



SNP Alliance

MAY 1, 2016

SNP Alliance Summary of Final Rule Highlights: *CMS Medicaid Managed Care NPRM*

Note to Members: This is a preliminary summary of selected provisions of the final rule relating to SNP Alliance comments submitted 7-24-2015 and is not meant to be a summary of the entire rule or a final interpretation of rule provisions. We will continue to monitor interpretations and key developments around this rule as implementation efforts move forward. Final rule provisions are highlighted for ease of identification. Page numbers reference related comments sections, not final rule section.

Quick Reference Highlights of Selected Medicaid Rule Provisions

- **§438.3 (t) Requirements for MCOs Responsible for Coordinating Benefits for Dually Eligible Individuals** (pages 218-219). CMS adopts its proposal that states be allowed to delegate Medicare cost sharing for dually eligible beneficiaries to managed care plans through coordination of benefits agreements with exemption from cross over fees for MCOs.
- **§438.3 and 438.6 (e). Services that May Be Covered by an MCO, PIHP, or PAHP** (pages 155-157 and 219-249) Allows FFP for a full monthly capitation for enrollees 21-64 in IMDs for those in the IMD for a portion of the month capped at 15 days, clarifies policy around in lieu of services.
- **§438.2, 438.3, 438.70, 438.71, 438.214, 438.330, 438.816. Managed LTSS** (pages 567-572) Incorporates LTSS elements and requirements throughout rule, broadens language to address non-medical nature of services.
- **§438.4, §438.5, 438.7 Actuarial soundness and Rate development standards** (pages 256-370) Strengthens general standards for actuarial soundness and sets more explicit rate standards for rate basis, and expected documentation.
- **§438.6 (c) Delivery System and provider payment initiatives under MCO, PHIP or PAHP contracts** (pages 316-351) Allows states to direct payments in several circumstances, allows flexibility to develop VBP arrangements specific to types of providers rather than across all, implements plan to phase out supplemental and pass through payments. In the future, if included in capitation rates, provider pass through or supplemental payments must be tied to utilization, delivery of services, outcomes, or quality. The transition must happen over a 10-year period for hospitals and a 5-year period for nursing facilities and physicians.
- **§438.8 New MLR Standards** (pages 91-140) Minimum MLR of 85% must be used in rate development, all plans must report MLR; however, states are not required to adopt a minimum MLR and can use a higher standard, MLR must be



considered in rate development, but rebate policy is at state discretion, broad definition of quality improvement activities allowed in numerator includes care coordination.

- **§438.10 Information Requirements** (pages 857-859)
Changes provider directory updates from original proposed 3 business days to every 30 days for online provider directories, monthly for paper copies, paper copies on request only, modifies language related to information on accessibility to “has accommodations.”
- **§438.54. Enrollment Systems Standards- Mandatory 14 Day FFS Coverage Period** (pages 431-451)
CMS drops requirement for 14-day FFS coverage for enrollment choice period prior to enrollment
- **§438.56 Disenrollment Standards Requirements and Limitations** (pages 451-468)
New “for cause” standard for disenrollment for where residential, institutional or employment supports provider is not in the network. CMS also drops its proposal to restrict members to one 90-day disenrollment period after initial enrollment.
- **§438.66 State monitoring requirements** (page 814-837)
Narrows scope for requirement of readiness reviews to three conditions: implementation of a new managed care program, managed care plan that has not previously contracted with the state, or when the plan is providing or arranging for covered benefits to new eligibility groups.
- **§438.68 Network adequacy standards, §438.206 and §440.262. Availability of Services** (pages 596-648)
Network adequacy documentation must be submitted to the state annually and when there is significant change as defined by the state. State must review and submit annual assurance to CMS, must include MLTSS, states must set time and distance standards for MLTSS providers. CMS states Medicare standards apply to plans serving dual eligibles participating in both the Medicare and Medicaid markets.
- **§438.70 Stakeholder engagement when LTSS is delivered through a managed care program, §438.110 MCO member advisory committee** (pages 587-596)
Adopted with inclusion of “other individuals representing beneficiaries or enrollees.”
- **§438.71 Beneficiary support system** (pages 468-497)
New requirements and conflict of interest standards for choice counseling, choice counseling entities treated as enrollment brokers, includes “access to personalized assistance-whether by phone, internet or in person,” as well as additional protections for MLTSS beneficiaries. CMS dropped its proposed requirement for training on community-based resources.
- **§438.104 Marketing activities** (page 27)
Clarifies that D-SNPs are a public program and not subject to tie in provisions for commercial insurance.
- **§438.208 Coordination and continuity of care** (pages 533-562)
Updates care coordination standards including new requirements for “best effort” for initial screening of all enrollees within 90 days of enrollment, includes MLTSS utilizers in requirements for special needs populations, requires sharing of health records, allows exception for MCOs serving dually eligible enrollees who are also enrolled in an MAO that allows the state to determine to what extent the MCO must meet the additional requirements for identification, assessment and treatment planning provisions. Clarifies that it is not a conflict of interest for MCOs to conduct assessments and develop care plans for their own enrollees. Care and treatment plans are required for MLTSS enrollees but are at states discretion for other enrollees.
- **§438.214(b) Credentialing and Recredentialing Policy** (pages 582-583).
Credentialing system required for MLTSS providers, may set different standards by provider type.
- **§438.242(c) Health information systems, enrollee encounter data** (pages 888-914),



