakeholder engagement, providing opportunities for public comment, especially around quality improvement and performance measurement.

- **More robust and accurate information**. In addition to transparency, more accurate and more robust information will help empower enrollees in managing their health. In sections regarding network adequacy, more critical details should be updated in a timely manner to ensure consumers have the most up-to-date information available to make informed decisions in seeking appropriate care (e.g., which providers are accepting new patients, which providers provide disability access, etc). We seek stronger information standards, such as more non-English language support and consistency with standards used by the DOJ and HHS' Limited English Proficiency Guidance.

- **Driving reductions in health disparities.** We are pleased that the proposed managed care regulations show movement toward modernizing managed care and alignment with other managed care requirements across the healthcare system, including with the recently proposed regulations governing parity in Medicaid and CHIP. We hope CMS will aggressively further pursue measures to reduce disparities in health, especially for populations of color and for the most medically frail enrollees. Our recommendations around care coordination, network adequacy in 438.68(c)(1)(viii) and quality of care will ensure that inclusion and considerations of vulnerable populations are interwoven throughout the long-term disparity reduction objectives of managed care.

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[4] Caswell, K.J. & Long, S.K. (2015). The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults. *Inquiry*. Retrieved from http://inq.sagepub.com/content/52/0046958015575524.full

[5] Sparer, M. (2012). Medicaid managed care: Costs, access and quality of care. *Robert Wood Johnson Foundation, 23.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106.

I. Medicaid Managed Care

§ 438.104 – Marketing

Community Catalyst supports extending the marketing regulations to communication via social media and other forms of electronic communication. Given the proliferation of online marketing and communications, any marketing protections that did not extend to cyber space would have very little meaning in 2015.

Community Catalyst also welcomes the new CMS definition of "PCCM entities" (often referred to as "enhanced PCCM") and the expansion of CMS' regulatory authority over these increasingly common managed care models. New federal review and approval standards for PCCM entities are necessary to enhance quality of care and align protections to enrollees with other managed care plans. For the same reasons, enrollees should have access to the same grievance and appeals protections and process as those in other managed care plans.

Appeals and Grievances

Ensuring strong appeals and grievances processes for Medicaid managed care enrollees is especially important in the context of capitated managed care or PCCM entities, where there can be economic incentives to underserve. While Community Catalyst supports the goal of creating uniformity between Medicaid managed care plan rules around appeals and grievances and those of Medicare Advantage of private market plans, we oppose any changes that restrict existing beneficiary protections to achieve this uniformity.

Given that Medicaid beneficiaries have some of the most complex health care needs and the fewest resources to navigate an appeals or grievance process, we oppose provisions that would have the effect of restricting their options or timelines for filing appeals or would create new hurdles between the beneficiary and a final ruling.

Subpart F, Part 438

We support adding PCCMs and PAHPs to the list of entities having to comply with grievance/appeals processes.

§ 438.402 – General Requirements

Community Catalyst supports the following changes:

- Reducing to one, the maximum number of internal appeals enrollees have to exhaust before they can request a State Fair Hearing. This places an important limit on the bureaucratic process that enrollees must navigate before getting their final ruling.
- Changing the timeframe within which enrollees must file an appeal to a minimum of 60 days from a state-specified standard which could be anywhere from 20-90 days. Twenty days may not be sufficient time for enrollees to understand their appeals rights and to gain sufficient counsel to move forward with an appeal.

Recommendation: While 60 days should be the new minimum to file, states should be allowed to set a longer time limit (up to 90 days) if they chose.

§ 438.406 – Handling of Grievances and Appeals

From language in the preamble and in HHS webinars, it is clear that the intent is for an individual requesting a timely appeal to receive continued health services beyond the length of the original authorization. We applaud CMS for proposing to eliminate the link between continued services and an authorization period, and requiring that plans continue services until a final appeal decision. This is an essential consumer protection that ensures that treatment plans and necessary care are not interrupted due to an arbitrary decision by the plan that may ultimately be reversed.

However, the regulation still retains a separate provision stating that the managed care plan must continue the enrollee's benefits only where "the original period covered by the original authorization has not expired." We urge CMS to amend this portion of the regulation to make it clear that benefits must continue pending an appeal with the health plan or the state.

> **Recommendation**: Adding a requirement that acknowledges receipt of each grievance and appeal within 3 calendar days in section (a). CMS amend (b)(4) to require that benefits must continue pending an appeal with the health plan or the state.

§ 438.408 – Resolution and Notification: Grievances and Appeals

Community Catalyst welcomes the following changes:

- Reducing the time by which MCOs, PIHPs, PCCMs and PAHPs have to make a decision about a standard appeal from 45 days to 30 days; and
- Increasing the timeframe for enrollees to request a state fair hearing from 20-90 days (depending on the state) from the date of notice of the MCO, PIHP, PCCMs or PAHP's notice to 120 calendar days.

We oppose the requirement in § 438.408(f) that Medicaid managed care enrollees must exhaust the MCO, PIHP or PAHP appeals process before filing for a State Fair Hearing ruling. Allowing beneficiaries to file for a State Fair Hearing at the same time as their internal appeals are pending with their MCO is an important protection that affords beneficiaries immediate independent review of an adverse decision. Requiring the beneficiary to exhaust internal appeals processes may significantly delay the final ruling for the beneficiary, potentially impacting his or her treatment decisions and plans and thus the quality of care. Indeed, statistics developed by CMS for the Part D program (where beneficiaries are also required to exhaust internal appeals processes before getting an independent review) show that the Independent Review Entity reversed internal appeal decisions in nearly a third of all cases. Given that problems with timely administrative decisions are rampant in the states, it is in enrollees' interests to promptly move them through the system toward a final administrative decision and not allow them to become caught up in delays at the plan level.

> **Recommendation**: Enrollees should be allowed access to the State Fair Hearing process, regardless of whether exhaustion is required, to obtain a decision on their claim for medical assistance when the MCO, PIHP or PAHP is not making decisions in a timely manner.

§ 438.416 – Recordkeeping Requirements

We support increasing the requirements for states to collect consistent information about appeals and grievances, and requiring them to review the information as part of ongoing monitoring.

> **Recommendation**: We suggest that states be required to produce annual reports on appeals and grievances for each of their Medicaid managed care plans so consumers have better information about the quality of these plans when they enroll.

Medical Loss Ratio

§ 438.4, § 438.5 – Medical Loss Ratio (MLR) as a Component of Actuarial Soundness

We are concerned that there is neither an actual requirement for a minimum MLR of 85 percent, nor a public reporting mechanism for MLRs. Additionally, even if a state chooses to take up a minimum MLR, there is no formalized structure for remittance or penalties.

> **Recommendation**: We urge that CMS set a 85 percent MLR to ensure that managed care organizations actually serve their beneficiaries by investing more in needed care and health improvement. As CMS seeks to align more closely with other public and private plans, we believe CMS could appropriately borrow MLR rules from Medicare Advantage, which sets certain penalties on plans after 3 and 5 years of non-compliance. Medicaid managed care could take on less severe penalties in order to balance out the difficulty of maintaining a stable MLR for a medically complex population. Perhaps CMS can provide guidance on remittance based on MLR adherence over a 3-year average. As 28 states currently maintain an MLR equal to or higher than 85 percent, such provisions are likely within reach.

§ 438.8 – Standards for Calculating and Reporting Medical Loss Ratio

Fraud and abuse. We plans to be aggressive about fraud and abuse and understand that paragraph (e)(4) is intended to encourage MCOs, PIHPs and PAHPs to conduct program integrity and fraud and abuse prevention activities. However, all MCOs, PIHPs and PAHPs are already expected to conduct such activities as part of their everyday operations, are required by contract under §438.608 to prevent fraud and abuse, and already have financial incentives to do so. Therefore, it is unnecessary to include the cost of activities to comply with program integrity requirements as part of the MLR calculation, especially when states can already add fraud and abuse prevention goals as part of an incentive payment under §438.6.

> **Recommendation**: Dropping fraud and abuse from MLR calculations as long as the amount excluded does not exceed 0.5 percent of premium. If it is retained in the final rule, we recommend maintaining the cap of 0.5 percent of premium revenue.

Quality improvement expenditures. We request that CMS give a clearer definition around quality improvement expenditures in paragraph (e)(3), which are allowed to go into the numerator when calculating MLR. Too broad of a definition – as specified in 45 CFR 158.150 – could give MCOs, PIHPs and PAHPs leeway to fold in general business operation and administrative costs into quality improvement to boost MLR. Expenses claimed here need to be tied to the Quality Improvement Strategy and should show results over time or be disallowed.

