January 14, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2408-P

Submitted electronically to http://www.regulations.gov

Dear Ms. Verma:

The Association for Community Affiliated Plans (ACAP) thanks you for the opportunity to comment on the proposed Centers for Medicare and Medicaid Services (CMS) rule Medicaid Program: Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care, published November 14, 2018 in the Federal Register. ACAP is an association of 60 nonprofit and community-based Safety Net Health Plans located in 29 states. Collectively, ACAP health plans provide coverage to 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly-supported programs.

ACAP’s comments on the proposed rule have been organized by subject area. However, we make two general comments to CMS as well. First, the prior iteration of the CMS managed care regulation was finalized during the spring of 2016, just over two and a half years ago, with compliance deadlines extending into 2019. As CMS revises these regulations, it is key to recognize the resources already expended by states and plans to implement the many complex parts of the final 2016 rule. Second, while the proposed rule published in November will not require as many amendments to Medicaid managed care programs as the final 2016 regulation, CMS should strive to ensure fair implementation timeframes for those changes that will be required. At present, the proposed regulation lacks clarity as to when states and plans must implement the changes in the proposed rule.

Additional ACAP comments on the following issue areas will be described in greater detail later in this letter:
Setting actuarially sound rates

ACAP supports CMS’ efforts to increase transparency, accountability, and flexibility in the rate-setting process. As we are all aware, Medicaid managed care financing is complex, requiring a strong partnership between CMS and states, and also between states and managed care organizations. The consequences of unfair rates can be dire, impacting access to care and health care quality for millions of individuals who very often have no other way to receive needed health care services. We believe that some of CMS’s proposed regulatory revisions demonstrate progress in this area. In addition, we applaud CMS for including submission and approval timelines for managed care rates in its first published Medicaid and CHIP Scorecard. While the data published in the 2018 Scorecard clearly demonstrate the need for improved state and federal practices, we agree that this increased transparency is the first step toward progress.

However, as we have discussed with CMS officials numerous times in the past, we firmly believe that more can be done to increase transparency in the rate setting process, particularly on the part of state practices with plans. ACAP has long argued that state rate-setting for Medicaid health plan services should be as transparent as practicable, and while CMS has in the past made strides to increase transparency and oversight between the federal government and states, it has so far declined to extend that transparency to rate-setting interactions between states and plans.

In 2017, ACAP surveyed our member plans on state rate-setting practices and actuarial soundness. The answers of the 24 responding plans, summarized below, justify our continued requests that CMS exercise increased oversight of state rate-setting processes.

- On a scale from 1 (not transparent) to 10 (very transparent), plans on average rated their states’ transparency in rate-setting at 5.
  - Nine plans rated their states’ transparency between 1 and 3.
- Twenty respondents said that states have used efficiency factors based on less than transparent data, including 13 plans that said their states set efficiency factors that were not realistic or achievable by any plan.
Sixteen plans said their states pay inadequate or actuarially unsound rates for certain populations, including aged/blind/disabled, childless adults, the Medicaid/Medicare Plan (MMP) population, and new populations.

Fifteen plans responded that their states have carved in new services with questionable rates or rates that are not transparent.

Thirteen plans responded that their states have implemented across-the-board cuts based solely on budgetary considerations without any other clear justification.

Nine plans responded that their states have reduced health plan rates that were previously approved by the state or a state-contracted actuary.

Only 9 of 22 respondents said their states disclosed information sufficient for the plans to replicate rate calculations.

Only 10 of 22 respondents said that their states release rate tables in advance of contract negotiations.

Given these challenges, ACAP makes the following unsolicited recommendations to CMS.

_CMS should require states to disclose in a timely manner sufficient information to permit plans to replicate the rate-setting methodology and underlying assumptions._

_CMS should establish an appeals process for plans related to actuarial soundness. Such a process would allow plans to request an additional review of the actuarial soundness of a state’s MCO rate setting process and/or methodology by the CMS actuary._

_CMS should develop a web page that lists the following information; this web page should be public-facing, or, at the least, accessible by Medicaid health plans and states:_

- The date CMS received each specific state’s contract and/or rates for review;
- The date CMS began review of each state’s contract and/or rates;
- A status indicator that defines stages of rate review and identifies which stage of the process the rate review is in; and
- The date on which CMS rate review is concluded.

