LeadingAge New York

July 27, 2015

Andrew Slavitt
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: **File Code CMS–2390–P**

Dear Mr. Slavitt:

I write on behalf of LeadingAge New York to comment on the Proposed Rule governing Medicaid Managed Care and CHIP Delivered in Managed Care, published in the June 1, 2015 Federal Register (80 FR 31097).

LeadingAge New York's nearly 500 members represent the entire continuum of not-for-profit and public providers of continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs, PACE programs, managed long term care (MLTC) plans and fully-integrated plans for dual eligibles (FIDA plans). Sponsored by not-for-profit providers of long term services and supports (LTSS), our MLTC members are partially-capitated plans that cover a comprehensive array of LTSS for dual eligibles and are classified as Pre-Paid Inpatient Health Plans (PIHPs) under federal regulations. Our FIDA plan members are also sponsored by not-for-profit providers of LTSS and cover the full spectrum of Medicare and Medicaid benefits, with limited exceptions.

We appreciate CMS's effort to update its regulations and its recognition of the growth of Medicaid managed care programs that serve individuals who need LTSS. Our comments focus on the implications of the Proposed Rule for FIDA plans and for PIHPs that principally cover long-term services and supports (henceforth collectively MLTSS plans). An overarching concern is the relationship between the Proposed Rule, the terms and conditions of New York's Medicaid Section 1115 waiver, and the Memorandum of Understanding (MOU) governing New York's financial alignment demonstration (known as the Fully-Integrated Duals Advantage Program (FIDA)). To the extent that there are inconsistencies between the proposed regulations and the waiver or the MOU, which requirements would govern? As New York continues to expand its MLTSS programs through mandatory enrollment in PIHPs and passive enrollment in FIDA plans, a clear understanding of the applicable requirements will be critically important.

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

I) Calculation of Medical Loss Ratio (MLR) and Use of MLR in Developing Rates (Preamble, Section I(B)(1)(c), p. 31107-13, 42 CFR §438.8)

We share CMS's interest in ensuring fair and equitable Medicaid premium rates and in using standardized measures to advance that goal. We further share CMS's desire to ensure that capitation rates are sufficient to support appropriate access to high quality care. While medical loss ratio (MLR) calculation and reporting may be appropriate tools to advance the goal of actuarially sound rates, we are concerned that CMS's proposal for the calculation of the MLR and the development of rates based on a minimum MLR of 85 percent may not achieve its intended result with respect to MLTSS plans.

1. MLR Thresholds and Administrative Costs Incurred by MLTSS Plans (Preamble Section I(B)(1)(c), p. 31107-09, 42 CFR §438.8(c), (e))

Under the Proposed Rule, states would be authorized to establish minimum MLRs of greater than 85 percent, and CMS indicates in the Proposed Rule's preamble that a minimum MLR higher than 85 percent may be "appropriate" for MLTSS plans (p. 31109). This assumes that non-claims/administrative costs represent a lower percentage of premium in MLTSS plans than in other managed care plans. On the contrary, it is reasonable to assume that administrative expenses would be higher as a percentage of premium in MLTSS programs. Because mandatory enrollment in managed care for Medicaid beneficiaries who need LTSS is in its infancy in New York and nationally, enrollment in MLTSS plans is low in comparison with the mainstream MCOs. These plans tend to have comparatively small enrollment, and consequently their fixed administrative costs are spread across a small premium base.

In addition to small enrollment, programmatic features also drive higher administrative costs in MLTSS plans. For example, MLTSS plan networks necessarily include a broad array of non-medical, community service providers. These community service providers often lack robust billing systems and expertise in Medicaid requirements. They require MLTSS plans to provide extra technical assistance and oversight to ensure that claims are submitted properly and Medicaid's complex requirements are satisfied. In addition, virtually all enrollees in MLTSS plans in New York State are dually eligible for Medicaid and Medicare. As a result, MLTSS plans incur high administrative costs on systems to cover their members' Medicare cost sharing and ensure that Medicare-covered, post-acute services are not billed as Medicaid services. MLTSS plans in New York State must also manage complex financial eligibility requirements, such as collection of net available monthly income and transfer of asset penalty periods when members transition from community-based to institutional care. All of these factors raise administrative expenses as a percentage of premium in MLTSS plans.

Comment: We recommend that the minimum MLR standard take into account the programmatic features that affect different types of plans and drive variations in their administrative costs. As a general matter, minimum MLRs for MLTSS plans should be lower than MLRs for mainstream plans.