> **Recommendation**: That CMS conduct or require states to implement some sort of approval and/or audit process to make sure that activities are actually improving the quality of health

care in managed care. Regarding implicit bias among health care providers and its correlation with quality of care (see more in our comments in Subparts D and E of Part 438), an important first step is to equip health care providers with tools such as the Implicit Associate Tests (IATs)[6] to assess and manage their own biases.[7] We suggest CMS require states to create incentives that reward health care providers who undergo implicit bias trainings and demonstrate perspective-taking and individuation when providing patient care.

Reporting quality measures. We urge CMS to require more robust reporting of quality measures. The Affordable Care Act (section 2717) requires health insurers to report to HHS their benefit and provider reimbursement structures that improve quality in various ways.

> **Recommendation**: To be most useful, CMS should synthesize and disseminate this information online in a fashion that consumers find useful and relevant, in order to stimulate competitive pressures for health plans to improve quality of care.

Reporting time period. We are concerned that giving states flexibility in defining their own MLR calculation and reporting time period in § 438.8 (b) would affect credibility adjustments.

> **Recommendation:** Align Medicaid managed care with both the private market and Medicare Advantage in using a calendar year to calculate MLR.

§ 438.74 – State Requirements

> **Recommendation**: We urge CMS to amend § 438.74(a) to include language that requires states to submit an annual report to CMS giving a summary description of the MLR reports and the reports themselves, received from the MCOs, PIHPs and PAHPs under contract with the State under § 438.8(k) with the actuarial certification described in § 438.7. The reports and summaries must also be made publically available by HHS, including by posting on an internet website."

Subpart A

§438.2 – Definitions

> **Recommendation:** Broaden the definition of Long-term Services and Supports (LTSS) to: "...supporting the ability of the beneficiary to *participate in community activities* and to live or work in the setting of their choice..." This will more fully encompass the full thrust of community based LTSS. We also recommend that the definition include a second sentence specifying that LTSS also includes services to support family caregivers for a beneficiary.

Standard Contract Provisions

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[6] Implicit Association Test is a computerized measurement tool designed to measure the strength of automatic associations people have in their minds. This took has been used to measure implicit bias in physicians https://implicit.harvard.edu/implicit/iatdetails.html

[7] US National Library of Medicine National Institutes of Health (November 2013). Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities http://www.ncbi.nlm.nih.gov/pubmed/23576243

§ 438.3 – Standard Contract Provisions

Overall, Community Catalyst applauds CMS' proposals to this section that restructures contract requirements. To that effect we support:

- Expanding inspection and audit rights in 438.3(g) and the requirement to submit audited financial reports;
- Requiring in § 438.3 (a) that contracts to CMS are submitted no later than 90 days before the planned effective date of the contract. It is imperative that CMS have ample time to review such contracts; and thorough review is in the best interest of both the state and health insurance consumers;
- Strengthening anti-discrimination prohibition at §438.3(d)(4). In particular, we commend HHS for adding sex, sexual orientation and gender identity as protected categories. These protections are crucial because discrimination on these bases creates barriers to accessing medically necessary care—either by discriminatory plan practices (e.g., in enrollment, covered and excluded services, medical necessity definitions, or utilization controls), provider refusals, or treatment avoidance due to perceived discrimination in treatment;
- Adding disability as a protected category. As stated in the preamble, beneficiaries with disabilities are increasingly enrolled in managed care and the protections for these enrollees reflect the challenges they often face, including lack of accessible information and services, discrimination in enrollment and difficulty navigating managed care generally. Adding disability as a protected category provides an important broad protection for beneficiaries with disabilities that will cover discriminatory actions that may not be specifically covered by other provisions but still have a strong adverse effect. This could include instances such as when enrollees with disabilities who have high service needs are treated poorly by managed care entities in an effort to get such individuals to switch managed care entities;
- Requiring states in § 438.330 to assess the performance of PCCM entities to detect over- or under-utilization of services, undertake performance measurement using standard measures and conduct a program review;
- Including PCCM entities (§ 438.340**)** in the state's quality strategy such that the state must describe how it is assessing the performance and quality outcomes achieved by each PCCM entity; and
- Requiring states in § 438.3(o) to ensure that LTSS contracts require services to be delivered in a manner consistent with the settings standards in Section 441.301(c)(4) regardless of how the services are authorized.

We believe these anti-discrimination protections should also apply at disenrollment at §438.3(d).

§ 438.3(d) – Discrimination in health plan and enrollment practices

Community Catalyst agrees that it is crucial to reference section 1557 of the Affordable Care Act's nondiscrimination provision for health programs that receive federal financial assistance. In addition, we applaud that health programs are required to comply with other federal rules including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act of 1964 and the Mental Health Parity and Addition Equity Act. This is an important step to ensure racial and ethnic minorities, LGBT communities and other vulnerable populations with the greatest health needs are appropriately protected.

> **Recommendation**: CMS should include language that prohibits states and managed care entities from adopting policies that discriminate against criminal-justice-involved individuals who qualify for services.

§ 438.3(u) – IMD exclusion

Community Catalyst supports revising the IMD payment exclusion. In many states, the IMD payment exclusion creates a barrier to consumers with substance use disorders (SUD) receiving needed treatment because it contributes to a shortage of allowable inpatient and residential treatment facilities in which they may receive care. The exclusion also runs contrary to the stated aim of federal parity laws, which are intended to ensure that behavioral health conditions are treated equally to other types of health conditions in health plans, including MCOs.

However, we believe that the proposal to lift the exclusion of short-term (15-day) stays in IMD facilities is not sufficient to support the medical needs of people with SUD, and could create barriers to appropriate care. Our reasons for this are as follows:

- Crisis residential services are critically important. However, allowing MCOs to receive payment from the state to provide only crisis residential services, and only for 15 days in a month, is just a first step;
- The proposed rule states that the 15-day limit was based on data from the Emergency Psychiatric Demonstration. That demonstration was limited to patients with severe psychiatric needs – not a typical patient with substance use disorders. An approach based on clinical need would also be more consistent with meeting Medicaid managed care's parity requirements;
- A 15-day limit may result in cyclical re-admittance as a result of incomplete or ineffective treatment. Any day limit per month may result in either delaying admittance until length of stay can be maximized across two consecutive calendar months or discharging patients before it is medically appropriate to do so and disrupting treatment until they can be readmitted the following month;
- Longer term stays, when clinically indicated, are a critical component of ensuring proper and medically appropriate treatment for people with mental health and substance use disorders. Many of the individuals in need of crisis residential services for mental health and SUD also need residential treatment once they are stabilized, and many of the facilities that provide stabilization also provide treatment services.

> **Recommendation**: Rather than time limited stays in IMD facilities, we strongly request that CMS allow *clinically appropriate* lengths of stay for crisis residential services. Also, in terms of longer-term stays, we ask for more flexibility and clarification on how these individuals will be linked to medically necessary inpatient treatment after stabilization and how those services will be financed.

We support that the proposed rule also clarifies that an MCO has the flexibility to provide alternative services or use alternative settings “in lieu of” what is covered under the Medicaid state plan. This provision allows MCOs to use IMDs as a means to ensure that appropriate care is provided in a cost-effective manner. This change will ensure that MCOs can meet the range of mental health and substance use disorders needs of their enrollees.

> **Recommendation.** Due to the long-standing exclusion of IMDs under managed care, we seek the following additions and clarifications from CMS:

- Explicit language in the final rule stating that MCOs can provide covered behavioral health benefits in facilities that are considered IMDs as long as CMS’s requirements for “in lieu of” services are met: the enrollee has agreed to the substitution and the service is cost-effective. CMS should also specify that MCOs can continue to receive payment for covered medical services provided to enrollees while they are patients in IMD facilities;
- Clarification for how states and MCOs should implement the proposed IMD flexibility in the context of parity requirements. Specifically, we seek clarity about whether parity *requires* MCOs to use the “in lieu of” provision in order to provide enrollees with covered inpatient behavioral health services in an IMD setting; and
- Remove substance use disorders in the IMD exclusion. Doing so would be a more effective way to ensure access to medically necessary care for people in need of residential or inpatient substance use disorders treatment or recovery support and to address a growing national epidemic of substance misuse and its negative effects.

Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs

§ 438.4 - Actuarial Soundness Standards

Community Catalyst supports CMS’ inclusion of new language that clarifies the definition of actuarially sound capitation rates, as well as standards for states and their actuaries. We applaud that CMS:

- Instructs capitation rates to include “reasonable, appropriate, and attainable costs that are required under the contract;”
- Provides guidance around how improper payments should be reported and recovered – and are not to be included in the calculation;
- Removes ambiguity and infuses stricter actuarial soundness of the rates, tying these standards to the proposed 85-percent MLR; and
- Pairs capitation rates with network adequacy, which will also support stronger consumer protections.