_CMS should develop a best practice toolkit for states on rate development transparency, highlighting state practices that encourage the provision of historical costs, trends, and assumptions to Medicaid MCOs._

In the draft rule, CMS proposes to add a new provision at § 438.4(c) to permit states to develop and certify a rate range of 5 percent per rate cell as long as states adhere to
certain requirements, including actuarial soundness standards. ACAP knows that flexible rate ranges have been used effectively in the past to ensure adequate payment to plans and providers, and in general we support CMS’ effort to provide states with more flexibility. However, plans harbor serious and well-founded concerns that without CMS’s clear commitment to oversight of state processes, rates may fall short of actuarial standards. ACAP feels strongly that these recommendations apply in all cases of rate setting, not just when states employ rate ranges.

*ACAP supports additional flexibility for states, such as use of rate ranges described in proposed § 438.4(c), only if CMS exercises strong oversight of states to ensure that all requirements, including actuarial soundness standards, are strictly met.*

CMS also proposes to add a new § 438.7(e) codifying its current practice of issuing annual subregulatory guidance with information related to federal standards for rate development, documentation required from states, updates or developments in the rate review process to reduce state burden and facilitate prompt actuarial reviews, and documentation necessary to show capitation rates competitively bid through procurement comply with these regulations.

*ACAP supports § 438.7(e) and CMS’s commitment to issuing annual subregulatory guidance on rate development, rate review process, and rate approvals. As these processes are of critical importance to plans, providers, and others, we also request that CMS provide a comment period each year when the guidance is published.*

**Special contract provisions related to payment**

CMS proposes to amend § 438.6(b)(1) to prohibit states from retroactively adding or modifying risk-sharing mechanisms such as reinsurance, risk corridors, and stop-loss limits, to protect against cost-shifting. ACAP comprehends CMS’s perspective when it suggests that states should document risk-sharing mechanisms in contract and rate certification documents prior to the rating period. However, we are also concerned that such a policy may restrict states from employing important tools for paying plans in a volatile health care environment. For example, addition of new technologies, drugs, and populations to the Medicaid managed care program often require retroactive adjustment of plan payments; rates may be adjusted, but states have also effectively employed risk-sharing mechanisms to ensure that plans receive appropriate payment. Continuing to allow this retroactive addition or modification of risk-sharing mechanisms will allow states to pay plans adequately when substantial coverage changes occur mid-year.

Furthermore, as described in our [August 2018 letter](https://example.com) submitted jointly with AHIP, BCBSA, and MHPA, we believe that CMS should encourage adoption by states of risk
mitigation strategies for new populations and new markets for which there is not enough experience or credible data to set rates with confidence. Such practices would minimize the need for retroactive rate adjustments. We believe that CMS’s proposed changes to § 438.6(b)(1) may have the unintended consequence of hampering state interest in effective risk mitigation strategies.

ACAP opposes CMS’s proposed amendment to § 438.6(b)(1) to prohibit states from retroactively adding or modifying risk-sharing mechanisms.

In the 2016 final rule, CMS permitted states to direct managed care plans’ expenditures under certain circumstances, with the goal of supporting the states’ quality strategies. With this NRPM, CMS proposes to clarify § 438.6(c)(1)(iii) and (2) to address and expand the specific types of directed payments states can use. At § 438.6(c)(3), CMS proposes to provide multi-year approvals to states for state-directed payments under certain circumstances. ACAP is not commenting on the types of allowable state-directed payments, nor on the possibility of CMS approving such payments for multiple years. While we understand that the underlying, approved regulation at § 438.4(c)(2) requires that states employing state-directed payments must adhere to § 438.4 in this context, we reiterate our strongest recommendation that CMS provide firm oversight of rates paid to MCOs also when state-directed payments are required.

ACAP urges CMS to provide strong oversight of state rate-setting practices when state-directed payments are employed. We reiterate our recommendations described in an earlier section, Setting actuarially sound rates.

CMS proposes to add a new § 438.6(d)(6) allowing states to employ pass-through payments for three years to certain providers when transitioning services and populations from a fee-for-service to a managed care delivery system. Currently, 81 percent of all Medicaid enrollees and nearly 50 percent of all Medicaid funding are in managed care. Clearly, states recognize the efficiencies that health plans bring to the Medicaid setting, including cost savings for states and higher-quality coverage and care for people enrolled in the program. We recognize that pass-through payments are time-limited due to the phase-out codified in the final 2016 rule, until 2022 for nursing facilities and physicians, and 2027 for hospitals. Still, we believe that the state flexibility proposed in § 438.6(d)(6) is likely to incentivize state Medicaid programs to continue this critical trend toward managed care.