2. Calculation of the MLR Numerator and Activities that Improve Health Care Quality (Preamble, Section I(B)(1)(c)(2), p. 31110, 42 CFR §438.8(e))

The Proposed Rule applies the definition of "activities that improve health care quality," under 45 C.F.R. §158.150, to incorporate outreach, engagement, care management, and service coordination activities in the numerator of the MLR. Recognizing that MLTSS plans may incur significant expenses related to activities such as outreach, care management, and service coordination, CMS requests comments on this approach.

We agree that these activities must be included in the numerator of the MLR, in order to arrive at a fair and equitable premium that appropriately covers necessary costs. However, the definition at 45 C.F.R. §158.150 refers principally to medical services and does not easily translate to non-medical services or community supports. For example, it requires activities to "increase the likelihood of desired health outcomes" and be "grounded in evidence-based medicine." The covered activities speak to "hospital" discharge planning, but not nursing home or home care discharge planning. Furthermore, they do not mention comprehensive assessments, which are a critical component of quality in MLTSS plans and can be frequent and resource-intensive.

Comment: In order to appropriately reflect expenditures related to outreach, care management, and service coordination for beneficiaries who require LTSS, the regulations should include in the MLR numerator expenses associated with assessments and activities related to optimizing the functional status, mental status, and community integration of beneficiaries.

3. Calculation of the MLR Numerator and Health Information Technology (Preamble, Section I(B)(1)(c)(2), p. 31110, 42 CFR §438.8(e)(3)(iii))

The Proposed Rule also provides for the inclusion of certain health information technology (health IT) expenses in the numerator of the MLR, provided they satisfy the requirements set forth in 45 CFR §158.151 for health IT expenditures by health insurers. To qualify for inclusion in the MLR numerator under section 158.151, expenditures related to the adoption and meaningful use of electronic health records (EHRs) must support "certified electronic health records technologies." Several provider types, including long-term/post-acute care (LTPAC) and behavioral health providers, have not been eligible for meaningful use incentive payments. As a result, certification bodies have been slow to develop certification standards for LTPAC products, and EHR vendors have been slow to seek certification of their LTPAC products. Currently, only a handful of EHR products are certified for LTPAC providers. Accordingly, as drafted, the regulations may discourage managed care plans from making EHR-related payments to LTPAC and similarly situated providers, as they may lack access to certified EHRs. Since EHR adoption by these providers will be critical to the success of MLTSS and other delivery system transformation efforts, the regulations should, instead, encourage MLTSS plans to incentivize the adoption of EHRs by LTPAC providers.

Comment: We recommend that the regulations include in the MLR numerator expenditures related to the adoption and meaningful use of EHRs, whether or not those EHRs are certified. MCOs and PIHPs should have the discretion to decide whether or not to make expenditures on non-certified

EHRs. If they make such expenditures, their investments should be recognized in the MLR calculation.

4. Calculation of the MLR Numerator and Telehealth Technology (Preamble, Section I(B)(1)(c)(2), p. 31110, 42 CFR §438.8(e)(3))

Neither the health IT provisions nor the quality-related activities provisions reference expenses related to telehealth technology. LTSS providers and MLTSS plans are increasingly using remote patient monitoring and medication management technologies to support management of chronic diseases and post-acute care.

Comment: Telehealth expenses, including remote patient monitoring, should be included in the MLR numerator.

5. Inclusion of State-Mandated Expenditures for Public Policy and Public Health Initiatives (Preamble, Section I(B)(1)(c)(2), p. 31110, 42 CFR §438.8(e))

As the primary payer for health care services for the majority of Medicaid beneficiaries, MCOs and PIHPs are frequently asked by states to make payments to providers to support public policy or public health initiatives, such as workforce recruitment and retention or value-based payment.

Comment: To the extent that plans are required by the state to fund public policy/public health initiatives, such expenses should be included in the MLR numerator.

II) Development of Actuarially Sound Capitation Rates (Preamble, Section I(B)(3), p. 3118, 42 CFR §438.4))

We support CMS's aim to promote "more transparent and consistent documentation of the rate-setting process. We further share CMS's goal of managed care rates that are "sufficient and appropriate for the anticipated service utilization of the populations and services covered" and provide "appropriate compensation to the plans for reasonable non-benefit costs" (p. 3119). In furtherance of these goals, we agree that the actual rate for each rate cell should be certified by an actuary and approved by CMS, not merely a range of rates.