As CMS has stated their aim to make the rate-setting and rate approval process more transparent, we make a request that CMS increase state oversight on plan accountability in this area.

> **Recommendation**: CMS should require states to conduct routine examinations of the effect of capitation payment rates on beneficiary access to care or establish a process by which MCOs, providers and beneficiaries can raise concerns about states’ capitation rates, which might trigger CMS review and possible adjustments. This is important in light of *Armstrong*

v. Exceptional Child Center, Inc. limiting private right of action to enforce adequate rates.

§ 438.5 – Rate Development Standards

Community Catalyst applauds CMS for providing more specific standards around rate development and risk adjustment. **However, we are concerned that as more beneficiaries move into Medicaid managed care, FFS data becomes less available and less reliable as a benchmark for establishing capitation rates.** They may not truly reflect the health status of, and spending for, individuals in managed care plans. At some point, we must move away from FFS and rely on the historical experience of managed care plus allowable trend. Accordingly, the final rule should eliminate the exception under (c)(3) allowing States to base their rates on data older than the three most recent and complete years prior to the rating period.

§ 438.6 – Special Contract Provisions Related to Payment

Incentive payments. We support limiting the size of incentive payments that states can establish to no more than five percent of the capitation payments attributable to the enrollees or services covered by the incentive arrangement. Five percent appears to be a reasonable limit that provides a financial incentive for achieving specified activities, targets, performance measures and quality-based outcomes, without distorting behavior at the expense of fulfilling the primary goal of furnishing all Medicaid-covered services to enrollees.

Withhold arrangements. We are concerned that no similar numerical limitation applies to the size of withhold arrangements. While the determination of actuarial soundness would take into account how much of a withhold payment is reasonably achievable, that standard is too weak. The goal of any withhold arrangement should be to reduce payments to MCOs, PIHPs or PAHPs that fail to meet goals and measures that all plans are expected to meet (in contrast to providing additional payments in the form of incentive payments for meeting goals and measures that the State hopes all plans meet.) Without any limits, withhold arrangements could unduly reduce rates and effectively make them actuarially unsound. Moreover, they could be improperly used to delay payments to MCOs, PIHPs and PAHPs, which could have a harmful impact on the provision of care to enrollees.

Recommendation: A five percent limitation should be applied to withhold arrangements.

Value-based purchasing models. We support that states may work with contractors to implement value-based purchasing models. It is our hope that the standards this rule proposes are not only common across all payers and providers but also measurable and meaningful for consumers. Also, no up-to-date source of comprehensive information currently exists regarding the payment approaches, risk adjustment, incentives and other arrangements used by states in contracting with comprehensive risk-based plans for Medicaid services. We hope CMS will take a more active role in developing some sort of comprehensive information bank to better define the Medicaid payment landscape and help stakeholders understand these methods.

Recommendation: We would like to see specific measures in tracking value, such as those related to preventable admissions, spending per patient, ER visits and adverse in-patient events. We also urge utilization of patient reported measures (PRM), which can support

> understanding of how patients do over time and to assess care performance. PRMs can help put together financial models for care and continually reduce costs while maintaining or even improving outcomes for patients.

Rate incentives to promote rebalancing of LTSS. We urge CMS to require states to use rate incentives to promote rebalancing of LTSS from a focus on institutional services to community based services. This is a way to speed movement toward the goal repeatedly stated in the pre-amble of ensuring that LTSS is person-centered and focused on ensuring access to the benefits of community living.

§ 438.7 – Rate Certification Submission

Community Catalyst supports the increased specificity of oversight provisions devoted to rate development of Medicaid managed care. We support the detailed processes for rate certification review and the approval process in sub-regulation guidance, including the 90-day minimum submission window for contract and rate certification submission.

We also support the specific documentation standards in § 438.7(b) that states have to meet for uniformity and consistency with accepted actuarial principles and practices and regulatory standards and to allow CMS to conduct more efficient reviews.

> **Recommendation**: We recommend that CMS clarify in the final rule that all such information should be publicly available to ensure transparency and public accountability.

We believe that risk adjustment is important to protect against adverse selection or "cherry-picking" healthier enrollees within some of these complex populations. We believe in including the use of behavioral health services in the risk adjustment methodology because those factors can exacerbate other medical conditions. **In the case of dual eligibles, because acute care services are primarily paid for by Medicare, risk adjustment techniques based on functional assessment are needed to estimate the use and costs of LTSS in Medicaid.**

Beneficiary Protections

§ 438.54 – Enrollment

Overall, we strongly support that CMS will provide stronger regulations governing enrollment of beneficiaries into managed care programs.

We strongly believe that a 14-day window is an insufficient time for potential enrollees to make an active managed care plan selection. Because managed care is inherently complex and many enrollees have low health insurance literacy, we believe that the 14-day enrollment window is insufficient for potential enrollees to research their options and make an informed plan selection.

> **Recommendation**: CMS should adopt at a minimum, a 45-calendar-day election period for both voluntary and mandatory managed care programs for exempt and potential enrollees. The 45-calendar-day period should start **five**, rather than three, days after the notice is sent – three days is likely to be insufficient time for an enrollee to receive and open a mailing.

We appreciate that CMS will provide clear and timely information regarding plan enrollment and disenrollment, as per paragraph (c)(3) and (d)(3). We support that notices will clearly explain the implications of not making an active plan selection and allowing the passive or default enrollment to take effect.

> **Recommendation**: Notices sent by the state should comply with our additional information standard recommendations in § 438.10. We also ask that these notices include the implications of making a plain choice (e.g., in states that limit disenrollment, that the enrollee can only disenroll without cause in the first 90 days, that after the 90 days they might need cause to disenroll; if the enrollee does not have cause to disenroll, they would be locked into their plan for up to 12 months, etc.). States must develop informational notices that clearly explain the implications to the potential enrollee of making versus not making an active choice between managed care and FFS and declining the MCO, PIHP, PAHP, PCCM, or PCCM entity selected by the state, if relevant to the State's managed care program.
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> **Recommendation**: We further urge CMS to require states to include enrollment and disenrollment forms in the informational packets. CMS should require that plans make enrollment/disenrollment forms available at member services departments, by posting on a website that is accessible to the public, and mail the form to a beneficiary within 3 working days of receiving a telephone or written request for a form.

§ 438.56 – Disenrollment Standards and Limitations

We appreciate the inclusion of the new cause for disenrollment for those in MLTSS programs—specifically, termination of a provider from the LTSS network that would disrupt the residence or employment of an enrollee. We also support the requirement that disenrollment requests for MLTSS services that are not approved by the MCE must be referred to the state for review, to better guarantee that valid disenrollment requests are granted.

> **Recommendation:** We urge CMS to add another cause for those in MLTSS. Specifically: If the member would be better served by an MTLSS provider out-of-network and there is no comparable in-network provider.

§ 438.71 – Beneficiary Support System

We strongly support the creation of a beneficiary support system that provides consumers with choice counseling, education and training regarding managed care. Our experience has taught us that when consumers receive in-person assistance, they are significantly more likely to successfully enroll. We further support the proposed rules that would provide:

- Access to beneficiary support systems through multiple avenues, such as by phone and email, so that they can reach as many consumers as possible;
- Training of managed care entities and network providers on community-based resources that can be linked to covered benefits because doing so will better ensure consumers receive information and education about these resources;
- Specific beneficiary support services to managed care LTSS enrollees, including an access point for complaints and concerns, education on grievance and appeal rights and assistance with navigating the grievance and appeals process;

- Requirements for identification, remediation and resolution of systemic issues in LTSS; and
- FFP to help to states with the costs of beneficiary assistance.

We ask that CMS consider establishing further standards that states develop and implement a beneficiary support system that provides:

- Language and cultural competency in developing these systems;
- Training about independent living and recovery philosophies for managed care entities and network providers to ensure that the services they provide are person-centered and facilitate community living;
- Assistance to all enrollees, not just those interested in LTSS; and
- Assistance via an "independent advocate or ombudsman" consistent with the MLTSS guidance issued by CMS in May 2013.

Lastly, we ask that CMS consider:

- Including support to caregivers under this section;
- Specifying, as in the 2013 MLTSS guidance, that these services must be provided at no cost to the enrollee;
- Expanding the requirement for addressing systemic issues to include review of grievances, appeals and complaints raised by LTSS consumers and all other beneficiaries; and
- Including additional language requiring that state funding for beneficiary assistance must be sufficient for an independent advocate or ombudsman to represent individuals, conduct systemic advocacy, and educate consumers and others.