§438.602-§438.608. State Responsibilities, Data Certification, and Program Integrity (page 394)

New standards for submission of encounter data by plans to state and by state to CMS, includes prices, requires standard formats but not standard transactions, must include data for MLTSS and capitated or VBP arrangements, FFP disallowances can be applied related to encounter data submission at both plan and state levels, drops requirement for public reporting of encounter data, acknowledges issues for non-standard codes for MLTSS, but does not propose solution.

- **§438.330 Quality assessment and performance improvement program**, (pages 663-701)

§438.334 Medicaid managed care quality rating system (pages 701-717).

Comprehensive State Quality Strategy, (pages 719-741)

Each MCO must have a QAPI program which is reported annually to the state, allows substitution of Medicare QIPs for Medicaid PIPs, requires MLTSS be addressed in QAPI and PIPs, removed original proposal that states adopt standards least as stringent as the standards used by a private accreditation entity, instead states must review and publicly report on existing accreditations annually. CMS may define a common set of QAPI and PIP topics though states can apply for an exception. CMS will develop a national QRS with stakeholder input process, states must adopt of QRS used to compare plans within a state, states can develop their own QRS alternative but must be comparable to CMS system, developed with stakeholder input and approved by CMS. CMS dropped proposal to allow default to MA Star system and dropped requirement for state quality strategy across both FFS and managed care, revised provisions to apply only to managed care. CMS acknowledged need for “harmonization” of measures with existing requirements and multiple other systems, and outlines current related activities.

- **§438.400-424 Grievance System** (pages 31-91)

Plan level appeal required within 60 days prior to SFH, with 120 days for SFH, 30 days for plan response. Providers must still have written permission to file appeal for beneficiary. Extends benefits throughout appeal even when authorized benefit period may have been exhausted.



**SNP Alliance Comments and Detailed Summary of Related Final Rule Provisions:
CMS Medicaid Managed Care NPRM
File Code CMS-2390-P
5/01/2016**

Note to Members: The original SNP Alliance comments submitted 7-24-2015 are listed first, followed by a summary of relevant sections of the final Medicaid rule as issued on April 25, 2016 highlighted. Additional items of interest on which we did not submit comments have been added, also highlighted. Page numbers refer to final rule comment sections, not the final rule. The final rule is found on pages 1132-1424.

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 (one-third) and nonprofit (two-thirds) 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 one 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 nine 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 nine 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 10 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:

- **§438.3(t) Requirements for MCOs Responsible for Coordinating Benefits for Dually Eligible Individuals** (pages 218-19). (The SNP Alliance did not comment on this section but is including it because of interest in this topic.)