However, we question whether the rate development process set forth in the Proposed Rule adequately reflects the regulatory environment in which MLTSS plans must operate. In order to ensure that managed care rates are "sufficient and appropriate," anticipated service utilization must be calculated appropriately not only based on the populations and services covered and trends, but also in light of regulatory requirements that influence utilization. Due to the stringent qualifications for enrollment in MLTSS plans in New York State, MLTSS enrollees have complex medical conditions, disabilities, and significant functional limitations. Their service needs do not lend themselves to aggressive utilization management. Moreover, MLTSS plans are working with the states, providers and stakeholders to advance the community integration goals of the *Olmstead* decision. This policy imperative further limits the ability of MLTSS plans to manage utilization to reduce costs -- community-based care for individuals with complex medical conditions and severe

disabilities can, in certain cases, be more expensive than institutional care. The person-centered planning standards incorporated into the Proposed Rule, and the requirement that plans continue services pending the conclusion of appeals and fair hearings, similarly limit the ability of plans to manage utilization. Given these constraints, it is not reasonable to assume that MLTSS plans will be able to manage utilization aggressively to achieve significant reductions in LTSS. Accordingly, the Proposed Rule should not allow the rate development process to include adjustments to base utilization that assume aggressive utilization management in MLTSS plans.

We are also concerned that assessment and care management costs are not appropriately captured in the rate development provisions of the Proposed Rule. While the Proposed Rule explicitly addresses engagement, outreach and care coordination costs as part of the numerator in calculating the MLR, it does not directly address the treatment of these and related assessment and care management costs in the context of developing actuarially sound rates.

Comment: We urge CMS to prohibit the use of base utilization adjustments in rate development that assume aggressive utilization management in MLTSS plans. In addition, we recommend that costs associated with assessment, engagement, outreach, and care management be incorporated into the rate development process as adjustments to the base rates. As these expenditures are essential to the beneficiary's ability to access necessary services and achieve optimal outcomes, they should be treated as benefit costs, rather than administrative or non-benefit costs.

III) Compliance with Home and Community-Based Setting and Person-Centered Planning Standards (Preamble Section I(B)(2), p. 31114, 42 CFR §438.3(o), 438.208(c)(3)(ii))

The Proposed Rule requires plans to provide services that could be authorized through a 1915c waiver or through sections 1915i or 1915k consistent with standards for home and community-based settings and person-center planning set forth in 42 C.F.R. §441.301(c)(4). These standards represent a comprehensive effort to ensure that Medicaid-funded, home and community-based services accessed by people with disabilities are delivered in a person-centered manner in the most integrated setting appropriate to the person's needs. While this goal is critically important, the implementation of these standards raises complex challenges, particularly in the context of a managed care program.

For example, under the home and community-based setting standards, community-based services provided on the campus of an institution are subject to heightened scrutiny and must be approved by the Secretary. If the setting is not approved, Medicaid funds cannot be spent on those services. Nationwide, many senior services organizations offer a continuum of care on campuses that may include nursing homes, adult day health care, social adult day care, assisted living, home care, and senior housing. Medicaid beneficiaries in New York have accessed services in these campus-based settings for years through waivers and the State Plan. However, under the Proposed Rule, MLTSS plans may be prohibited from authorizing services in these settings, absent approval by the Secretary.

The person-centered planning standards present additional implementation challenges for MLTSS plans. The standards appear to be geared toward providers, rather than managed care plans that serve potentially thousands of individuals, each of whom receives services from multiple providers. It will be challenging, for example, for an MLTSS plan to secure the signature of the enrollee and all of

his/her providers on the service plan (42 CFR §441.301(c)(2)(ix)). Moreover, the consensus-based, person-centered planning envisioned by section 441.301 limits the ability of MLTSS plans to manage utilization. Accordingly, as discussed above, in developing actuarially-sound rates, states and their actuaries should not assume significant reductions in LTSS utilization under MLTSS plans.

Comment: New York State has adopted a five-year transition plan for implementation of these standards by home and community-based services providers. At a minimum, MLTSS plans should not be asked to implement the standards in advance of service providers. Given New York's policy of mandatory enrollment in managed care, a requirement that Medicaid managed care plans implement the standards in advance of the transition plan would effectively render the transition plan moot and prevent the careful planning it is intended to enable. The implementation of the standards by MLTSS plans should be phased in, in accordance with the State's transition plan, to take place within a reasonable time after implementation by providers.

IV) Quality Measurement and Managed Care Quality Rating System (Section I(B)(5)(g)(2), p. 31144, 42 CFR §§438.330, 438.334)

The Proposed Rule would require each MCO, PIHP, and Pre-Paid Ambulatory Health Plan (PAHP) that covers LTSS to "include as part of its performance measurement activities . . . and in addition to other measures required of all MCOs, PIHPs and PAHPs, measures that assess the quality of life of beneficiaries and the outcomes of the [plan's] rebalancing and community integration activities for beneficiaries receiving LTSS" (42 CFR §438.330(c)(4)(proposed)). It further requires states to establish a quality rating system for Medicaid managed care plans that reports on the measures identified by CMS, but allows states to use an alternative quality rating system with CMS approval (42 CFR §438.334 (proposed)).