§ 438.210, § 438.420 - Coverage and Authorization of Services and Continuation of Benefits While the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending

We applaud CMS for eliminating the link between continued services and an authorization period – requiring that plans continue services until a final appeal decision is made. This will be extremely critical for enrollees, especially those with chronic conditions and/or users of long term services and supports (LTSS). It is also a step in the right direction to set standards within the contracts that will ensure ongoing support services for those with chronic conditions or LTSS**.**

Recommendations. We urge CMS to:

- Provide set standards that states must comply with in order to ensure monitoring and compliance of ongoing services is effectively being carried out;

- Strengthen the requirement that utilization management reviews ensure LTSS services are appropriate. Specifically, we recommend 438.210(a)(4)(ii)(B) be reworded to say: The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that *meets* the enrollee's ongoing need for such services and supports;
- Add language in the "medically necessary services section" 438.210(a)(5) to ensure that services that are court-ordered are not excluded from coverage. Currently, in some states court-ordered substance use treatment is excluded from coverage even though it is medically necessary; and
- Strengthen the wording in 438.210(a)(5)(iii)(D) to read: All necessary LTSS to remain independent and in the most integrated setting.

§ 438.62, § 438.208 – Continued Services to Beneficiaries and Coordination and Continuity of Care

We applaud the alignment of Medicaid managed care with other public and private programs to improve care coordination and continuity of care. These provisions serve as a critical safeguard for enrollees, many of whom have longstanding provider relationships and for whom an interruption of that relationship would cause serious harm.

We have a number of concerns that the proposed regulations leave a lot of flexibility to the states with no set criteria or standards. Experience with the Financial Alignment Demonstrations (FAD) shows that despite safeguards, there have been numerous violations of these rights in continuity of care, including replacement of providers without notification or consent of enrollees, or providers not being paid for months at a time, causing disruptions in care.[8]

Recommendation: To that end, we also recommend that CMS set the following standards for transitions:

- Change (b)(1)(i) to require specific continuity periods for consumers receiving LTSS as follows: Out-of-network reimbursement be available for a *pre-existing provider* for up to one year after initiation of managed care, or until a transition satisfactory to the consumer is in place. Such a transition could consist of the provider entering the network, or the care being provided by a network provider satisfactory to the consumer. There is precedence for a year transition in states pursing a FAD;

- Honor existing authorizations for continuity of LTSS *services (as opposed to providers)* for at least 120 days following a consumer's enrollment in a plan. This will allow time for consumers to make a case for continuity of services to a new MCO;

- Require that all prior services be honored regardless of those services being under contract or not during the continuity of care period;

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[8] MACPAC Report on "Experiences with Financial Alignment Initiative Demonstration Projects in Three States". Retrieved: https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf

- Prohibit plans from requiring residents of an out-of-network Medicaid contracted nursing home or assisted living facility from having to change facilities when they enroll in a new managed care entity; and

- Share continuity of care protections with both beneficiaries and providers. The current proposed regulations do not specify outreach and education to the provider community, especially community and LTSS providers. As has been experienced in the Financial Alignment Demonstrations, a lack of knowledge on the part of the provider community stemmed from the lack of appropriate outreach from CMS and the state. This resulted in many providers turning consumers away even though consumers had a right to continue seeing that provider.

This regulation would also establish a framework in both Medicaid and CHIP for care coordination that includes treatment plans for "individuals identified by the state as having special health care needs." It is crucial that all individuals with special health care needs have access to a treatment plan that includes a transition of care policy; limiting the scope of this regulation to enrollees "identified by the state" potentially excludes individuals—especially children—who might have complex care needs, but whose conditions are not severe enough to meet the criteria for supplemental security income (SSI) or the Maternal Child Health Bureau definition of children and youth with special health care needs. Expanding the scope of this regulation to allow providers who are managing the care of individuals with complex care needs to determine when a treatment plan is necessary—including a time-limited transition of care policy—would ensure all enrollees can receive needed care.

§ 438.208(b) – Care Coordination

Community Catalyst applauds the proposed rules to align care coordination activities with Medicare Advantage and the Marketplaces. Appropriately streamlining care coordination will provide seamless care to the beneficiary, especially those who have multiple chronic conditions, are from communities of color and/or are users of LTSS. Additionally, we support:

- Requiring entities to coordinate services across the full range of community based support services and in the most integrated setting. This is especially important for MCOs who are also serving dually eligible individuals. It will be of utmost importance to coordinate Medicaid *and* Medicare services to ensure that gaps in services are not experienced.

- Encouraging working with community based organizations on care coordination activities.

Recommendation. We find some parts of this section fairly vague in terms of setting standards for states and recommend strengthening care coordination through the following:

- Assign every enrollee a coordinator/manager whose job is to help the beneficiary and caregiver navigate the system and take the steps necessary to pursue a care plan established by the team. This person should preferably be someone who speaks the same language and/or has a similar cultural background as the enrollee.

- Require managed care plans to work with community organizations (AAA, Legal Aid, CILs, etc) to assist in coordinating non-medical services in the community.
- Require MCOs to offer a LTSS coordinator to every enrollee who needs LTSS. This coordinator should be contracted from an independent community-based organization with expertise in serving those with LTSS needs. The LTSS coordinator should be part of the initial assessment process and help the beneficiary create their LTSS care plan.
- Conduct the initial comprehensive assessment in person to fully understand the medical and non-medical needs of the enrollee. It is hard to tell over the phone what kind of condition a person is living in and what is required to improve their quality of life;
- Ensure that training for care coordinators/managers in person-centered care planning includes a cultural competency component. This training should be required annually, at a minimum.
- Set a <u>30 day</u>, not 90 day, allowance for plans to assess the needs, goals and preferences of new enrollees. We have heard of cases where consumers have had adverse experiences waiting up to 3 months to receive appropriate services, particularly for LTSS needs that are critical to ensuring they can live in the setting of their choice and participate in community activities. While the 30 day limit is preferable, a time period of no more than 60 days should be allowed if the former is difficult to attain.

§ 438.208(c) Additional Services for Enrollees with Special Health Care Needs or Who Need LTSS

We believe that there is insufficient specificity about the assessment and service planning process.

Recommendation:

- Require the assessor to have extensive experience with LTSS and be independent of service provision and the health plan’s business decisions;
- Incorporate language included in CMS' guidance from May 2013 (page 11) that stated: *"states must require all MCOs to use a standardized, person-centered and state-approved instrument to assess the participant’s physical, psychosocial, and functional needs. The instrument must include such elements as current health status and treatment needs; social, employment, and transportation needs and preferences; personal goals; participant and caregiver preferences for care; back-up plans for situations when caregivers are unavailable; and informal support networks. Approved instruments must be capable of producing a similar assessment result from MCO to MCO."*
- If a family caregiver or other unpaid caregiver is providing services, require the needs of that caregiver to be assessed;

- Require all states with MLTSS to mandate the creation of individual service plans for those who need LTSS. These plans are essential to ensure individuals get the services they need to live in the setting of their choice and participate in community activities;
- Revise the language in (3)(i) to ensure the process is truly person-centered, by specifying that the enrollee choose the person who leads development of the service plan, which may be the enrollee;
- Specify that the participants in planning for enrollees who need LTSS should include people chosen by the enrollee and persons with expertise in person-centered service planning and enabling community living. They should exclude the enrollee's providers, except under special conditions, as previously spelled out in CMS Guidance on MLTSS (page 11) and as spelled out in CFR 441.301(c)(1) and (2). While the current proposed regulations reference 441.301(c)(1) and (2) in (3)(ii), as currently worded, they do not apply the full thrust of 441.301 and they reflect a medicalized and disempowering view of service planning;
- Spell out a clearly defined consumer right to appeal a care plan that he or she feels is inappropriate or inadequate; and
- Ensure that the consumer has information sufficient for decision-making, by requiring each be clearly informed of the services available to him or her.

§ 438.70, § 438.110 – MLTSS Stakeholder engagement

We appreciate the special focus on LTSS stakeholder engagement in §438.7. To ensure that stakeholders, and particularly consumers, are robustly engaged by the state in design, implementation and oversight, we urge CMS to be more specific and to provide further requirements for states to adhere to. We note that the Medical Care Advisory Committees (MCACs) in many states are ineffective.