Final CMS Rule: CMS adopts its proposal that states be allowed the option to delegate Medicare cost sharing for dual eligibles to managed care plans through coordination of benefits agreements and participation in Medicare's automated cross over process, with exemption from cross over fees for MCOs. Cross overs will include Medicare FFS data only. CMS notes it may take some time for these COBA agreements to be put into place and that it will provide TA to plans and states to facilitate the process.

- **§438.3 and 438.6 (e). Services that May Be Covered by an MCO, PIHP, or PAHP.** (The SNP Alliance did not comment on this section but is including it because of interest in this topic.)

Final CMS Rule: (pages 155-157 and 219-249)

In lieu of services: CMS codifies and clarified specifications for in lieu of services as follows: the state determines whether the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the plan, such services must be at plan discretion, and listed in the contract, the enrollee cannot be required to use them, the utilization and costs can be included in the rate setting process.

IMD Policy: While statutory limits continue to prohibit FFP for capitation payments for Medicaid recipients age 21-64 residing in IMDs for more than 15 days, CMS clarifies that FFP is allowed for a full month of capitation for enrollees aged 21 to 64 in an IMD where the enrollee elects services in an IMD as an alternative to otherwise covered settings, and where the IMD meets certain criteria and the stay is no more than 15 days in that month. CMS indicated that stays can extend into the second month for no more than 15 days in each month and costs included for rate setting purposes must be the same as those for the same services under the state plan.

- **Managed LTSS (§438.2, §438.3, §438.70, §438.71, § 438.214, §438.330, and §438.816.** Page 567-572. (The SNP Alliance did not comment on this section but is including it because of interest in this topic.)

Definition of LTSS and Inclusion of MLTSS Elements. CMS requested comments on the appropriateness and scope of a proposed definition of LTSS for the purposes of this rule.

Final CMS Rule:

CMS modified their proposed LTSS definition slightly as follows: (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of



their choice, which may include the individual's home, a worksite, a provider owned or controlled residential setting, a nursing facility, or other institutional setting.

They explained that they intended 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. Examples of what they consider community based LTSS include Home- and Community-Based Services (HCBS) delivered through a section 1915(c) waiver, section 1915(i), or section 1915(k) state plan amendments, as well as personal care services otherwise authorized under the state plan. They note that individuals with chronic illness that may receive LTSS include individuals with mental health conditions and substance use disorders.

10 LTSS Elements Incorporated into the Rule. (page 573) CMS notes that provisions relating to these 10 items are found in relevant sections throughout the rule.

- (1) Adequate Planning.
- (2) Stakeholder Engagement.
- (3) Enhanced Provision of Home and Community Based Services.
- (4) Alignment of Payment Structures and Goals.
- (5) Support for Beneficiaries.
- (6) Person-centered Processes.
- (7) Comprehensive, Integrated Service Package.
- (8) Qualified Providers.
- (9) Participant Protections.
- (10) Quality.

- **§438.4, §438.5, 438.7 Actuarial soundness and Rate development standards**

Original SNP Alliance Comment: 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.

Final CMS Rule: (pages 256-370)

CMS generally strengthens requirements for actuarial soundness and rate development under these sections. CMS clarifies that the actuarial soundness and rate development standards do apply to the FAI demonstrations operated under 1115A authority. Withhold arrangements must ensure that the capitation payment minus any portion of the withhold that is not reasonable achievable is actuarially sound as determined by an actuary and must consider specific populations covered and other criteria. CMS also adds language to clarify that any proposed differences among capitation rates must be based on valid rating factors and not on network provider reimbursement requirements that apply only to covered populations eligible for higher percentages of FFP. They explain that capitation rates must be specific to the payment attributable to each rate cell under the contract and that rates must appropriately account for the expected benefit costs for enrollees in each rate cell, and for a reasonable amount of the non-benefit costs of the plan. Further they state that payments from any rate cell must not be expected to cross-subsidize or be cross-subsidized by payments for any other rate cell but also that the prohibition on cross-subsidization is tied to the



FMAP associated with individuals covered under the contract and is not a barrier to incentivizing the delivery of home and community based services.