ACAP supports CMS’s proposal at § 438.6(d)(6) allowing states to use pass-through payments to hospitals, nursing homes, and physicians for services and populations transitioning from fee-for-service to managed care delivery systems. Furthermore, we urge CMS to extend the three-year time limit for such payments
until the end of the phase-out periods for nursing facilities, physicians, and hospitals.

CMS does not propose at this time to amend § 438.6(e) – Payments to MCOs and PIHPs for enrollees that are patients in an institution for mental disease. Instead, CMS clarifies the final 2016 regulation and confirms the underlying legal analysis that led the agency to restrict inpatient treatment in an institution for mental disease (IMD) for 15 days. CMS clearly recognizes the growing need in the United States for behavioral health services – including treatment services for substance use disorder and mental health/psychiatric inpatient care. ACAP strongly supports CMS’s treatment of IMD services as an “in lieu of” service to improve access to needed behavioral health services. However, we continue to have strong concerns about the arbitrary 15-day per month limit on payment for IMD services, as well as CMS’s decision not to utilize the IMD rate as a proxy in setting the actuarially sound rate. We again urge CMS to take two specific steps to improve current IMD in lieu of policy.

CMS should void the 15-day per month limit established at section 438.6(e), allowing states to pay plans for full-month stays at an IMD. Given that this policy is intended to promote patient-centered care, we believe that any limitations to use of these services should be based solely on medical necessity.

CMS should change section 438.6(e) to require states to use the actual IMD rate when calculating actuarially sound rates for MCOs. There is precedent for CMS to take such an approach, as described in the preamble to the 2015 NPRM.

Information requirements

In § 438.10(h)(3)(i), CMS proposes to allow health plans to update paper provider directories at least quarterly if the plan’s directory is also mobile-enabled, electronic directory. It should be noted that when responding to the 2015 draft regulation, ACAP held that the requirement for paper provider directories to be updated within 30 days would be unnecessary and inefficient, due to the considerable time required to conduct data pulls and compile information. We also noted that in some states, the directory is subject to state review prior to printing. Given these factors, plans needed a slightly extended timeframe for updates. As noted in ACAP’s letter to the CMS Administrator dated February 5, 2018, ACAP asked that CMS amend the regulations to require provider directory updates on a quarterly basis, rather than monthly. We also requested that regardless of the timeframe for updating the paper document, CMS should allow the use of inserts that indicate all adds, deletes and changes from the last printing should be clearly authorized in the regulation as meeting the standard in a cost-effective manner rather than requiring a reprinting of the entire document.
ACAP supports the CMS proposal to permit quarterly updates – rather than monthly – to provider directories if a managed care plan offers a mobile-enabled provider directory. However, we still would request the allowance of inserts as opposed to full reprinting as noted above.

In § 438.10(d)(2), CMS proposes to replace the requirement for taglines to be in 18-point font with the adoption of the “conspicuously-visible” font size standard which is used by the HHS Office of Civil Rights.

ACAP supports this flexibility in the required standards for the font of taglines.

Network adequacy standards

In § 438.68(b)(1), CMS proposes to allow additional flexibility with regards to the network adequacy standards. ACAP appreciates the intent behind this proposal. We also appreciate CMS’s recognition that the use of telemedicine by health plans to provide services may have implications for meeting certain time and distance network adequacy requirements.

However, for services not being offered through telemedicine and if a provider/patient ratio standard is being used, we believe CMS should specify some type of geographical requirement or that ratio may be meaningless. For example: if a plan is required to have one (1) specialist for every 1,000 members but a distance or some other type of geographical criteria is not in place, all of the specialists could be in one geographic area and not readily accessible to many of the plan’s members.

More generally, we believe that CMS should require network adequacy standards that preserve access to the providers and services upon which Medicaid beneficiaries depend. In addition, as we have noted in previously submitted comments, network adequacy standards should reflect local conditions as they exist today and not as the state would like them to be.

Health information systems

In § 438.242(c)(93), CMS proposes to require Medicaid health plans to submit to CMS all enrollee encounter data, including allowed amount and paid amount.