Recommendation: We urge CMS to require states to adopt the following practices to ensure that the state-level LTSS advisory body is effective:

- Develop a state-level stakeholder advisory committee that includes at least 50 percent representation from consumers or consumer representatives;
- Offer consumers, as CMS required in 2013 MLTSS guidance, "supports to facilitate their participation, such as transportation assistance, interpreters, personal care assistants and other reasonable accommodations, including compensation, as appropriate;"
- Provide staff support to the committee;
- Ensure transparency of the meetings, including publication in advance of the agendas and locations of upcoming meetings, prompt release of minutes of the meetings and annual reports about changes in managed care resulting from the committee's recommendations;
- Hold public meetings across the state to gather public input and develop other methods for those not able to attend meetings, such as focus groups and in-person or telephonic surveys about outcomes, experiences and quality of life. The advisory committee should play a lead role in these additional gatherings and surveys

Recommendation: We urge CMS to provide stronger language regarding these advisory committees:

- Describing the required membership of this state-level committee, as it did in 2013 MLTSS guidance, to "include cross-disability representatives of the LTSS stakeholder community such as participants (and their families or caregivers, where appropriate) in LTSS, LTSS providers and community-based organizations involved in the support of those using LTSS;" We also recommend that CMS require that the membership include members of consumer advocacy groups and legal services providers who represent the constituencies served by the MLTSS program;
- Spelling out minimum responsibilities of the committee, and allow states to add additional responsibilities. Mandated responsibilities should include
    - Participation in policy development, program administration and oversight, including input into quality strategies, quality assessment, quality rating systems and state monitoring systems; reviewing quality outcomes, reviewing consumer satisfaction data, reviewing data on consumer complaints, grievances and appeals; and vetting proposed new policies;
- Requiring the committees meet at least quarterly; and
- Reviewing state compliance with these requirements at least every three years.

Recommendation: We urge CMS to require these state contracts includes these additional requirements for managed care entities:

- Establish these member advisory committees at the local or regional level to ensure they represent the full range of members (CMS previously required this in the 2013 MTLSS guidance);

- Include members or member advocates on their boards of directors and to include a mechanism by which the advisory committees' views are relayed to the board.
- Provide the advisory committee with periodic reports on member grievances and appeals, quality assessments including results of member experience and quality of life surveys, actions resulting from state oversight of the MCO, and findings of the LTSS ombudsman or beneficiary advocate.
- Consult with the advisory committee about significant changes in policy and program administration.
- Keep records of input from the advisory committee and how it addresses that input. The committee should periodically share this with all plan members.
- Publicize the existence of the advisory committee and how individual consumers may contact the committee to raise questions or issues.

- Include MCO compliance with these requirements as a quality withhold measure, as CMS does in the FAD for dual eligibles.

We also urge CMS to strengthen requirements for MCACs, including following the recommendations above as they pertain to all Medicaid services.

Availability of Services, Assurances of Adequate Capacity and Services, Network Adequacy Standards, and Provider Selection

§438.68 – Requirements for the Network Adequacy Standards Set by the State for a Specific Set of Providers

Overall, Community Catalyst applauds the expansion of requirements on network adequacy. We are encouraged to see a specified set of providers to be subject to network adequacy standards, which includes primary care, OB/GYN, behavioral health services, specialty services, hospital, pharmacy, pediatric dental services, and LTSS.

> **Recommendation:** Addition of family planning providers as well as Essential Community Providers (ECP) to this list in §438.68(b).

Time and distance standards. While we understand the rationale of maintaining state flexibility regarding time and distance standards in §438.68(b)(1), we strongly believe that a national level of protection with clear, quantitative access standards is critical to ensuring adequate access to covered benefits for beneficiaries. We appreciate that CMS considers a variety of existing network adequacy standards applied in Medicare Advantage (MA) and Marketplaces for qualified health plans (QHPs), in deciding what approach to take to these Medicaid managed care rules. We believe that network adequacy standards for QHPs are too broad, while the MA approach is highly technical and specific with respect to travel time and distance and provider-patient ratios.

> **Recommendation:** We suggest that CMS consider the following quantitative standards for managed care plan services, which are largely in line with existing standards at the state level and should be applied nationwide to ensure greater consistency across the country. While these standards mostly apply to urban areas, rural area standards are generally two times greater:[9]

- Services that provide primary care (adults and pediatrics), behavioral health (adult and pediatric), women's health care, hospitals and pharmacies – 30 minutes or 15 miles;
- Specialty services (adults and pediatrics) and Indian Health Care Providers, as defined in § 438.14(a) – 60 minutes or 30 miles.

Additional standards: We believe that time and distance standards alone are insufficient to guarantee timely access to care for beneficiaries. We recommend that CMS require states to account for foreseeable road closures due to weather conditions in certain regions. In addition, we strongly urge CMS to set additional standards in § 438.68(c)(1) regarding wait times.

> **Recommendation:** Maximum appointment wait times within request of appointment:

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[9] Department of Health and Human Services: Office of Inspector General (September 2014). State Standards For Access To Care In Medicaid Managed Care. Retrieved from http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

- Primary care and specialty care – 15 business days
- Urgent care for medical and dental services – within 24 hours
- Urgent care for mental illness and substance use disorders – 24 hours
- Non-urgent mental and behavioral health services – 10 business days
- Accessing providers by phone – 24 hours a day and seven days a week;
- Making appointments during non-typical office hours including after 5 p.m. and on the weekend;
- Immediate access to life-threatening emergency care, including care for substance use and mental health emergencies, and emergency access to child-specific emergency services and specialists; and
- Separate behavioral health standards for children. Given that wait times to see behavioral health providers can be high for both adults and children and that the behavioral health needs of children are, in some ways, distinct from those of adults, it would be prudent to establish a standard that distinguishes between adult and pediatric behavioral health providers, to ensure children's access is not compromised. Specific provider-patient ratios for adult and pediatric primary care should also be established.

Alternative options. We urge CMS to require MCOs, PIHPs or PAHPs to arrange alternative options for beneficiaries to receive care in a timely manner whenever medically necessary care is not available in-network within required time and distance standards. These options might include:

- Arranging beneficiaries to see out-of-network providers;
- Arranging for a provider to travel to the enrollee or a designated location that is within the state's standard for travel time and distance. These options should not result in additional out-of-pocket cost to beneficiaries.

Reducing disparities by addressing demographic factors. We are pleased to see the emphasis on the need to address demographic factors in § 438.68(c)(1)(viii)—race, ethnicity, language, or disability status—that contribute to disparities in access to care.

Recommendation: To further mitigate these disparities, we recommend including the following:

- Free language access services, such as translated materials and interpretation services available for all languages spoken by the lesser of 5 percent or 500 beneficiaries; and for taglines indicating the availability of language access services in the top 15 languages spoken by Medicaid beneficiaries.[10]

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[10] We draw the 5 percent standard from the Department of Justice (DOJ) and HHS' Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans. The 'top 15 languages spoken' standard is currently used by Medicare.

- Services that ensure physical accessibility and culturally appropriate services for beneficiaries with disabilities. These services include but are not limited to sign language interpretation services, transportation, dedicated outreach and follow-up to assist individuals with severe mental illnesses to make and attend appointments according to their plan of treatment, team-based care and other models that facilitate integration of behavioral, physical health care and long-term services and supports.

§438.68 (b)(2) (c)(2) Criteria for Development of Network Adequacy Standards for MLTSS program

We appreciate the separate standards that CMS has proposed for LTSS provided in the enrollee's residence and for those provided outside that residence. We also appreciate that these standards must also support consumer choice of providers and support consumer community living.

Recommendation: To develop these standards, we recommend that CMS convene a working group that includes Medicaid members and consumer advocates, and vet the proposed standards through a public comment period. Following the conclusion of that process, we recommend that CMS:

- Add more specificity to the requirements contained in these regulations;
- Require the state and plans to track how quickly LTSS services are started, what services are used and any missed visits, as Tennessee does; and
- Require needed adjustments in the networks.

§ 438.206, § 440.262 – Availability of Services

We are pleased to see that states would be required to take into consideration a number of factors—geographic location, accessibility for enrollees with physical and mental disabilities, ability of providers to provide culturally and linguistically appropriate care—while assessing network adequacy for MCOs, PIHPs, PAHPs and FFS in § 438.206(c)(2). Having adequate numbers and types of providers is important both as an access measure and a quality measure, and also to prevent plans from using network design as a way to discriminate against medically frail enrollees.

However, we urge CMS to ensure inclusion of a sufficient number and types of providers to deliver all health care services included in the plan's benefit package. MCOs, PIHPs and PAHPs must be held accountable for providing access to all covered services.

Recommendation: Include a wide range of providers for each of the following categories:

- Primary care providers such as family physicians and practitioners, nurse practitioners, physician assistants, general physicians and practitioners, internists and pediatricians;
- Specialty care providers such as oncologists, dental providers, providers specialized in LGBT health (i.e. treatment for gender Dysphoria), women's health and chronic diseases (i.e. cancer treatment, HIV/AIDS, diabetes);
- Pediatric providers such as pediatric subspecialists, pediatric dental providers and providers providing care for children with special health care needs;

- Ancillary service providers such as diagnostic services, home health services, physical therapy, speech therapy and occupational therapy;
- Essential community providers (ECP), as many of them have experience providing care for vulnerable populations;
- Providers providing LTSS as a result of a significantly growing number of LTSS beneficiaries; and
- Behavioral health providers, including providers specializing in the full range of substance use disorders services, including recovery support services.

