January 11, 2019 **Submitted electronically to www.regulations.gov**

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Comments on CMS-2408-P, "Medicaid and Children's Health Insurance Plan (CHIP) Managed Care"

Dear Administrator Verma:

The American Association for Homecare (AAHomecare) is pleased to submit comments to the Centers for Medicare and Medicaid Services' (CMS') above captioned Proposed Rule. AAHomecare members include a cross section of suppliers, manufacturers, and other industry stakeholders that assist, make or furnish Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) that Medicaid beneficiaries use in their homes. Our members are proud to be part of the continuum of care that assures Medicaid beneficiaries receive cost effective, safe and reliable home care products and services. As such, our comments are focused on the Proposed Rule as it pertains to DMEPOS.

Background

On May 6, 2016, CMS published a Final Rule[1] designed to modernize the Medicaid and CHIP managed care regulations. In relevant part, the rule implemented a number of changes to the Medicaid managed care grievance and appeals process. The rule also incorporated that grievance and appeals process into the Childrens's Health Insurance Program (CHIP). On November 14, 2018, CMS published a Proposed Rule[2] that would make several revisions to the 2016 Final Rule, including revisions to the Medicaid managed care grievance and appeals process, and that process's incorporation into CHIP.

[1] 81 Fed. Reg. 27497 (May 6, 2016).
[2] 83 Fed. Reg. 57264 (Nov. 14, 2018).

Option to Develop and Certify a Rate Range (§438.4(c))

Proposal - CMS proposes to provide an option for states to develop and certify a rate range per rate cell within specified parameters. The proposal is designed to address concerns over the lack of transparency when large rate ranges were used by states to increase or decrease rates paid to managed care plans without providing further notification to CMS or the public of the change.

AAHomecare Comments - We suggest that CMS require states to conduct studies designed to address whether rates are sufficient to facilitate access to all products and services for patients in all geographical areas of the state. We further suggest that CMS publish guidelines for states to follow when conducting such studies. There have been numerous incidents in which Plans retroactively reduce reimbursement. We suggest that CMS publish guidance that prohibits such retroactive reimbursement adjustments. We further suggest that CMS publish guidance stating that (i) reimbursement modifications by the Plan can be made only at the end of the term of the Plan's contract with the state and (ii) the Plan must give at least 90 days prior written notice to providers before making a reimbursement modification.

Medical Loss Ratio (MLR) Standards: Technical Correction (§438.8)

Proposal - CMS proposes a requirement for submission by each Plan of data showing the expenditures for specifically-defined activities. CMS further proposes to revise §438.8(k)(1)(iii) to replace "expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b)" with "fraud prevention activities as defined in §438.8(e)(4)" to be consistent with CMS's changes to §438.8(e)(4) in the previous Final Rule.

AAHomecare Comments - We suggest that CMS issue guidance that requires publication of MLR at both the federal level and at state levels. AAHomecare recommends evaluation of the managed care organizations to include parent companies at a national level to ensure they are meeting the MLR standards established.

Network Adequacy Standards (§438.68)

Proposal - CMS proposes to revise §438.68(b)(1) and (b)(2) by deleting the requirements for states to set time and distance standards and adding a more flexible requirement that states set a quantitative minimum access standard for specified health care providers and LTSS providers. CMS proposes to use the broader standard of "a qualitative network adequacy standard" rather than "time and distance," because each type of standard addresses a different issue.

AAHomecare Comments - We suggest that CMS provide increased oversight of (i) the capacity of providers to furnish products and services and (ii) the ability of providers to furnish products

and services in geographical areas that, too often, are not adequately served by providers. We further suggest that CMS publish minimum standards that providers must meet before they will be eligible to join a Plan network.

Medicaid Managed Care Quality Rating System (QRS)(§438.334)

Proposal - CMS proposes to revise the requirement in §438.334(c)(1)(i) (redesigned as paragraph (c)(1)(ii) in the Proposed Rule) that an alternative state QRS produce substantially comparable information to that yielded by the CMS-developed QRS and to require that the information yielded be substantially comparable to the extent feasible to enable meaningful comparison across states, taking into account differences in state programs that complicate achieving comparability. CMS further proposes to add a new paragraph (c)(4) to explicitly provide that CMS will engage with states and other stakeholders in developing subregulatory guidance on what it means for an alternative QRS to yield substantially comparable information, and how a state would demonstrate it meets the standard. CMS also proposes revisions to paragraph (b) to provide that, in developing the CMS-developed QRS framework in consultation with states and other stakeholders and using public notice and an opportunity to comment, CMS will identify a set of mandatory performance measures. CMS proposes to redesignate §438.334(c)(1)(i) and (c)(1)(ii) as paragraphs (c)(1)(ii) and (c)(1)(iii), respectively, and add new paragraph (c)(1)(i) which would provide that a state alternative QRS must include the mandatory measures identified in the framework. CMS proposes to revise §438.334(b) to provide that the CMS-developed QRS would align with the QHP QRS where appropriate. CMS proposes revisions at §438.334(b) that the CMS-developed QRS also align, where appropriate, with other CMS approaches to rating managed care plans. CMS proposes to revise the current introductory language in §438.334(c)(1) and (c)(1)(ii) to eliminate the requirement that states obtain prior approval before implementing an alternative QRS. Lastly, CMS proposes at §438.334(c)(3) that states would, upon CMS request, submit their alternative QRS framework, including the performance measures and methodology to be used in generating plan ratings; documentation of the public comment process described in §438.334(c)(2)(i) and (ii) including issues raised by the Medical Care Advisory Committee and the public, any policy revisions or modifications made in response to the comments, and rationale for comments not accepted; and other information specified by CMS to demonstrate compliance with §438.334(c).

AAHomecare Comments - We agree with the establishment of set CMS standards; these are a positive change. We suggest that the standards include all of the fail-safe standards pertaining to rate changes, program changes, and notification time frames. We further suggest that the standards emphasize the quality standards of time frame for payments, authorization time frames, audit programs, and the quality of the provider network. We further suggest that the QRS include transparent information on the appeal process for providers when the Plans do not meet the standards of the (i) quality measures or (ii) contract between the state and the Plan. We suggest that CMS publish repercussions if the Plan does not meet the standards. Lastly, we

suggest that use of the QRS be nationwide and available for states to use in evaluating Plan contracts.

Managed Care State Quality Strategy (§438.340)

Proposal - Currently, §438.340 sets forth the minimum elements of a managed care state quality strategy and the requirements for development, evaluation, revisions and public display of the quality strategy. Each state contracting with an MCO, PIHP, or PAHP as defined in §438.2 or with a risk-bearing PCCM entity, as described in §438.310(c)(2), must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity. CMS proposes to add PCCM entities described in §438.310(c)(2) to the list of managed care plans identified in §438.340(b)(2), (b)(3)(i), (b)(6) and (c)(1)(ii). CMS further proposes to delete §438.340(b)(8) and to redesignate paragraphs (b)(9), (b)(10), and (b)(11) as paragraphs (b)(8), (b)(9), and (b)(10), respectively. Lastly, CMS proposes to remove the sentence defining disability status from §438.340(b)(6) in addition to adding the reference to PCCM entities described in §438.310(c)(2).

AAHomecare Comments - Bidding by Plans for state contracts leads to low cost/low quality products and services. We suggest that CMS publish quality standards to be followed by Plan providers.

Grievance and Appeal System: Statutory Basis and Definitions (§438.400)

Proposal - CMS proposes redefining "adverse benefit determination" to exempt denials made simply because the claim is not a "clean claim." If a Plan denies a claim submitted by a provider based on the provider's administrative error, then under the Proposed Rule, the Plan will typically not need to notify the enrollee. However, if the provider resubmits the claim as a clean claim and the Plan issues an adverse benefits determination, the Plan will still have to notify the enrollee of the second denial.

AAHomecare Comments – We support CMS's proposal.

Grievance and Appeal System: General Requirements (§§438.402 and 438.406)

Proposal - Current CMS regulations require that when an enrollee orally requests an appeal of an adverse benefits determination, the oral request must be confirmed in a signed writing. See 42 CFR §§438.402(c)(3)(ii); 438.406(b)(3). Based on stakeholder feedback, CMS has concluded that the signed writing requirement poses an unnecessary barrier for enrollees seeking to appeal. Plans have expressed uncertainty about what to do when an enrollee makes an oral request but neglects to confirm it in writing. To remedy these issues and to streamline the appeals process,

CMS proposes eliminating the signed writing confirmation requirement. Plans are still expected to treat oral appeals in the same manner as written appeals.

AAHomecare Comments – We support CMS's proposal.

Resolution and Notification: Grievances and Appeals (§438.408)

Proposal - In 2016, CMS revised the time frame for an enrollee to request a state fair hearing from 90 days to 120 days. See 42 CFR §438.408(f)(2). This revision inadvertently created a distinction in the appeals time frame between managed care (120 days) and Medicaid FFS (90 days); this, in turn, has required states to track multiple hearing processes on multiple time frames. CMS proposes revising §438.408(f)(2) to state that the permissible time frame to request a hearing must be no less than 90 calendar days and no more than 120 calendar days. This revision will allow states to align the managed care and Medicaid FFS time frames if they so choose, or, for states that have already adjusted to the 120-day time frame, to maintain the status quo.

AAHomecare Comments – We support CMS's proposal.

Grievance System (§457.1260)

Proposal - In 2016, CMS incorporated the Medicaid managed care grievance and appeal process, 42 CFR §438.400 *et seq.* ("Medicaid Subpart F") into CHIP. It did so via a wholesale incorporation. This wholesale incorporation has proven problematic, as CMS has determined that several provisions of Medicaid Subpart F should not apply to CHIP, or are redundant with the existing CHIP requirements for protecting applicants and enrollees found at 42 CFR § 457.1100 *et seq.* ("CHIP Subpart K").

CMS proposes to replace this wholesale incorporation with a revised §457.1260. The revised §457.1260 would continue to incorporate much of Medicaid Subpart F, but would exclude or alter the following provisions:

- *Definition of "Adverse Benefit Determination"*: Under 42 CFR § 438.52(b), if a state offers a rural enrollee the choice of only a single plan, the enrollee has certain rights for obtaining out-of-network services. The Medicaid grievance process defines "adverse benefits determination" to include a Plan's denial of a rural enrollee's §438.52 out-of-network services request. See 42 CFR §438.400(b)(6). CMS's 2016 final rule incorporated this definition of "adverse benefits determination" into CHIP. CMS proposes to eliminate the denial of a §438.52 out-of-network services request from the definition of "adverse benefits determination" in CHIP, because CHIP does not incorporate § 438.52 from the Medicaid managed care program.

- *External Medical Reviews*: CHIP Subpart K, 42 CFR § 457.1100 *et seq.* gives two options for establishing an external medical review process. See §457.1120. When CMS incorporated Medicaid Subpart F into CHIP, it inadvertently introduced another medical review option. See §438.402(c)(1)(B). CMS now proposes to omit from CHIP the external medical review option provided in Medicaid Subpart F, such that CHIP Subpart K supplies the only options for external medical review under CHIP. Consistent with this change, CMS replaces some related provisions of §438.402 with references to Subpart K. These additional revisions are not designed to be substantive.

- *Timing of Adverse Benefit Determination Notices*: 42 CFR § 438.404 establishes several requirements for the content and timing of notices of an adverse benefits determination sent from a Plan to an enrollee. CMS originally incorporated all of these requirements into CHIP. Its proposed revision would retain all of the timing and notice requirements, with one substantive exception. Section 438.404(c)(1) requires plans to give enrollees 10-days notice (with some exceptions) for any "termination, suspension, or reduction of previously authorized Medicaid-covered services." CMS's revised CHIP grievance and appeals process would eliminate this provision. Instead of a set 10-day time period, plans must generally provide "timely" notice for any termination, suspension, or reduction of previously authorized CHIP-covered services. See 42 CFR § 457.1180; proposed § 457.1260(c)(3) (establishing general timeliness requirement).

- *Resolution and Notification Provisions*: 42 CFR § 438.408 establishes time frames and other requirements for the resolution of grievances. The current §457.1260 incorporates all of §438.408 into CHIP. The proposed § 457.1260 would continue to incorporate much of §438.408, but would carve out a couple of minor exceptions. First, §438.408(a) specifies that Plans must resolve grievances and appeals within state time frames established pursuant to "this section." In the proposed §457.1260, CMS would (i) not cross-reference §438.408(a) and (ii) restate the "this section" language, such that "this section" refers to the timing requirements set forth in the new §457.1260. Second, the proposed §457.1260 would not incorporate the portion of §438.408 that relates to external medical reviews, since Subpart K of CHIP already covers that process.

AAHomecare Comments – We support CMS's proposal.

Other Comments

- Promoting flexibility to the states is appropriate but there need to be checks and balances in place to ensure proper administration by the Plans. It is important that CMS establish these checks and balances because, at present, states are just handing over control to Plans without providing adequate oversight. Federal funding is a large profit component

to Plans and, therefore, the Plans need to be closely monitored by CMS. There must also be established penalties for those Plans that do not follow the CMS standards.

- CMS is considering modifying how Plans communicate with beneficiaries. Communications between providers and Plans need to be clearly defined. We suggest that CMS issue guidelines regarding how Plans communicate with providers concerning setting reimbursement, reimbursement changes, and preferred provider arrangements. Preferred provider arrangements should be subject to an RFP process. We suggest that sole source contracts be prohibited. We suggest that preferred provider arrangements be subject to state and CMS approval.

- We suggest that a minimum of a 90-day notice be given for the termination of a contract between a Plan and a provider. A 30-day timeframe does not allow adequate time frames for transition of care for beneficiaries. We furthermore recommend that the authorization for services and the established time frame be honored regarding the transition of patients to new providers.

Sincerely,

Laura L. Williard

Laura Williard
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