We support quality measurement of plan and provider performance using well-defined, risk-adjusted, tested, and reliable quality measures. However, it is important to recognize that quality measures applicable to primary and acute care typically cannot be imported into the LTSS field. Thus, applying the measures required of mainstream MCOs, PIHPs and PAHPs to MLTSS plans, as the Proposed Rule suggests, will not provide useful information about MLTSS plan performance. In addition, quality measures for non-medical LTSS are generally not well-developed, tested, and uniformly implemented.[1] Outcome measures related to quality of life and community integration are particularly scarce.[2] The National Quality Forum Measure Applications Partnership has identified a gap in measures to evaluate home and community-based services and has initiated a multi-stakeholder committee of experts to prioritize performance measurement opportunities in these services."[3] While assessing the quality of life and the outcomes of community integration activities

[1] Reeves, E.L. and Musumeci, M., "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, May 2015, available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/ .

[2] Musumeci, M., "Measuring Long-Term Services and Supports Rebalancing," Kaiser Family Foundation, Feb. 2015, available at http://kff.org/medicaid/fact-sheet/measuring-long-term-services-and-supports-rebalancing/ .

[3] National Quality Forum, *Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework*, Interim Report, July 2015, available at

for beneficiaries receiving LTSS is unquestionably an important goal, it is premature to implement a national system of measurement of these domains.

Comment: The regulations should require that performance measurement activities evaluate plans based on quality measures applicable to the services and populations covered. In addition, quality measures should be deployed only if they have been developed, risk-adjusted, and tested based on available data for the applicable plans and have proven to be reliable indicators of performance. Quality rating systems should compare only plans that cover the same categories of services and populations (e.g., MLTSS plans should not be rated against mainstream MCOs). Consistent with these basic principles, the regulations should provide states with considerable flexibility in implementing MLTSS quality measures and alternative quality rating systems for MLTSS plans. New York State has made significant strides in measuring and reporting on quality in MLTSS plans. The regulations should be crafted carefully to support, not undermine, state-based quality improvement efforts.

V) Provider Screening Enrollment (Section I(B)(4)(c)(1), p. 31128, 42 CFR § 438.602(b))

The Proposed Rule would require states to screen, enroll and revalidate all providers in Medicaid managed care plan networks, as if they were fee-for-service providers. Many providers that participate in Medicaid managed care plans are not also enrolled in the Medicaid fee-for-service program. In MLTSS plan networks, providers of community services, in particular, may not be enrolled as providers in the Medicaid program. Their services may not be covered by the state plan and may not be reimbursable by Medicaid on a fee-for-service basis. For example, providers of home-delivered meals and certain personal care providers are not eligible to enroll as Medicaid fee-for-service providers. Furthermore, states may lack the systems to screen, enroll and revalidate all managed care network providers, particularly providers that will not be participating in the fee-for-service program. This requirement will prove to be burdensome to community services providers and state Medicaid agencies alike and will likely result in delays in network development.

Comment: The regulations should continue to permit plans to screen and enroll their network providers.

VI) Grievances and Appeals (Section I(B)(1)(b), p. 31104-07, 42 CFR Part 438, Subpart F)

As a general matter, we support the alignment of Medicaid managed care grievance and appeal processes with those of Medicare Advantage plans. In New York State, all of the beneficiaries served by partially-capitated MLTC plans are dual eligibles. Some may be simultaneously enrolled in Medicare Advantage plans. The alignment of the grievance and appeal timeframes and procedures between the two programs will reduce confusion among beneficiaries.

We request clarification on whether the regulations will supersede the grievance and appeal provisions of a waiver or financial alignment MOU and the extent to which a state's program may deviate from the processes set forth in the Proposed Rule pursuant to a waiver or MOU. The 1115 waiver governing New York's partially-capitated MLTC program and the MOU and 3-Way Contract

governing its FIDA program differ in several respects from the processes set forth in the Proposed Rule. For example, New York State has recently eliminated from its partially-capitated managed long term care program the internal appeal exhaustion requirement as a prerequisite for a fair hearing, whereas the Proposed Rule appears to require exhaustion. In addition, New York's timeframes for certain steps in the process are different from the timeframes set forth in the Proposed Rule. The FIDA MOU, by contrast, sets forth an appeals process that corresponds to the timeframes in the proposed rule, but unlike the proposed regulations, the MOU does not require prompt oral notice of a FIDA plan request for an extension of time to render a decision on appeal; it requires written notice only.