Recommendation: We urge CMS to reconsider the language used throughout this section and other parts of the regulations to refer to providers. Using phrases such as "health care professionals" may inadvertently exclude providers such as peers, community health workers and paid family caregivers.

§438.207 – Assurances of Adequate Capacity and Services

We appreciate that CMS recognizes that health plan networks would require network adequacy documentation to be submitted periodically for review and certification. We agree with the timeframe of once per year for states to review and certify the adequacy of provider networks. We are also pleased to see the modification in the external quality review (EQR) process to mandate validation of plans' provider network adequacy and state access standards.

Recommendation: In addition to the annual certification process, we recommend that states be required to conduct annual reviews of data regarding compliance with the timeliness standards and to post findings from the reviews, and any approved waivers or alternative standards on the website of the state Medicaid managed care agency. Data can be collected from beneficiary complaints, beneficiary satisfaction surveys and secret shopper surveys.

§438.10 (g) – Publication of Network Adequacy

Provider networks must be exceptionally clear, accurate and accessible to beneficiaries. We applaud CMS' inclusion of PCCM entities in standards regarding oral and written translation standards, general and miscellaneous enrollee information standards, and enrollee handbook and provider directory content standards. We urge CMS to include stronger language around the accuracy of provider directories and to be clearer about the out-of-network protections afforded to enrollees.

Recommendation: CMS should require that this information should be clearly stated in beneficiary handbooks and enrollment notices: 1) that beneficiaries have a right to see out-of-network providers for covered benefits when in-network providers are not available on a timely basis; and 2) beneficiaries need to know how to file complaints if they receive balance bills from out-of-network providers.

Recommendation: We urge CMS to set strong requirements on the accuracy of provider directories for MCOs, PIHPs, PAHPs and PCCM entities, such as maintaining:

- Minimum accuracy rate of at least 97 percent with updates every 15 days;
- Easy online access: Plans must provide an email address and a telephone number for beneficiaries to notify them if any information on the provider directory appears to be

inaccurate. The reporting options should be accessible in a variety of languages, including American Sign Language and Braille;

- Uniform provider directory template that includes information on: whether providers are accepting new patients; the language spoken by each provider; specialty and subspecialty providers; language assistance services that are available at the provider's facilities and information about how enrollees can obtain such services; and the physical accessibility of the provider's facilities;
- Establish separate standards for substance use disorders providers and list them separately in network directories. Mixing them in with mental health providers in a category labeled behavioral health is confusing for consumers and may hide the existence of provider shortages; and
- Printed provider directories that are regularly updated and ready to be sent to beneficiaries if requested.

§ 438.214 – Provider Selection

We support proposed requirements that each state establish a uniform credentialing policy for LTSS providers and behavioral health providers. However, we urge CMS to include language cautioning that such policies must not exclude essential providers such as peer coaches, peer counselors, community health workers and paid family caregivers, who may not be licensed or have specific certification. Setting training requirements might be a method of addressing this issue, while ensuring that LTSS consumers are served by qualified providers;

Quality of Care (Subparts D and E of Part 438)

We are pleased to see the proposed regulations take a significant leap forward in strengthening and expanding on the quality of care provisions. We strongly support the following:

- Requiring states to implement comprehensive quality improvement standards
- Providing greater opportunity for stakeholder engagement in quality assessment and performance improvement planning
- Mandating external review quality reports to include performance measure data for any collected performance measures and performance improvement projects and to make these public on a state's Medicaid website.

Recommendation. Community Catalyst urges CMS to include provisions that can further strengthen quality of care in Medicaid and drive reductions in managed care health disparities:

- **Require states to incorporate into contracts with plans the use and reimbursement of Chronic Disease Self-Management Programs (CDSMP).** This is a threshold requirement for an evidence-based intervention that has demonstrated its cost-effectiveness.[11] Reimbursement should extend to organized group programs as well as

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[11] http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMP-Fact-Sheet.pdf

individual patient counseling and coaching, both of which are effective in helping patients develop personalized plans to manage their conditions, establish a more-healthy lifestyle, navigate the healthcare system and better understand their diagnoses.[12]

- **Improve data collection and reporting, by requiring states in contracts with plans to include data stratified by race, ethnicity, primary language, gender identity and sexual orientation for measuring success.** Collection and reporting of data on these measures will be an important contribution to creation of a long-term agenda for improving health care quality for populations experiencing disparities. We note that neither adjusting, nor failing to adjust, quality measurement or financial incentives for race/ethnicity or SES will actually reveal persistent disparities in treatment and outcomes. Improved data collection and reporting is essential for this purpose. CMS should:
    - Reinforce the data collection requirements under section 4302 of the Affordable Care Act by offering a financial incentive for improved data collection.[13]
    - Require plans to use the new consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services.[14] Implementing these measures is critical in addressing provider biases, poor patient-provider communication and poor health literacy.
- **Improve provider-patient communications by incorporating tools to assess, manage and reduce implicit biases among health care providers, which in turn can lead to better quality of care for beneficiaries of color.** These new regulations create an important opportunity that CMS should seize to move aggressively to reduce persistent disparities in treatment and outcomes. Evidence shows that implicit bias among health care providers is a key contributing factor to health disparities because it negatively affects treatment delivery and medical interactions between providers and patients.[15]
    - While race and ethnicity are two areas in which providers sometimes demonstrate implicit bias, a number of studies examining clinical decision-making suggest that implicit bias manifests in other areas, including gender and age.

§438.320 – Definitions

The definition of quality, as it pertains to external quality review, needs to be revised to be inclusive of LTSS. Although the pre-amble (on page 31150 of the Federal Register) discusses the importance of examining quality of life for LTSS recipients, the definition in this section speaks only to "desired health outcomes" of enrollees.

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[12] Bennett, H., Coleman, E., Parry, C., Bodenheimer,T. Chen, E.(2010). Health Coaching for Patients With Chronic Illness. *Fam Pract Manag*, 17(5), 24-29.

[13] We do not recommend imposition of financial penalties because the decision on whether to provide data rests with the patient.

[14] National Quality Forum (August 2012). Healthcare Disparities and Cultural Competency Consensus Standards. http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

[15] Smedley, B., Stith, A. & Nelson, A. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. *Institute of Medicine of the National Academies.* Retrieved from http://books.nap.edu/openbook.php?record_id=10260

§438.330 – Quality Assessment and Performance Improvement Program

We appreciate the inclusion of LTSS-specific mechanisms in section (b)(5) about basic elements of quality assessment programs. Assessing care received during and following transitions in settings is important, as is whether a consumer is receiving the services set out in their individual, person-centered service plan. **However, even more important is the outcome of these services, which should be examined by measuring quality of life.**

Recommendation: In overall performance measurement and quality assessment, not specific to LTSS, we recommend that CMS require the inclusion of the following additional measures:

- Progress in reducing health disparities;
- Rates of problems reported to state oversight, ombudsmen or other external sources, including those arising from consumer grievances and appeals;
- Number of cases of denials and reductions in service;
- Number of cases of neglect or abuse;
- Rates of preventable events including ambulatory-sensitive admissions, readmissions, preventable ER visits and hospital complications; and
- Patient activation score or similar measurement tools.

LTSS performance measurement. We appreciate CMS's proposed requirement in paragraph (c)(4) that states mandate through the contracting process that managed care plans measure enrollees' quality of life and improvements in rebalancing and community integration.

Recommendation: We recommend that CMS require:

- States to measure quality of life using surveys of consumers receiving LTSS that specifically ask about their ability to maintain independence and participate in work, relationships and community activities, if desired, and live in their preferred setting. CMS could specifically recommend use of consumer surveys, such as the National Core Indicators – Aging and Disability survey, to collect data on quality of LTSS services and outcomes including whether services are helping the consumer meet their goals for community living.
- Use of the four measures Community Catalyst and other national groups recommended in *Is It Working?Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers*;
- Measurement of the extent of consumer self-direction, a topic CMS mentions in the pre-amble on page 31151 of the Federal Register, but does not include in the regulations;
- Measurement of the timeliness and effectiveness of enrollee needs assessments;
- Measurement of the effectiveness of care coordination that includes assessing health status, functional status/ability, independence and community integration, patient

satisfaction and experience with care, outcomes for family members and informal caregivers, cost and resource use; and[16]

- Measurement of the adequacy of the direct care workforce, including turnovers and vacancies in the ranks of direct care workers and the impact on consumers – the latter including impact on quality and access to care.

Performance improvement projects. We oppose the proposal in paragraph (d)(3) to allow states to substitute a Medicare Advantage plan's quality improvement project for a Medicaid one. Medicare Advantage does not typically cover LTSS, so this could lead to exclusion of focus on LTSS.

Program review by the states. For consistency of paragraph (e)(1)(iii) with other parts of this section, we recommend CMS add the words "and rebalancing" to this paragraph so that it reads: "the results of any efforts by the MCO, PIHP, PAHP or PCCM entity to support community integration and rebalancing for enrollees using LTSS."

§438.332 – State Review and Approval of MCOs, PIHPs, PAHPs and PCCM Entities

We support requiring health plans to undergo an accreditation or similarly rigorous review before being approved to contract with states to provide Medicaid managed care. This will help ensure that higher performing plans are hired. However, we are concerned that both options suggested by CMS may not be appropriate for assessing whether a health plan is qualified to provide LTSS services, since many accreditation processes do not address LTSS.

> **Recommendation**: We urge CMS to reconsider the criteria for accreditation in the context of the growing use of managed LTSS. We also urge CMS to require states setting their own accreditation standards to use a process that includes meaningful stakeholder and consumer engagement.

§ 438.334 – Medicaid Managed Care Quality Rating System

We strongly support the requirement that each state establish a quality rating system for Medicaid managed care plans, as well as post it prominently and publicly on thestate’s websites. We believe such "report cards" can provide essential information to help consumers in their choice of a managed care plan during the enrollment process. **However, we are concerned that the rating criteria laid out by CMS will not capture the plans' performance on LTSS.**

> **Recommendation**: Revising the required components §438.334(a)(2) so that the quality rating system is based on the following four components:
> 1. Clinical quality management and, if applicable, management of LTSS;
> 2. Member and provider experience, including quality of life;
> 3. Enrollee access to care services; and
> 4. Plan efficiency and management.

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[16] Au, M., Simon, S., Chen, A., Lipson, D., Gimm, G., & Rich, E. (2011). Comparative Effectiveness of Care Coordination for Adults with Disabilities. *Mathematica Policy Research*. Retrieved from http://www.mathematica-mpr.com/~/media/publications/PDFs/health/comparative_care_rschbrief.pdf

- Disallowing use of the Medicare Advantage 5-star rating system § 438.334(d) for plans serving only dually eligible consumers. This system does not include any information about LTSS performance.
- Developing, in the long run, with consumer and other stakeholder input, a standard rating system that would be used across all states, as CMS proposes in the pre-amble on page 31153 of the Federal Register. This would help set national standards for plan performance.

§438.52 – Choice of MCOs, PIHPs, PAHPs, PCCMs and PCCM Entities

We are encouraged to see CMS' commitment to choice in the proposed regulations. **We have identified a few areas where CMS can strengthen the proposed regulations around choice:**

- Provide beneficiaries with at least <u>90 days</u> to make their decision between two entities;
- Ensure network adequacy, particularly in rural areas, where provider access may be limited; enrollees in particular communities should be able to access the type of provider they need if they have LTSS, behavioral health or multiple chronic condition needs.
- Ensure effective health communication
    - This is as important to health care as is clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language religious belief and health literacy of diverse patients. Health care organizations receiving federal funds must comply with nondiscrimination provisions addressed in Section 1557 of the ACA, as well as other applicable federal regulations including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Title VI of the Civil Rights Act of 1964. Additionally, health care organizations and providers should be required to meet all 14 standards of the National Standards for Culturally and Linguistically Appropriate Services (CLAS).[17]

§ 438.66 – State Monitoring Standards

We support the proposed rule which would establish new standards for the state's monitoring standards and the data that must be collected for purposes of quality improvement, readiness reviews and annual performance reports for MCOs, PIHPs, PAHPs and PCCM entities.

> **Recommendation**: Add "structures for engagement of consumers and consumer health advocates in quality plan operation, monitoring and quality improvement" to the list of elements in (e)(2) that should be required in each of these areas. As we mention in our comments on § 438.334 (Medicaid managed care Quality Rating System), stakeholder

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[17] U.S. Department of Health and Human Services, Office of Minority Health (March 2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

> engagement and inclusion of methods to measure the patient experience in managed care plans is critical to protecting quality of care.
>
> **Recommendation**: The state should be required to incorporate a public comment period before it finalizes the annual performance reports and readiness review of managed care plans. A summary of these public comments should be included with the annual reports and readiness reviews submitted to CMS.

We also appreciate the inclusion of LTSS in state monitoring. We also have a few recommendations to strengthen this.

> **Recommendation**: As part of the readiness review in § 438.66(d), CMS should require each state to assess its own readiness to provide LTSS through managed care, including development of expertise in LTSS. This point is very clearly made in CMS MLTSS guidance (page 5) but is missing here.
>
> **Recommendation**: Explicitly include in this section the language in the pre-amble stating that annual state assessment of and reporting on MLTSS "include alignment of payment rates and incentives/penalties with the goals of the program, any activities the managed care plans have undertaken to further the state's rebalancing efforts, and the satisfaction of enrollees with their service planners."
>
> **Recommendation**: Require that the state also assess and report on outcomes for LTSS consumers regarding their quality of life.

<u>Information Standards</u>

§ 438.10(a)(b) – Definitions and Applicability

It is critical that beneficiaries have meaningful access to vital information about their insurance plan in a language in which they are conversant. We support the changes made to § 438.10(b).

However, we strongly suggest CMS amend the definition of "prevalent" in § 438.10(a) to be consistent with standards used by the Department of Justice and HHS' Limited English Proficiency Guidance—in which "prevalent" means a non-English language determined to be spoken by 500 individuals or 5% of potential enrollees or enrollees in the plan's service area that are limited English proficient.

> **Recommendation**: Require MCOs, PAHPs, PIHPs and PCCMs to comply with language adopted by Department of Justice and HHS' Limited English Proficiency Guidance when conducting targeted marketing, outreach or other activities directed at a specific non-English language group.

§ 438.10(c) – Basic Rules

We applaud CMS for expanding transparency by requiring states to post to the state Medicaid agency website: the enrollee handbook, provider directory, state network adequacy standards, EQR technical report, contracts, audits and encounter data.

§ 438.10(d) – Language and Format

We generally support CMS' requirements, but suggest the following specifications:

- Adopt the prevalent non-English languages spoken by enrollees and potential enrollees we suggested for § 438.10(a);
- Provide oral information in all languages and written information in each prevalent non-English language. All written materials, for potential enrollees and enrollees must include prominent taglines in at least 15 non-English languages as well as large print explaining the availability of written translation and oral interpretation;
- Require each MCO, PIHP, PAHP, and PCCM to make its written materials, including at a minimum, provider directories, member handbooks, appeal and grievance notices, denial and termination notices and other notices that are critical to obtaining services; and
- Make interpretation services available to each potential enrollee and require such MCO, PIHP, PAHP and PCCM entity to make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language.

§ 438.10(e)(f)(g) – Information for Potential Enrollees, all Enrollees of MCOs, PIHPs, PAHPs and PCCM Entities

We appreciate that MCO, PIHP, PAHP, and PCCM entities must provide information to enrollees about Medicaid benefits that are not covered, which include family planning services and supplies and abortion services due to religious restrictions. We believe the same information should be provided to potential enrollees so they have sufficient information about what different plans cover to help them make an informed choice of plan.

> **Recommendation**: Require MCOs, PIHPs, PAHPs and PCCMs to send enrollee handbooks to enrollees within 5 calendar days after they receive notice of the beneficiary’s enrollment.

In regard to grievances, appeals and fair hearing procedures and timeframes, we strongly recommend CMS to require MCOs, PIHPs, PAHPs and PCCMs to provide clear information about:

- The availability of free, competent oral interpretation and written translation of materials for individuals who are limited English proficient and free auxiliary aids and services for individuals with disabilities, and
- How to access these services, including additional information in alternative formats or languages.

§ 438.10(h) – Provider Directory

Community Catalyst supports the inclusion of additional information related to accessibility for individuals with physical or behavioral disabilities as well as language capacity information. Further, the adoption of a standardized provider directory format and standardized open application programming interfaces (APIs) would be helpful in ensuring that provider directories are relatively easy for enrollees to use and for those operating the directories to update. Requiring plans to make formulary information available on their websites would also increase transparency for enrollees.

> **Recommendation**: With respect to language access for provider directories, we recommend that provider directories be available in languages spoken by the lesser of 5 percent or 500

plan enrollees or feature taglines indicating the availability of translations in the top 15 languages spoken by enrollees.

§ 438.10(i) – Information for All Enrollees of MCOs, PIHPs, PAHPs and PCCM Entities

We strongly support CMS' proposal to increase formulary transparency so that consumers can select the Medicaid managed care plan that best meets their individual health care needs. We agree that requiring plans to submit formulary information in a machine-readable format will facilitate search tools that allow potential enrollees and others to search across plans. We recommend adding the following, which would be critical information for consumers who must evaluate formularies and seek to understand treatment alternatives that could address their health care needs:

> **Recommendation**: We urge CMS to make sure that plans send adequate notice and explanation to beneficiaries regarding (1) which tier each medication is on; (2) access to non-preferred medications at preferred drug cost-sharing, as well as emergency access to medication; and (3) information on preferred and non-preferred medications; (4) evidence-based information from HHS, including links for consumers, on medication and non-medication alternatives for treatment of key medical and behavioral health conditions. The information referenced should include easily understandable summaries of research on the effectiveness of treatment alternatives; and the comparative costs of medications. At a minimum, links should be provided to the consumer guides published by the Agency for Healthcare Research and Quality's Effective Health Care program.

§ 438.14 – Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities

Community Catalyst commends the proposed rule for addressing both payment standards and network adequacy concerns tied to the delivery of health care services for American Indian/Alaska Native (AI/AN) populations. Specifically, we appreciate that the proposed rule:

- Provides AI/ANs enrolled in managed care programs with additional opportunities to choose providers who can best serve their health care needs.
- Seeks to address the limitations of current protections and standards, especially for AI/ANs living in rural areas and on reservations, which are prone to network adequacy issues and shortages of providers

Despite protections under current law requiring QHPs to include Indian health providers in their networks, AI/ANs, including those living in rural areas and on reservations, continue to face shortages of providers to provide culturally competent and improved health care services directly to AI/AN populations.[18] [19]

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[18] Kaiser Family Foundation. (2013). Health Coverage and Care for American Indians and Alaska Natives. Retrieved from http://kff.org/report-section/health-coverage-and-care-for-american-indians-and-alaska-natives-issue-brief/

[19] Gonzalez, A. & McGlaston, K. (2014). How the Affordable Care Act Impacts American Indian and Alaska Native Communities. *Community Catalyst.* Retrieved from http://www.communitycatalyst.org/resources/publications/document/aca-american-indian-alaska-native-communities.pdf

> **Recommendation**: To ensure health outcomes are addressed and responded to in AI/AN communities, CMS will need to ensure that there are providers available to service AI/AN populations directly. CMS will have to better address the shortage of providers available to provide health care services directly to AI/AN populations.

While CMS has proposed ensuring MCOs, PIHPs, and PAHPs participate in states' efforts to promote access in a culturally competent manner, CMS should address cultural and linguistic barriers can that hinder access (as per our recommendations in § 438.10), as does the burdensome documentation required for AI/AN consumers to prove eligibility for Medicaid, IHS or other types of coverage. Enrollment can also be curtailed by insufficient technological resources, including limited internet access.

> **Recommendation**: Provide more robust cultural competency considerations in this section as per our recommendations in § 438.10. CMS should also strengthen quality of care in considering diverse consumer populations as we have written in Subparts D and E of Part 438).

II. CHIP Requirements

Community Catalyst supports the goal of aligning regulations for the Children's Health Insurance Program (CHIP) with those governing Medicaid and the Marketplaces. As the health coverage landscape continues to shift, churn among coverage types is a key challenge that stands to impede access to health care services. Aligning these coverage types to the extent possible—with respect to network adequacy standards, provider directories, access standards, etc.—can help mitigate the challenges of enduring a change in coverage.

Moreover, given that CHIP's appropriation lasts only through September 2017 with the future of the program beyond that date being uncertain, it is prudent that processes and the enrollee experience in CHIP resemble those in Medicaid and Marketplace plans.

§457.204 – Federal Financial Participation

The proposed regulation does not seem to allow withholding federal financial participation (FFP) in the case that a CHIP managed care entity is in "substantial non-compliance" with the state plan, as is the case in Medicaid. **Community Catalyst urges CMS to apply this Medicaid standard to separate CHIP programs, in order to ensure that CHIP programs are operating in accordance with the state plans approved by CMS.**

§457.950, §457.1201 – Contracting Requirements

Community Catalyst supports the proposed regulation that requires contracts to guarantee that an entity "will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources" (such as school-based health services). This requirement is reasonable and will prevent entities that are being paid to provide care with public funds from shirking this responsibility and passing the costs of enrollee care onto public entities.

The proposed CHIP regulations do not include the LTSS standards laid out at §438.2(o) or the standards for enrollees who are patients in an IMD at §438.3(u), on the grounds that these standards are not applicable to the CHIP population. **Community Catalyst disagrees with the**

premise that the CHIP population does not overlap with the populations in need of LTSS or IMD services. While many children who require LTSS are eligible for Medicaid, CHIP enrollees who have special health care needs but who do not meet the SSI criteria for disability would benefit from access to these services.

> **Recommendation**: Encouraging use of LTSS, including community based LTSS, as a way to prevent acute care episodes makes sense in terms of prudent use of CHIP dollars and improved enrollee outcomes. Moreover, CHIP enrollees could require care through an IMD. As such, Community Catalyst encourages CMS to apply the standard proposed for Medicaid to CHIP as well.

§ 457.940, § 457.1203, § 457.1205 – Rate Development and Medical Loss Ratio

We have the same comments as we do in sections § 438.4, § 438.5, § 438.8, and § 438.74.

§ 457.1210, § 457.1212, § 457.1216 – Managed Care Enrollment Disenrollment and Continued Services to Beneficiaries

Community Catalyst supports the addition of §457.1216, which would provide that "states must follow the Medicaid standards related to continued services at §438.62." Individuals with special needs—especially children—rely on relationships with their providers, and disruptions to those relationships for any reason, including changes in health coverage, can impede access to care and be detrimental to health. Moreover, adjusting regulations to reflect an updated view of primary care that includes a broader set of enrollee needs—including behavioral health services and non-health care services delivered in the community—ensures that enrollees' full range of needs can be met.

> **Recommendation**: Community Catalyst would support the addition of a paragraph naming managed care entities as organizations that link enrollees to other community based supports and resources.

§457.1218 – Network Adequacy

Given the structure of the network adequacy standards proposed for Medicaid at §438.68, additional CHIP regulations do not appear to be needed, assuming that concerns related to standards for pediatric providers are strong and include separate standards for pediatric behavioral health providers and a separate ECP category for children's hospitals. These pediatric-specific standards should apply to Medicaid as well.

§457.1240, §457.760 – Quality Measurement and Improvement

The proposed regulations would require states to "incorporate CHIP into their state comprehensive quality strategy." Community Catalyst agrees that this approach makes sense, given the overarching goal of integrating CHIP into the broader health coverage landscape. That said, throughout the process of selecting measures for entities and states to report, specific attention to pediatric care and the features that distinguish it from adult care will be important to consider.

§457.126 – Grievances

Community Catalyst disagrees with the proposal to exclude §438.420 from being applied to CHIP. This exclusion would allow states to allow managed care entities to terminate services for CHIP enrollees pending an appeal. Applying the prohibition on termination of services would ensure children have access to needed services during the appeals process.

§457.1208 – Requirement Related to Indians, Indian Health Care Providers, and Indian Managed Care Entities

We support aligning CHIP standards with Medicaid for this section. With regard to these requirements, we have the same comments as in section §457.14.

§457.1230 – Access Standards

Broadly speaking, aligning CHIP access standards with those for Medicaid is a reasonable policy. With respect to assurances of adequate capacity and services (§438.207), entities should be able to document their ability to provide access to pediatric specialty providers; adding this stipulation to the requirements for certification would ensure children have access to a full range of services. §438.210, which addresses continuity of coverage during an appeal, makes clear that enrollees need access to continuous care, especially with regard the behavioral health and LTSS, and subpart (a)(5)(ii) proposes that medically necessary services must include Early, Periodic Screening, Diagnosis, and Treatment (EPSDT).

Community Catalyst supports this clarification, as it ensures children can access the full range of recommended services on schedule, even if an appeal is ongoing. **Although this portion of the regulation is not carried over from Medicaid to CHIP, this is an important clarification of Medicaid policy.**

The proposed regulations raise a question about exemption for §438.210(b)(2)(iii) related to LTSS and care planning for CHIP. It would be reasonable and an appropriate policy shift to encourage CHIP programs toward offering needs assessment and care planning by creating this exemption.

Thank you for this opportunity to provide comments on this proposed rule, and for keeping consumers a priority as you continue your important work implementing the Affordable Care Act. If you have any questions regarding our comments, please contact Amber Ma (ama@communitycatalyst.org)

Respectfully submitted,

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