As CMS acknowledges in the preamble of the proposed regulations, health plans are worried about states and CMS protecting the contractual payment terms between the managed care plans and providers as they consider those data to be trade secrets. We appreciate that CMS affirms its commitment to safeguarding the data from
inappropriate use and disclosure. Additional information about the measures CMS uses or proposes to use to safeguard the data would be welcome.

Medicaid managed care quality rating system

In section § 438.334(b) CMS describes its proposed approach to the Medicaid managed care quality rating system (QRS).

ACAP supports CMS’s recommendation to use a subset of standardized measures across the federal QRS and state alternative QRSs.

We would encourage that steps are taken to reduce the burden on health plans on the design and maintenance of any new measures to report for the QRS. Thus, we encourage CMS to make use of standard NCQA HEDIS measures, the mandatory (eventually) Adult and Child Core Measures, or industry standards with established benchmarks.

In addition, since numerous states have “carve outs” for certain services (e.g., pharmacy, behavioral health, dental), it should be made clear that health plans not responsible for certain carved out services are accordingly not held responsible for any standardized measures related to those services.

Additionally, we would encourage CMS to take into consideration differences in Medicaid programs when designing comparisons across QRSs and consider only comparing plans across states with similar characteristics (e.g., compare states that have Medicaid expansion populations). In order to reduce administrative burden and costs, we would encourage an analysis of minimum/maximum number of measures necessary to build a useful QRS and the recommend limiting the number of required and standardize them as much as possible.

We appreciate CMS making more explicit the framework for consulting with states and other stakeholders in developing the QRS including the development of sub-regulatory guidance on the “substantially comparable” standard for an alternative QRS. Any guidance developed on the “substantially comparable” standard should be submitted for additional comment prior to implementation.

Finally, we would urge CMS to provide an expected timeline for QRS development and implementation.

In addition, as noted in ACAP’s [letter to the CMS Administrator] dated February 5, 2018, ACAP has long supported required quality measurement and reporting in all delivery systems serving the Medicaid population, including managed care, fee-for-service, and
primary care case management. We believe that the quality program and reporting as finalized in the 2016 final regulation missed an opportunity to ensure comprehensive, accurate and efficient quality reporting across the entire Medicaid program. We understand that an enhanced quality program – Medicaid and CHIP Scorecards – is under development at CMS. We anticipate that our positions on quality measurement and reporting would support such a comprehensive effort. As such, we ask that CMS consider our ideas on how to ensure the quality reporting and standards are comprehensive, accurate and fair.

Regarding the Quality Reporting System (QRS) described at section 438.334 of the 2016 final rule, ACAP and our member Safety Net Health Plans have developed a set of principles in anticipation of CMS regulations which will establish and govern the new system:

1. The goal of a QRS should be to measure aspects of quality care that health plans can impact.
2. Transparency should be a major tenet in the development and implementation of the QRS.
3. Alignment with other QRS is encouraged, but should not be controlling.
4. A QRS system must be developed in a manner that strives to avoid measurement fatigue.
5. The QRS should rely on standardized HEDIS measures whenever possible.
6. The QRS system should not only align with other systems, but also support efficiency.
7. The QRS must account for variations in populations served and the varying needs of specialized population.
8. The QRS measure selection must be timely in order to be actionable.
9. The QRS must provide for stability in the measurement set over time.
10. The measures selected should be an accurate reflection of care provided.
11. The QRS must take into account the role of carve-outs in providing an apples-to-apples comparison.

Grievance and appeal system

In § 438.400-408, CMS proposes several clarifications to the grievance and appeals processes finalized in 2016.

*ACAP supports the elimination of an enrollee notice requirement for a claim denied for not meeting the definition of clean claim, since it is not considered an adverse benefit determination. Along those same lines, we further suggest that CMS not require enrollee notifications for any matters in which an enrollee is not financially liable.*
Again, we thank you for this opportunity to comment on this important proposed rule. Please feel free to contact me (mmurray@communityplans.net, 202-204-7509), Jennifer Babcock, our Vice President for Medicaid Policy (jbabcock@communityplans.net, 202-204-7518), or Enrique Martinez-Vidal, Vice President for Quality and Operations (emartinez-vidal@communityplans.net, 202-204-7527), if you would like to discuss any of these issues in greater depth.

Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer