SNP Alliance Comments for CMS Medicaid Managed Care NPRM

7/24/2015

The SNP Alliance is a national membership organization dedicated to improving policy and practice of Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 31 members operate 266 SNPs in 39 States and the District of Columbia, and 29 MMPs in all nine states currently participating in the capitated Financial Alignment Initiative (FAI). Total SNP Alliance membership exceeds 1.1 million in beneficiary enrollment and includes both for-profit (1/3) and nonprofit (2/3) organizations.

The SNP Alliance is pleased to comment on the proposed Medicaid managed care regulation. SNP Alliance members are committed to working with CMS and states to advance integration of Medicaid and Medicare benefits and services for dual eligible beneficiaries through managed care plans as effectively as possible, with priority on improving quality and cost performance of plans in caring for high risk/high need beneficiaries. SNP Alliance members serve nearly 1 million dually eligible beneficiaries through D-SNPs, FIDESNPs, and MMPs. Three-quarters of Alliance members operate fully integrated managed care programs through a FIDESNP and/or an MMP platform.

Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans authorized to offer models of clinical care and benefit packages to exclusively meet the needs of dually eligible beneficiaries. The Medicare Improvement and Patient Protection Act (MIPPA) requires all D-SNPs to have contracts with Medicaid agencies in order to operate. Fully Integrated Dual Eligible SNPs (FIDESNPs) must meet additional criteria for coordination with states, including provision of primary, acute and long-term care services. MMPs provide primary, acute and long term services and supports to dually eligible beneficiaries through Memorandums of Understanding (MOUs) between 9 states and the CMS Medicare-Medicaid Coordination Office (MMCO). The MMCO was specifically established by Congress in 2010 to improve coordination of Medicare and Medicaid for dually eligible beneficiaries. MMPs operate through three way contracts with CMS and states which include extensive requirements for integration of Medicare and Medicaid services.

Both FIDESNPs and MMPs are designed to coordinate the delivery of covered Medicare and Medicaid health and long-term care services through a single plan, and to employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement. As of June 2015, 1.7 million dually eligible beneficiaries were enrolled in 336 D-SNPs, including 37 FIDESNPs with enrollment of about 110,000. An additional 330,000 dually eligible beneficiaries are enrolled in the 29 MMPs.

Overall Comments:

The SNP Alliance appreciates and supports CMS' considerable efforts to improve the alignment of Medicaid managed care with Medicare and related public programs in serving more than 9 million dually eligible beneficiaries, and to enhance the transparency of Medicaid managed care programs.

Our comments will focus primarily on issues related to the advancement of Medicare-Medicaid integration for dually eligible enrollees and improving quality for high-risk/high-need beneficiaries through FIDESNPs, MMPs and/or D-SNPs offered in combination with Medicaid managed care. We

recognize the complexity of aligning Medicaid and Medicare regulations, given long standing differences in approach and law, but we are nevertheless committed to integration of these two programs in order to improve care for poor, frail, disabled, and chronically ill beneficiaries.

We support CMS' clarifications and inclusion of MLTSS requirements based on the ten LTSS elements previously outlined in CMS guidance to states, and the manner in which they are woven into the specific regulatory sections of the proposed rule. We agree with CMS' decision to allow some flexibility in the definition of LTSS services to leave room for future innovation. We note that new developments in telehealth, telemedicine, electronic devices, and alternative living arrangements will be critical to meeting the needs of the growing LTSS population. We also note the continued importance of MCO partnerships with small community providers in providing MLTSS services to MCO enrollees and that these providers may need additional support from CMS, plans and states to assist them in meeting these new requirements.

In order to build upon the commendable efforts contained in these regulations for aligning Medicare and Medicaid requirements for dual eligible beneficiaries over time, we request that CMS:

1. Continue to assess opportunities for further aligning Medicaid and Medicare regulations and oversight structures with particular regard for enabling MMPs, FIDESNPs and Medicaid MCOs operating in combination with D-SNPs to better serve dually eligible beneficiaries through integrated managed care structures.
2. Acknowledge in the preamble to the final regulation that CMS has the discretion to waive or modify Medicaid managed care requirements in the context of any dual eligible integrated demonstration in order to clarify the permissibility of inconsistencies between the Medicaid managed care regulations and the MMP or D-SNP demonstrations.
3. Add an explicit provision in the final rule indicating that CMS, where necessary and appropriate, may continue to modify regulatory requirements for Medicaid managed care programs that are part of integrated programs for dually eligible beneficiaries *that are not operated under demonstration authority*.
4. Revise MOUs and/or provide other clarity for the FAI MMPs and the Minnesota D-SNP demonstration in the context of these new rules where there are not already established rules for MMPs and where there would otherwise be inconsistencies beyond the effective date of the final Medicaid managed care rule.
5. Consider additional alignment of Medicare and Medicaid requirements for FIDESNPs and MMPs as MMPs and D-SNP demonstrations are extended or transitioned beyond demonstration status. Current alignment efforts have skewed towards application of Medicare policies and requirements to these integrated programs. Additional alignment of Medicaid and Medicare requirements for care management, network performance, and program evaluation and oversight functions must actively preserve important flexibilities necessary to accommodate state Medicaid policies, particularly around MLTSS related functions.
6. Give more flexibility to tailor program, network, and reporting requirements to the unique care needs of subsets of the dually eligible population, such as frail elderly, adults with certain types of disabilities including SPMI, and persons with certain complex medical conditions, such as ESRD and HIV-AIDs.
7. Streamline its accountability efforts to focus on issues that are most important to improving total quality and cost performance of plans rather than the generic layering of state and federal requirements across the full spectrum of Medicaid activity.