Comment: CMS should clarify the relationship between the proposed amendments to the regulations and the provisions of existing waivers and financial alignment demonstrations.

VII) Beneficiary Support System for beneficiaries who use LTSS (Section I(B)(5)(c) p. 31136, 42 CFR §438.71)

The Proposed Rule provides for the creation of a Beneficiary Support System for Medicaid beneficiaries who use LTSS. Among the various responsibilities of this entity would be oversight of LTSS program data to identify and resolve systemic issues. In New York State, Medicaid managed care plans are subject to oversight by a variety of State and federal agencies, including: the State Department of Health, the Office of the State Comptroller, the Department of Financial Services, the Managed Care Advisory Review Panel, the Attorney General, the Office of the Medicaid Inspector General, CMS, and the Department of Health & Human Services' Office of the Inspector General. Their responsibilities include identification and resolution of systemic issues related to compliance, finances, health care quality, rights of beneficiaries, and more.

Comment: We ask that CMS clarify the oversight role of the Beneficiary Support System, in order to ensure that it would supplement, but not duplicate, the existing work of other governmental entities charged with overseeing Medicaid managed care programs.

VIII) Coverage and Authorization of Services (Preamble, Section I(B)(5)(d), p.31138, 42 CFR §438.210(a)(4))

Current regulations require state contracts with managed care plans to ensure that "services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which [they] are furnished." However, the contract may allow the plan to "place appropriate limits on a service -- [o]n the basis of criteria . . .such as medical necessity." The Proposed Rule would require that the contracts define medical necessity in a manner that specifies the extent to which the MCO, PIHP, or PAHP is responsible for covering services that "address the opportunity for an enrollee to have access to the benefits of community living."

Comment: While we agree that the standards for authorizing services should be modified to address non-medical services that support community living, the proposed definition is both broad and vague.

IX) Care Coordination Activities (Preamble, Section I(B)(5)(e)(3), p. 31140, 42 CFR §438.208(b)(5))

The Proposed Rule would require managed care plans to ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.

Comment: To the extent that this contemplates an electronic health record, this requirement is not realistic at this time. LTPAC, behavioral health, and social services providers have not been eligible for meaningful use incentives. As a result, adoption of EHRs by these providers is lagging, and even those providers that have adopted EHRs rarely have the ability to share information electronically.

X) Definition of LTSS (Preamble, Section B(5)(g)(1), p. 31142, 42 CFR §438.2)

The Proposed Rule provides a definition of long-term services and supports (LTSS). While we have no objection to the definition itself, the commentary on the definition in the preamble of the Proposed Rule reflects a misconception that we would like to correct. The preamble states: "We intend for community based services within the scope of this definition to be largely non-medical in nature and focused on functionally supporting people living in the community." In fact, "medical" community-based services, such as home health care, private duty nursing, and medical adult day health care, are important elements of the continuum of LTSS that enable people with disabilities and complex health care needs to optimize their independence and live in community settings.

Comment: Any program that provides a continuum of LTSS should contemplate and accommodate the inclusion of medical community-based LTSS.

XI) Network Adequacy (Preamble, Section B(6)(a)(2), p. 31146, 42 CFR §438.68)

The Proposed Rule would require states to establish network adequacy standards, including MLTSS-specific standards. States would be permitted to implement an exceptions process, provided that the standard by which the exceptions will be evaluated and approved must be specified in the managed care plan contract. In addition, a state's approval of an exception "must be based on the number of health care professionals practicing in that specialty in the [plan's] service area." As currently drafted, this exception appears to apply only to medical services and only in the context of a shortage of health care professionals. It does not take into account the variety of non-medical services that could be covered by an MLTSS contract and the non-clinical or non-professional staff who may also be in short supply.

Comment: The exception should be expanded to include the number of providers of the particular type of LTSS operating in the service area.

XII) Information Requirements (Preamble, Section B (6)(d), p. 31162, 42 CFR §438.10(h)(3))

The Proposed Rule includes provisions to ensure that provider directories are periodically updated by managed care plans. In particular, the Rule would require plans to update paper directories monthly. We assume that the paper directories need not be mailed out to all beneficiaries each time they are updated.

Comment: Please clarify that updated paper directories must be mailed to beneficiaries only upon request.

We appreciate the opportunity to comment on this Proposed Rule. Please do not hesitate to contact us, if you have any questions. We look forward to working with CMS on these and other issues. Thank you for your consideration.

Sincerely yours,

Karen Lipson
Executive Vice President For Innovation Strategies