Comments on Specific Provisions:

Following are comments on specific provisions of the proposed Medicaid regulations**.**

- **§438.4, §438.5, 438.7 Actuarial soundness and Rate development standards**
  The SNP Alliance is concerned about differences between the new NPRM actuarial soundness requirements and the manner in which rates have been calculated for MMPs. For example, MMP rates include significant withholds. Under the NPRM, rates are not considered actuarially sound if they include withhold amounts that are not reasonably expected to be achieved by the plan. There are significant concerns about the financial viability of some of the savings expectations and withholds in these MMP arrangements. We recommend that as MMP demonstrations are extended, NPRM actuarial soundness criteria should be applied to MMP Medicaid rates.

- **§438.6 (c) Delivery System and provider payment initiatives under MCO, PHIP or PAHP contracts**
  The SNP Alliance is generally supportive of value-based purchasing (VBP) initiatives that tie provider payment to performance measurement in order to improve outcomes and support innovations in service delivery. SNP Alliance members have long experience in designing and implementing provider and member incentives that result in improved health outcomes, lower cost and higher patient satisfaction. We agree that it is important to encourage states to engage with MCOs on VBP arrangements, particularly for dually eligible beneficiaries. While supportive of the intent, we also have concerns about the impact of mandated Medicaid VBP initiatives on dually eligible beneficiaries, the potential for locking in specific requirements that may not be the most important factors to consider for certain targeted subsets of the Medicaid population, and potential restrictions on innovation and growth of competencies as new learning is accrued. We support CMS' clarification that states may only direct payment in limited situations and request that CMS consider that such limits be clarified to address additional factors as described below.

  We recognize that for dually eligible beneficiaries, it is difficult for states to influence primary and acute care service delivery without involving Medicare providers. But, because Medicare, including D-SNPs, is the primary payer for many services commonly included in such arrangements, we believe that arrangements involving willing and voluntary partnerships between plans and providers will be more successful for dually eligible enrollees than arrangements mandated by the state. Therefore, in establishing parameters for such VBP initiatives, CMS should clarify that states would not have authority to include dually eligible beneficiaries in mandatory Medicaid VBP arrangements directed at primary and acute care services where Medicare is the primary payer. At the same time, we recommend that CMS recognize that states contracting with D-SNPs or other MA plans to provide both Medicare and Medicaid services through the same plan, have unique opportunities to support voluntary value based purchasing based partnerships between D-SNPs and their providers that span both Medicare and Medicaid services and settings of care.

  Further, under the limited situations where states are allowed to direct payments, we remain concerned that the proposed parameters outlined in this section may not include appropriate protections and provisions tailored for certain subsets of the population such as dually eligible enrollees, non-dual eligibles in the waiting period for Medicare eligibility, frail seniors, people with behavioral health needs, under 65 groups with disabilities including those with Intellectual and developmental disabilities, or for the providers of LTC and MLTSS that may serve these groups. For example, VBP benchmarks and financial targets in models serving these populations must consider higher spending levels and levels of chronic conditions as well as measures more targeted to the

special needs of these populations. In addition, the parameters appear to be designed for Medicaid primary and acute care and may not be flexible enough to allow for innovation and shared savings in VBP initiatives involving nursing homes or LTSS providers. CMS should clarify that parameters may need to vary dependent on the population served and the services included in the arrangements. Finally, because this is an area of growing innovation and opportunity, the SNP Alliance recommends that CMS consult stakeholders and request further comment to evaluate and help define any additional parameters for value-based purchasing applicable to special needs populations.

- **§438.8 New MLR Standards**
  The SNP Alliance is concerned with how multiple MLRs for integrated Medicare-Medicaid programs will be calculated and used in rate setting, and whether administrative and service cost allocation methodologies will be sufficiently consistent between Medicare and Medicaid to avoid further disconnects that disrupt incentives for integration. We are also concerned about how two separate MLRs for integrated Medicare-Medicaid programs will be understood and viewed by CMS, states and the public when there are bound to be differences in methodologies applied in each program despite attempts at alignment.

  We also note that state Medicaid contracts may be composed of multiple program elements, each with its own rate segments, such as childless adults, families and children, seniors and people with disabilities, and dually eligible enrollees, etc. Some MCOs participate in all of these programs while some participate in only one or two of these programs. The MLRs for each of these segments and for each of the MCOs participating in these segments will vary. For example, an MCO that enrolls large numbers of beneficiaries with high levels of chronic conditions such as dually eligible enrollees may experience higher levels of administrative and claims costs compared to other Medicaid populations. We suggest CMS give additional consideration to how the MLR provision will be applied across programs and special needs population rate segments as these rules are finalized.

  The SNP Alliance also appreciates and supports CMS' inclusion of care coordination activities that improve health care quality in the numerator of the MLR. These activities are critical to meeting the needs of individuals with multiple chronic conditions served by MCO/D-SNP combinations under their Medicaid agreements. We agree with CMS' decision to utilize existing definitions of MCO activities related to service coordination, case management, and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS. We appreciate and support that CMS intends to allow states to include the costs of appropriate outreach, engagement, and service coordination in this category.

  We seek confirmation that plans will be allowed to include costs for "extra" Medicaid benefits such as air conditioners and other preventive items and services used to reduce costs or substitute for more expensive services, in the numerator of the MLR. In addition, CMS should allow states to identify and designate other "non-medical" services related to quality improvement to be included in this the calculation.

- **§438.10 Information Requirements**
  The SNP Alliance notes that differences between Medicare and Medicaid continue in standardized member materials and requirements for language and accessibility. These differences are challenging for MCO/D-SNP combinations and states interested in integrating, streamlining or simplifying Medicare and Medicaid member materials. The SNP Alliance recommends further review

of differences between Medicare and Medicaid to encourage alignment of requirements including those related to translation and prevalent non-English language requirements, and ADA accessibility. In addition, the SNP Alliance supports increased collaboration between CMS and state Medicaid reviewers for improved coordination of member materials reviews.

The SNP Alliance appreciates new flexibilities proposed that would not require members to first affirmatively opt-in in order to receive materials other than hard copies. We agree with CMS that this will permit access to notices, handbooks and provider directories more quickly, accurately and less expensively via electronic means, and that not permitting materials other than hard copy "would be unrealistic, unnecessarily costly, and not in the beneficiaries' or managed care plans' best interest." However, we point out that Medicare does not follow the same policy and we recommend that CMS align Medicare with this Medicaid requirement, especially for dually eligible beneficiaries enrolled in an MCO offered in combination with a D-SNP.

In addition, we are concerned that the 3 business day timeline for updating network changes in on line provider directories may not be realistic. We recommend online provider directory timelines be aligned with QHP standards which require monthly online directory updates.

Also, while states and MCOs and advocates share CMS concerns about provider accessibility for beneficiaries with physical disabilities, it is not clear how provider directory and network information for office, exam room and equipment accessibility would be collected or verified under this rule given the variation in building codes and interpretations of ADA requirements. The National Association of Medicaid Directors (NAMD) has pointed out that state Medicaid agencies do not have the expertise, mechanisms or authority to oversee or enforce these requirements which are legally the responsibility of other entities outside of Medicaid. CMS should clarify the regulation to recognize this.

- **§438.56 Disenrollment: Requirements and limitations**
  With regard to the provision allowing "for cause" disenrollment for LTSS beneficiaries related to network changes in residential, institutional or employment supports, we note the importance of maintaining continuity of care for LTSS enrollees. SNP Alliance member plans are committed to working with members to accommodate their network needs in a variety of ways as appropriate for that individual. In addition, the SNP Alliance supports CMS' clarification that new enrollees will be allowed a single 90-day "without cause" disenrollment per enrollment period.

- **§438.66 State monitoring requirements**
  With respect to the proposed requirement that states undertake readiness reviews each time new benefits are provided to current or new eligibility groups or eligibility groups are modified, CMS should consider that states often make minor changes to their Medicaid benefits. A literal reading of this provision would require a readiness review for any change in benefits or population served regardless of scope. The SNP Alliance recommends that CMS refine this provision to consider the scope of the change, and to exclude minor eligibility adjustments or changes in current benefits that should not trigger a full readiness review. CMS could do this by defining significant changes and limiting readiness reviews to those situations and/or by limiting the focus of the readiness reviews to only those areas impacted by the change.

- **§438.68 Network adequacy standards**
  §438.602-§438.608. State Responsibilities, Data Certification, and Program Integrity
  §438.358-64 Activities related to External Quality Review, Non-duplication of mandatory activities, Exemption from External Quality Review, and External Quality Review results
  The SNP Alliance is concerned about redundancies and duplications between Medicare and Medicare network standards that Medicaid MCOs operating in combination with FIDESNPs and D-SNPs and exclusively enrolling dually eligible beneficiaries would experience under the proposed requirements for annual state Medicaid network adequacy assessment and annual EQRO validations.

  We recommend that state network reviews and EQRO validations not be conducted every year, for example they could be conducted every other year or every two years with certain triggers related to significant changes, and between reviews, MCOs could continue to submit any significant network changes to the state with appropriate notification to affected enrollees and updates to provider directories. We note that in total, these regulations will require significant administrative effort for states and plans, and this approach would be less burdensome while assuring that networks are updated and maintained. We also recommend that, to the extent Medicare networks approved by CMS are also part of a Medicaid network for an MCO serving dually eligible enrollees, CMS Medicare approval for this portion of the Medicaid network should be accepted by the state and that additional network reviews should be limited to the additional Medicaid providers required. We also request clarification of how network adequacy will be assessed in situations where access to services and providers is less available overall, particularly with respect to linguistic and physical access.

  We believe that states are in the best position to develop network standards for MLTSS programs and must retain the flexibility to establish standards that align with local patterns of care including the availability of more common and specialty care providers, emphasize beneficiary choice, and be tailored to address the variation in needs of MLTSS subpopulations enrolled. CMS should also consider that it may be difficult to apply time and distance standards to MLTSS providers due to limited market availability and related barriers to development of such providers in some geographic areas.

  In addition, for Medicare-Medicaid integrated programs, we note differences between Medicare and Medicaid network standards with regard to the use of telehealth and telemedicine. Telehealth and telemedicine can be useful tools for filling network gaps, but more flexibility is allowed under Medicaid than under the Medicare basic benefit where there is a very limited benefit under Part B, and it largely must be provided through added benefits or value based initiatives. As CMS explores additional areas of alignment between Medicare and Medicaid, CMS should consider adopting Medicaid telehealth/telemedicine flexibilities in both Medicare and Medicaid network standards and network reviews for application to integrated Medicare-Medicaid programs.

  With respect to CMS' request for comments on whether state enrollment of all MCO network providers would delay network development, we believe this would depend on the length of time MCOs are given to finalize networks between contract award and readiness review dates. If timelines were adequate, state involvement could be helpful if it does not interfere with the ability of Medicare-Medicaid plans to leverage additional network participation for Medicaid through other related Medicare or commercial network contracts.

Finally, we suggest that greater consideration be given to addressing network adequacy in terms of how well providers who serve the same person, either at the same time or in sequence to one another, work together to optimize total quality and cost performance. This is particularly important in serving poor, frail, and disabled persons, and persons with complex medical conditions such as serious and persistent mental illness (SPMI), end stage renal disease (ESRD), and HIV-AIDS, where collective performance is critical to patients' health and wellbeing. Current standards are not only separately defined for Medicare and Medicaid purposes but defined primarily in the context of ensuring the availability of services. Care of high-risk/high-need persons, where significant costs are incurred by both Medicare and Medicare programs, requires additional and different network adequacy considerations.

- **§438.70 Stakeholder engagement when LTSS is delivered through a managed care program**
  §438.110 Member advisory committee
  The SNP Alliance wholeheartedly supports the new requirements for state-level stakeholder engagement groups and plan-level member advisory groups. We recommend that FIDE SNPs, D-SNPs and Medicaid MCOs also be consulted and considered stakeholders under §438.70.

- **§438.71 Beneficiary support system**
  The SNP Alliance endorses CMS' efforts to improve beneficiary supports. We recommend that choice counseling requirements and materials include explanation of integrated plan options such as MMPs, FIDESNPs and D-SNPs, where available, and that brokers be allowed to facilitate and assist potential members in choosing and enrolling in these integrated options.

- **§438.104 Marketing activities**
  In the preamble, CMS notes that there has been concern that the provisions of §438.104(b)(1)(iv) would prohibit a carrier that offers both a qualified health plan (QHP) and a managed care organization (MCO) from marketing both products. This provision in the regulations implements section 1932(d)(2)(C) of the Act, titled "Prohibition of Tie-Ins." In issuing regulations implementing this provision in 2002, CMS clarified that this is intended to preclude tying enrollment in the Medicaid plan to purchasing other types of private insurance (67 FR 41027) and therefore, it would not apply to the issue of a possible alternative to the Medicaid plan, which a QHP could be if the consumer is determined as not Medicaid eligible or loses Medicaid eligibility. In this preamble, CMS further clarified that Section 438.104(b)(1)(iv) only prohibits insurance policies that would be sold "in conjunction with" enrollment in the Medicaid and proposes an additional rule clarification that marketing under this Medicaid rule does not include communications to a Medicaid beneficiary from the issuer of a QHP about the QHP. Further, CMS states that "selecting a carrier that offers both types of products may be the most effective way for some consumers to manage their health care needs."

  The SNP Alliance recommends that CMS extend this clarification to MCOs that offer Medicare D-SNP products to dually eligible Medicaid enrollees served under their Medicaid contracts. While we understand the need for the "tie in" provision prohibiting requirements for Medicaid MCO enrollees to enroll in a D-SNP product, we also note that CMS Medicare FIDESNP and MMCO policy, along with that of a number of states, supports encouraging enrollment of dual eligible beneficiaries in combined D-SNPs and Medicaid MCOs under the same plan sponsor in order to promote integration of Medicare and Medicaid service delivery. Operating under Medicare Advantage, D-SNPs are currently allowed to market to dual eligible beneficiaries including those enrolled under their Medicaid contracts and in previous CMS interpretations of the "tie in" provision CMS has clarified

that this continues to be allowed. However, now we are concerned that providing this rule clarification only for QHPs may be confusing and result in an unintended impact on Medicaid MCOs offering companion D-SNP plans and their ability to continue to reach dually eligible beneficiaries for enrollment in integrated Medicare-Medicaid programs. We request that CMS provide more explicit clarification in the final rule that MCOs that also sponsor D-SNPs can continue to market those D-SNPs to those dually eligible members enrolled in their Medicaid MCO contracts.

- **§438.206 and §440.262 Availability of Services**
  CMS requests comment on standards for timely access to state plan and MLTSS services and the mechanisms that should be used to ensure that these standards are being met by the MCO networks. CMS should strike a balance between prudent oversight and increased regulatory burden on MCOs. CMS should consider using existing mechanisms such as surveys, encounter data already reported, and HEDIS measures to the extent possible.

  We recommend that CMS review and align Medicare and Medicaid procedures for verifying access for integrated Medicare-Medicaid programs to reduce redundancy and duplication between Medicare and Medicaid. For fully integrated MCOs such as MMPs and FIDESNPs, CMS should coordinate these Medicare and Medicaid activities. However, as alignment is considered, CMS must also recognize that there are differences in approaches between Medicare, which is very focused on equal access to benefits and general equity, and Medicaid, which is more focused on patient centered care and services that are tailored to the beneficiary. Services needed for beneficiaries with special needs may not be as amenable to traditionally defined access standards, because the services may not be available in every geographic area. In the person centered care approach, the MCO tries to use whatever is available in the community to support the beneficiary, for example an adult day care center, or a friendly visitor program. Not every community has these services, so where they are lacking, the MCO may need to meet the beneficiary need in a different way. The patient centered care approach requires a level of flexibility that needs to be considered, particularly with regard to MLTSS services which may vary in availability and where it may not be possible to apply traditional access standards to every service.

  Further, CMS should ensure that for small rural plans, sample sizes and frequencies for any secret shopper calls are in proportion to the number of enrollees served and that both Medicare and Medicaid review protocols take into consideration that integrated Medicare-Medicaid plans are providing both Medicare and Medicaid services.

- **§438.208 Coordination and continuity of care**
  The SNP Alliance supports adding MLTSS enrollees to current requirements for enrollees with special health care needs for needs identification, assessment and treatment planning in §438.208 (c). We support CMS' continuation of current exceptions for MCOs serving dually eligible beneficiaries enrolled in MA organizations that allow states the flexibility to determine the extent to which the MCO must meet these identification, assessment and treatment planning requirements as this flexibility assists states and D-SNPs in alignment between D-SNP Model of Care requirements and similar Medicaid activities. In order to avoid duplication of assessments, we request that CMS clarify that states can and should coordinate Medicaid HRA requirements with Medicare D-SNP HRA requirements. For example, states could accept the D-SNP HRA as meeting the new 90-day initial assessment requirement for Medicaid enrollees in D-SNPs who do not require MLTSS services, and coordinate the Medicare HRA with Medicaid required assessments for Medicaid MLTSS members.

In the preamble, CMS proposes that identification of members with special needs can be conducted by state staff, enrollment brokers and/or MCO staff. CMS also states that comprehensive assessments are conducted by "appropriate LTSS service coordinators having qualifications specified by the state or the MCO, or by health professionals". In the preamble, CMS states that these changes are intended to permit an MCO to use internal staff for service coordination, even though those staff would not be considered providers, and thus, not permitted to perform assessments under current regulations. The preamble also states that under (c) (3) (i), treatment and service plans must be developed by the enrollee's provider "or an individual meeting the health plan's or state's service coordination provider standards". The SNP Alliance commends CMS for recognition of the MCO role in its clarification of these important flexibilities.

The SNP Alliance suggests that CMS provide further clarification of the broad requirement under 438.208(b)(5) that each provider (including practitioners and suppliers, as stated in the preamble) maintain and share, as appropriate, an enrollee health record in accordance with professional standards. While the SNP Alliance certainly supports sharing of care plans and health records among interdisciplinary team members, we note that this can also be a confusing issue for plans and providers. Some state laws preclude sharing of information related to mental health and substance abuse. In addition, some states have experienced confusion between MCOs and MLTSS providers about which portions of the enrollee record should be shared, when providers may not have a "need to know" for access to full assessment documents or other care planning information not directly related to services they provide. CMS should also consider that many small MLTSS providers lack capacity, systems and sophistication needed to share electronic health records and may have difficulty complying with some of the new requirements in this rule without additional support from states and/or plans. Further, while all providers must comply with state and federal data privacy requirements, some MLTSS provider types have no established "professional standards" as guidance. CMS could clarify this provision to ensure that states are allowed to establish additional parameters for sharing enrollee information in these instances.

The SNP Alliance supports coordination efforts that encompass the entire spectrum of a person's care needs, including services that are provided under FFS and related social services. SNP Alliance members typically coordinate services with a variety of community resources outside their capitations including services provided through FFS. In addition, they provide value added benefits outside of the standard benefit sets that are tailored to special needs members through both Medicaid MCOs and Medicare D-SNPs. A comprehensive care coordination approach is critical in order to optimize total quality and cost performance which is central to the work effort of all SNPs and MMPs. However, CMS should also recognize that that an MCO may have some limitations on its ability to affect care delivery when services are not financed directly through its capitated arrangement and therefore should avoid performance measures related to expectations for specific service outcomes beyond the scope of the MCO's benefit package.

- **§438.242(c) Health information systems, enrollee encounter data**
  CMS proposes new encounter data standards that would be incorporated in all MCO contracts and states that they anticipate issuing clarifying guidance in the future to provide additional specificity. CMS also proposes FFP penalties on states and MCOs related to the accuracy of encounter data. While CMS proposes some standardization of data and formats, the SNP Alliance points out that variations among states in programming for and processing of encounter data and lack of alignment between encounter data collection and other CMS data reporting requirements for states (for example TMSIS) may further impede the accuracy and consistency of encounter data and data

collection as well as add to administrative burdens and compliance issues for plans that operate in multiple states. While we recognize that standardization across states is not likely feasible, the SNP Alliance recommends that in future guidance, CMS consider establishing a core set of aligned principles that CMS, all states and plans could use as a base for programming and data collection.

- **§438.330 Quality assessment and performance improvement program**
  §438.334 Medicaid managed care quality rating system
  The SNP Alliance supports CMS' efforts to strengthen quality measurement and improvement efforts in Medicaid managed care and the principles of transparency, alignment, and stakeholder and consumer engagement underlying these efforts, recognizing that quality assessment and performance rating practices are an evolving art and currently do not capture the most important aspects of caring for poor, frail, disabled, chronically ill persons. The SNP Alliance also welcomes CMS requirements to extend state quality improvement programs to fee-for-service Medicaid.

  While the SNP Alliance is very committed to quality and maintaining high performance standards, we are increasingly concerned about a constant layering of additional reporting requirements without assessing the potential adverse effect that the *totality* of reporting can have on a plan's ability to provide quality care. More is not always better. We believe greater attention must be paid to assessing what combination of reporting is most likely to produce the greatest value for defined population segments, rather than simply applying a broad set of generic measures for all beneficiaries served and adding new measures whenever new metrics are tested to be valid and reliable. We believe that not only must care be tailored to meet the unique needs of certain population subsets but performance evaluation of specialty care service must also be tailored accordingly. We note the thoughtful concerns expressed by the National Association of Medicaid Directors (NAMD) on this section of the rule and encourage CMS to pay particular attention to issues they raise on this topic.

  We are concerned, in spite of good intentions, that the new proposed Medicaid Quality Rating and Performance Measurement systems proposed may further complicate the already overwhelmingly complex performance measurement systems applied to MMPs, FIDESNPs and MCOs offering D-SNPs in combination with Medicaid services. While some details vary for MMPs vs D-SNPs, integrated plans serving dually eligible beneficiaries are typically subject to a large array of both state and federal measures including traditional HEDIS and CAHPS measures that may or may not be most important or applicable to the dually eligible population subsets enrolled, while at the same time there are significant gaps in measurement development for dually eligible enrollees with highly complex co-morbid conditions, behavioral health needs and those requiring MLTSS services. Further, with both Medicare and Medicaid requirements applied to integrated programs for dually eligible beneficiaries, the sheer number of measures that must be tracked is often an obstacle for alignment between federal, state and local priorities and for focusing provider level performance improvements.

  We support CMS' plans for a robust stakeholder engagement process for this effort including extensive consultation with MCOs and integrated Medicare-Medicaid MMPs and D-SNPs and appreciate that CMS indicates that this process may take several years. We recommend that as part of this ambitious new process, CMS consider a comprehensive review of both Medicare and Medicaid measures applied to integrated programs serving dually eligible beneficiaries and of issues that are of unique importance to producing quality outcomes for the major population subsets served. The goal and outcome of such a review should be to align Medicare and Medicaid

measurement requirements applicable to dually eligible MMP enrollees or enrollees in MCOs that offer integrated D-SNPs in combination with Medicaid services by identifying a more limited but more relevant set of priorities for measurement across both programs and by addressing gaps in measures important to key subsets of dually eligible beneficiaries such as those with IDD, end of life, behavioral health and MLTSS needs.

In anticipation of the stakeholder engagement process, we have a number of questions and several comments related to CMS' proposed requirements for standardized performance measurement and quality rating and how they will impact MMPs and Medicaid MCOs that are offered in combination with D-SNPs.

1. While D-SNPs are required to have contracts with Medicaid agencies around coordination of Medicaid services, the specifics of these contracts vary with regard to the characteristics of the dual population enrolled and the range of Medicaid benefits provided. For example, some D-SNPs provide Medicare cost-sharing only while others, namely FIDESNPs, provide all Medicaid covered benefits including long term services and supports under a single managed care organization. In between there may be D-SNPs with Medicaid contracts under which a more limited range of Medicaid covered benefits may be provided to their dual-eligible enrollees.

   In addition, referring to §438.330 and §438.334 and proposed requirements related to performance measurement and states' quality rating systems, variation exists in terms of how MCOs are structured. In some cases, managed care organizations operate a single plan or product serving a relatively homogenous subset of the Medicaid population, e.g. older adults including individuals with LTSS needs, young adults and children, adults with physical disabilities, or adults with behavioral health diagnoses. In other cases, a single MCO may operate multiple plans or managed care products involving multiple and diverse subsets of the Medicaid population. These differences across MCOs with respect to the characteristics of enrollees and Medicaid benefits provided lead to the following questions which we request CMS consider in developing the NPRM for the proposed QRS and performance measurement system, and in finalizing its proposed rule:

   a) Who will perform the rating calculations? Will each state conduct its own, using a CMS methodology?
   b) How will performance measurement and quality rating accommodate differences in state contracting structures for MCOs in order to address variations in benefit packages and populations served?
   c) Will performance measures be specific to the characteristics and needs of Medicaid subpopulations? What is most important to providing high quality care to dual eligible beneficiaries and multiple population subsets served in MLTSS programs may be very different from what is most important to providing high quality care to young adults and children.
   d) If a single contract-level rating is provided for a managed care organization operating numerous plans serving various Medicaid population subsets, how will this rating provide the information needed for individual consumers to make informed choices? How will MCOs be compared so as to provide Medicaid beneficiaries the information they need to make informed choices based on plans' performance related to their specific needs?

2. While the SNP Alliance is supportive of CMS efforts to improve the measurement of performance related to MLTSS services, we note that there are still very few measures applicable to MLTSS services or populations that have been tested, approved and endorsed by major consensus-building organizations such as NCQA and NQF. Further, current measures in use may not be appropriate to key population subsets receiving MLTSS services such as people with IDD, behavioral health needs, seniors receiving end of life care and enrollees electing self-directed service options. CMS should consider revising timelines for inclusion of MLTSS measures in performance rating and measurement systems while at the same time increasing development efforts to address these measurement gaps.

3. Referring to §438.334(d), which allows states the option to utilize Medicare Star Ratings for MCOs exclusively enrolling dually eligible beneficiaries, we have five primary concerns:
    a. *Stars does not adequately account for social determinants of health*. It fails to account for a broad spectrum of psycho-socio, environmental, cultural, educational, behavioral and economic conditions that affect the health and health outcomes for people in poverty. While state Medicaid agencies may very well not have the same level of concern about these issues if all of the plans they evaluate exclusively enroll Medicaid beneficiaries, it does become a problem for states to the extent states contract with plans that enroll a significant number of dual beneficiaries, and where the MCO under contract also has responsibility for providing a companion set of Medicare benefits. Moreover, all the Medicaid plans to which Stars are applied will be adversely affected if CMS and/or states choose to compare the performance of Medicaid plans on Stars with Medicare plans using the same metrics and methods.
    b. *The Stars metrics do not adequately account for the complexity and chronicity of chronic disease and disability*. While many poor people clearly have chronic conditions, such as diabetes, that must be treated effectively and are addressed by Stars, the composite of Star metrics are focused primarily on the early diagnosis and treatment of medical conditions with an acute care orientation and do not adequately address the co-morbid, multi-dimensional, disabling, interdependent, and ongoing nature of care for persons who are frail, disabled, and/or have complex medical conditions, such as ESRD and HIV-AIDS, and who consume the vast majority of Medicare and Medicaid resources. Moreover, persons with these conditions require a DIFFERENT approach to care than what is embodied in Stars and, in some cases, require interventions that are not only not addressed in Star measures but are critical to their very survival. This is particularly problematic when bonus payments are used to incent plans to choose one intervention or approach to care over another, and when the metrics tied to bonus payments are not necessarily the ones of greatest important to the people they serve.
    c. *The process for monitoring Medicare and Medicaid metrics are different, even for the same measures*. For example, while State Medicaid agencies and CMS may be monitoring performance using the same metrics, plans serving dually eligible beneficiaries and responsible for Medicare AND Medicaid benefits frequently must use separate samples, and submit separate reports, on different timelines, even when the same metrics are being used.
    d. *Current CMS Star Ratings procedures are to measure performance at the contract level*. This makes it virtually impossible to risk stratify plans' performance, with comparisons of plans serving like population segments.
    e. *The Medicare Star Rating system does not include CMS' proposed MLTSS performance measures to assess quality of life and outcomes of the MCOs rebalancing activities for*

MLTSS enrollees. These are also important issues for plans serving a preponderance of high-risk/high-need beneficiaries. It is not clear how states that opt to use Star ratings would address these MLTSS measures and whether they would have to develop a separate rating system for those requirements.

While the SNP Alliance appreciates and supports CMS's interest in aligning Medicare and Medicaid performance measurement requirements for integrated Medicaid Medicare plans, we are concerned about a host of unintended consequences that could result without addressing the issues outlined above.

4. Where states do not opt to use Star Ratings and decide to use the new CMS QRS system, or where states propose to develop their own alternative QRS systems as allowed under this proposed rule, we are also concerned about how those systems will be applied to MCOs engaged in integrating Medicare and Medicaid services. CMS should clarify whether it is the expectation that MCOs offering D-SNPs in combination with Medicaid services in such states will be subject to two separate but possibly overlapping ratings i.e., a Medicare Star rating and a second Medicaid quality rating. If so, we are concerned about the duplication of effort this will cause plans and providers, and questions this may raise for consumers who will see multiple and different ratings on the same or similar measures for the same plans. We recommend that CMS carefully consider how both of these proposed options would align with Medicare requirements and take action to reduce overlap and duplication of included measures to avoid conflicting results on the same measures.

5. We also request clarification of when the requirement for states to implement a quality rating system for their Medicaid MCOs takes effect. Assuming that the public notice and comment process that CMS is proposing will take several years to complete, will implementation be delayed in the meantime to accommodate necessary activities related to development, such as development and identification of new measures?

6. Referring to §438.330(b)(5), in response to CMS' request for comment on the use of surveys to collect information to assess the quality and appropriateness of care provided to enrollees using LTSS, we request that CMS and states consider the validity of survey data collected from enrollees with significant cognitive impairment. While we believe that it is important that states and MCOs pay attention to and assess the experience of all enrollees including those with severe dementia in order to provide person-centered care, some of this data may not accurately measure performance or be appropriate for inclusion in performance measurement and quality rating systems. For example, these surveys may be filled out by provider staff such as personal care attendants or nursing home aides due to lack of protocols or controls around proxies. For the purpose of performance measurement, we suggest that CMS/states consider excluding individuals who have been determined to have significant cognitive impairment from the denominators of survey-based performance measures used in quality rating systems unless a "qualified" party is available to serve as a proxy respondent under an established protocol.

   We also have concerns related to the use of survey data for performance measurement when member experiences impacting responses are outside MCOs' control. For example, the Star measure Improving or Maintaining Mental Health is based on members' responses to HOS survey questions intended to determine whether members' mental health is the same or better

than expected after two years. Members' responses to this question may be influenced by circumstances outside the MCO's control such as death of a spouse.

7. Lastly, referring to §438.330(d)(3), we support CMS' efforts to align Medicaid performance improvement project requirements with Medicare quality improvement project requirements by giving states the option to substitute a Medicare QIP for a Medicaid PIP.

- **§438.400-424 Grievance System**
  In general, the SNP Alliance supports the changes to the grievance system requirements, in particular the alignment of the Medicare and Medicaid timeframes for appeals processes, and the requirement for exhausting a one level internal health plan appeal before moving on to a State Fair Hearing. However, CMS should reconsider allowing providers to submit appeals without beneficiary written permission. That provision may allow providers to initiate appeals without an enrollee's knowledge or understanding which may not always be in an enrollee's best interest.

- **§438.602-§438.608. State Responsibilities, Data Certification, and Program Integrity**
  Draft Comment: While the SNP Alliance appreciates CMS efforts to increase transparency, we are concerned that the requirement that states post data and information about rate setting and encounters are too broad and may violate existing provisions governing data privacy and trade secret information. The rule appears to literally require that the state must post on its website or make available upon request, contracts, audits, documents and reports including those listed in §438.604. Items listed in §438.604 include: **encounter data in the form and manner described in §438.818,** data used as the basis for actuarial soundness and MLR compliance, data for the basis of adequate provision against risk of insolvency and network certifications, information on ownership and control and overpayment recoveries, audit results and other information related to the performance of the entity's obligations required by the state or the Secretary. **Encounter data listed in §438.818** includes *all encounter claims submitted to the state and reported through MSIS* which could be read to include claim level personal data. The SNP Alliance recommends that CMS revise the scope of these provisions and work with states and MCOs to clarify these requirements to protect trade secret and private information and provide additional definition of which documents states must post and/or share, including clarification of information that could be posted in aggregate forms. In addition, MCOs should be given an opportunity to be informed of and to review information that is being utilized and posted for these purposes.