CMS notes that the definition of actuarially sound capitation rates provides that the rates “must provide for all reasonable, appropriate, and attainable costs that are required under the contract” and that actuarial soundness is tied to an evaluation as to whether the capitation rates are adequate to meet the requirements on MCOs of the managed care plans for maintenance of an adequate network for ensuring timely access to services and coordination as those are obligations specified under the managed care contract. The underlying base data, cost and utilization assumptions, as well as the consideration of the MCOs, PIHPs, or PAHPs MLR experience, inform the evaluation as to whether the capitation rates are sufficient to maintain provider networks that ensure the availability of services and support coordination and continuity of care.

CMS also requires that rates must be developed in such a way that the MCO would reasonable achieve an MLR of at least 85% for the rate year and that the plan would reasonable achieve an MLR of greater than 85% “as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-claims costs.”

States must certify specific rates (not rate ranges) but CMS allows states to increase or decrease the capitation rate certified by 1.5% (range of 3%) without having to submit a revised rate certification stating that “it is reasonable for the capitation rate to be modified a *de minimis* amount and still remain actuarially sound.” Retroactive adjustments beyond this amount (other than application of approved retrospective risk adjustment methodologies) require a rate certification and full submission.

Importantly, CMS also stated that federal review of Medicaid managed care capitation rates will be conducted by actuaries. CMS dropped its proposal to place FFP penalties on states if actuarial soundness is not achieved. (page 430). They also reject appeal rights for MCOs and state they will not arbitrate actuarial soundness disputes formally with states but will meet with plans to hear their concerns.

- §438.6 (c) Delivery System and provider payment initiatives under MCO, PHIP or PAHP contracts**
Original SNP Alliance Comment: 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.

Final CMS Rule. (pages 316-351).

CMS finalized the state option to require plans to participate in value-based purchasing arrangements as an exception to the prohibition on directed supplemental payments. The state can direct expenditures in the following situations: (i) to implement value based purchasing arrangements; (ii) to participate in multi payer or Medicaid specific delivery reform or performance improvement project; or (iii) Adopt minimum or maximum fee schedules or a uniform dollar or percentage increases for network providers that provide a particular service. States need written approval from CMS prior to implementation. The general rule was modified to grant exceptions for specific provisions of Title 19 of the Social Security Act (to allow for statutorily required payment levels to FQHCs and other such scenarios and to ensure VBP arrangements don't interfere with federal statutory requirements).

CMS will allow states to set a maximum fee schedule for their plans as well as a minimum fee schedule so long as the managed care plan retains the ability to reasonably manage risk and have discretion in accomplishing the goals of the contract. CMS finalizes, and clarifies, language that allows states to require their contracted managed care plans reimburse providers that provide a particular service in accordance with a minimum or maximum fee schedule or at a uniform dollar or percentage increase as an exception to the general rule regarding state direction of managed care plan expenditures under the contract. CMS writes this is not intended to prohibit the managed care plans from negotiating higher provider rates.



CMS modified the proposal to remove the proposed requirement that a minimum fee schedule or uniform dollar or percentage increase in provider payments apply to all providers that provide a particular service under the contract and made a technical modification to insert “network” before “providers” in each of these paragraphs. The final regulation specifies that expenditures must be directed equally, using the same terms of performance, for a class of providers under the contract. Similarly, the opportunity to participate in VBP, delivery system reform, or performance improvement initiatives must be made available to a class of providers, rather than to all public and private providers subject to the initiative as initially proposed.

CMS finalized the requirement that participation in supplemental directed payment arrangements not be contingent on provider participation in IGT arrangements.

Page 344. In addition, CMS finalized §438.6 with a new paragraph (d) to define pass-through payments, to permit pass-through payments to hospitals subject to a specific calculation and schedule so that the availability of pass-through payments for hospitals under managed care contracts ceases for contracts starting on or after July 1, 2027. This new paragraph permits pass through payments for physicians and nursing facilities for contracts starting on or after July 1, 2017 through contracts starting on or after July 1, 2021.

After outlining long-standing concerns on certain supplemental and pass through payments, CMS states “We also share commenters concerns that an abrupt end to pass-through payments could create significant disruptions for some safety-net providers who serve Medicaid managed care enrollees. As such, we are retaining our proposal to transition pass through payments into value-based payment structures, delivery system reform initiatives, or payments tied to services under the contract as provided in §438.6(c)(1)(i) through (iii).

CMS defines pass-through payments as any amount by the state to be added to the contracted payment rates between plans and hospitals, physicians, or nursing facilities that isn’t for the following:

- A specific service or benefit covered under the contract and provided to a specific enrollee;
- A permissible provider payment methodology under the final rule;
- A sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract;
- GME payments; or
- FQHC or RHC wrap-around payments.

Pass-through payments will be phased out, and payments will only be directed on the basis of utilization, delivery of services to enrollees covered under contract, or the quality and outcomes of services. This phase-out will occur on the following timelines:

- 10 years for hospitals, with annual phase-downs throughout the transition period (full amount for 2017, declining 10% each year until no pass-throughs after July 1, 2027)
- 5 years for physicians and nursing facilities, with no phase-down requirements (no pass-throughs after July 1, 2022)

- **§438.8 New MLR Standards**

Original SNP Alliance Comment: 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.

Final CMS Rule: (pages 91-140)

States must ensure that each MCO reports an MLR and a minimum MLR of 85% must be considered in the rate development setting process for actuarial soundness purposes. The consideration of the MLR may result in rate increases or decreases. If a state mandates a specific MLR it must be equal to or higher than 85%. If a specific MLR is not met, states can require a remittance and/or include adjustments in future rate development. CMS provides considerable detail on the calculation of the MLR and which claims and costs can be included or excluded from the calculation. (Activities related to quality improvement can generally be included.) CMS will also calculate credibility adjustments to be used.

Pg. 106, CMS states the MLR will apply to integrated plans unless there is an MLR across both Medicare and Medicaid "consistent with CMS requirements for those products." CMS will provide TA in those instances. CMS removes the term "medical" from covered services to avoid confusion about inclusion of MLTSS and other services in the MLR.

Page 97. CMS retains the inclusion of care coordination activities as costs counted toward the MLR and rejects comments on being more specific about defining these stating they intend to be broad as follows. "Because of our understanding that some managed care plans cover more complex



populations in their Medicaid line of business than in their private market line(s) of business, we believed that the case management/care coordination standards are more intensive and costly for Medicaid managed care plans than in a typical private market group health plan. We proposed to use the definition of activities that improve health care quality in 45 CFR 158.150 to encompass MCO, PIHP, and PAHP 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 but specifically requested comment on this approach and our proposal not to specifically identify Medicaid-specific activities separately in the proposed rule. We indicated our expectation that MCOs, PIHPs, and PAHPs would include the cost of appropriate outreach, engagement, and service coordination in this category.”

- **§438.10 Information Requirements**

Original SNP Alliance Comment: 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 three 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.

Final CMS Rule. (pages 857-859) Allows monthly updates for network changes for paper directories and within 30 calendar days of receipt for electronic directories for consistency with MA and QHPs. Does not reflect comments that directories in some states have to be reviewed by non-Medicaid agencies who are on different timelines and thus may not be able to be reviewed and updated in a timely manner. The rules do not appear to address directly whether CMS requirement would



override such state specific requirements. Paper directories need to be provided only upon request. CMA also changes “is accessible” to “has accommodations” in order to avoid legal issues around assurances of accessibility, but rejects proposals to eliminate collection of accessibility information. CMS makes many small wording changes and also DTR notices as an item to be translated upon request.

§438.54. Enrollment Systems Standards- Mandatory 14 Day FFS Coverage Period:

While the SNP Alliance did not comment on this item, CMS proposed that states provide beneficiaries with 14 days of FFS coverage while a plan choice is made, in order to ensure beneficiaries had sufficient time to make an informed choice. This was opposed by many states who argued that it would require states to operate small inefficient FFS systems, would be confusing to enrollees and providers, cause delays in access to care and needed care coordination, and lead to disruptions in care and service authorizations.

CMS Final Rule: (pages 431-451)

CMS removed the 14 day FFS coverage period for potential enrollees to make an active choice of managed care plan. CMS acknowledged that, among other things, the proposal was incompatible with the direction of state Medicaid programs to effectuate enrollment at the point of the eligibility determination or soon thereafter. CMS wrote that the 90 day without cause disenrollment window afforded to all enrollees in connection with their initial managed care enrollment, serves as a choice period. CMS also cites that potential enrollees and enrollees will have easier access to information given the provisions that require member handbooks, provider directories, and drug formularies be publicly available (§438.10). The rule also permits states to make passive enrollments effective upon eligibility determination, subject to the enrollees’ right to opt-out or elect a different managed care plan.

- **§438.56 Disenrollment: Requirements and limitations**

Original SNP Alliance Comment: 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.

Final CMS Rule: (pages 451-468)

CMS standardizes enrollment processes for both mandatory and voluntary managed care programs including processes for passive enrollment under both types of enrollment. CMS adds the new cause for disenrollment for enrollees where residential, institutional or employment supports provider is not in the network. However, CMS dropped their proposal to limit the initial without cause disenrollment to one 90-day period after initial enrollment.

- **§438.66 State monitoring requirements**

Original SNP Alliance Comment: 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.

Final CMS Rule: (pages 814-837)

CMS Modifies readiness review requirements to consider the scope of changes, but retains them for key changes, i.e. when the state is implementing a new managed care program, when the managed care plan has not previously contracted with the state, or when the managed care plan will be providing or arranging for the provision of covered benefits to new eligibility groups. However, CMS still intends to review and approve these reviews prior to contract effective dates.

- **§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**

Original SNP Alliance Comment: 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 Medicaid programs, requires additional and different network adequacy considerations.

- **§438.206 and §440.262. Availability of Services**

Original SNP Alliance Comment: 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.



Final CMS Rule: (pages 596-648)

Please note, we are addressing both sections above (Network Adequacy and Availability of Services) here due to overlap in the provisions.

CMS continues to require that states set network adequacy standards and submit an assurance of compliance that plan networks are adequate on an annual basis or when there is a significant change (as defined by the state). Managed care plans are required to submit network adequacy documentation to the state on at least an annual basis at §438.207(c)(2) according to documentation requirements determined by the state, except that CMS now requires that the documentation include information about MLTSS.

Page 608-9. In response to a specific SNP Alliance comment, CMS states that “it is unclear how the network adequacy standards finalized in this rule would be redundant or duplicative of Medicare standards” because “if a managed care plan operates in both Medicare and Medicaid markets and is serving dually eligible enrollees, *Medicare’s network adequacy standards would apply.*” (Emphasis added.) (Please note: We are checking into this with CMS as this statement seems to ignore the fact that providers and services provided under Medicare and Medicaid may overlap, meaning that both CMS and the state may still be doing network reviews for the same providers and the rule does not appear to contain an exemption for states to conduct network activities for Medicaid in these instances.)

CMS generally resists adding more specificity for network standards, does not require CMS approval of standards, and defers most standards to states. CMS does add requirements for minimum standards including time and distance standards for MLTSS services but allows states to define them. CMS adopts its proposed requirement for states to enroll all MCO providers as state Medicaid provider, clarifies the meaning of that enrollment, and allows providers and MCOs to have temporary agreements while waiting for state enrollment of up to 120 days. (See 438.602 (b)(2).)

- **§438.70 Stakeholder engagement when LTSS is delivered through a managed care program**
§438.110 Member advisory committee

Original SNP Alliance Comment: 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.

CMS Final Rule: (pages 587-596).

CMS adopts §§438.70 and 438.110 as proposed with a revision to include other individuals that represent beneficiaries or enrollees to the list of individuals included in the committees required by the two regulations.

- **§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.



CMS Final Rule. (pages 468-497)

CMS finalized rules for choice counseling including “having access to personalized assistance- whether by phone, internet or in person- to help beneficiaries understand materials provided about enrollments, answer questions about options available and identify factors to consider when choosing among plan options, and facilitate enrollment with a particular managed care plan or provider.”

Four minimum functions of the support system were proposed: (1) choice counseling for all beneficiaries; (2) training of plans and network providers on the type and availability of community based resources and supports; (3) assistance to all beneficiaries in understanding managed care; and (4) assistance for enrollees who receive or desire to receive LTSS. However, CMS did not finalize the requirement that the support system provide training on community based resources so that function was eliminated in the final rule.

Choice counseling entities must meet independence and conflict of interest standards requirements for enrollment brokers (must not have a financial relationship with or be a network provider for any managed care plan which operates in the state. CMS clarifies that governmental entities (such as counties) that operate managed care plans would not be able to provide choice counseling. CMS clarified that choice counseling does not include making recommendations for or against enrollment into a specific MCO. While FFP is not available for legal representation of beneficiaries at hearings, entities that provide such services under non Medicaid funding sources can also provide choice counseling with appropriate firewalls as defined by the rule.

Additional elements are required for beneficiaries who use or desire to use LTSS including: (1) an access point for complaints and concerns about enrollment, access to services and related matters; (2) education on enrollees’ grievance and appeal rights, the state fair hearings process, enrollees rights and responsibilities and additional resources; (3) assistance (without representation), upon request in navigating the grievance and appeals process and appealing adverse benefit determinations made by a plan to a state fair hearing; and (4) review and oversight of LTSS program data to assist the state Medicaid agency on identification and resolution of systemic issues.

States are permitted to draw on and expand existing resources to meet these standards including some LTC Ombudsman functions but CMS points out that not all LTC Ombudsman or other existing functions are eligible for FFP (which is available at the normal administrative level) and states must have an allocation plan in place to assure there is not duplicate payment for activities already offered or required by other entities or programs. CMS also modified the final rule to require the inclusion of beneficiary support systems in state monitoring efforts, that ongoing assessments of performance of the support system be conducted to drive continual improvements, that assessments of the system be included in the managed care assessment reports, and that such reports be shared with the LTSS stakeholder group.

- **§438.104 Marketing activities**

Original SNP Alliance Comment: 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.

CMS Final Rule: (page 27) CMS clarifies that D-SNPs are not considered “private insurance” and are not affected by the “tie in” issue. “As discussed in the proposed rule (80 FR 31102), section 1932(d)(2)(C) of the Act, which is implemented at §438.104(b)(1)(iv), prohibits the influence of enrollment into a Medicaid managed care plan with the sale or offering of any private insurance. CMS states that since 2002, the ‘offering of any private insurance’ has been interpreted as any other type of insurance, unrelated of its relationship to health insurance, such as burial insurance. The explicit exemption for QHPs was to avoid any confusion that ‘private insurance’ included health insurance policies through the private market. Types of health care coverage, such as integrated D-SNPs, are public health benefit programs that are not insurance. Therefore, they cannot be considered ‘private insurance’.”

- **§438.208 Coordination and continuity of care**

Original SNP Alliance Comment: 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.

CMS Final Rule: (pages 533-562) CMS received strong support for many of their proposed provisions which outlined expanded requirements for care coordination standards, best efforts for initial screenings for all new members within 90 days of enrollment, updates to include acknowledgement of LTSS by removing the previous focus on medical needs and services, and requirements for sharing of health of assessment and needs identification and health records with the state and among MCOs and/or providers as appropriate. Provisions also included updated



requirements applicable to special needs populations and added LTSS populations to those provisions. CMS generally resisted suggestions to make these requirements more specific, keeping them broad and allowing states flexibility in determining details.

CMS adopted their proposed exception for MCOs serving dually eligible enrollees who are also enrolled in an MAO that allows the state to determine to what extent the MCO must meet the additional requirements for identification, assessment and treatment planning provisions required for enrollees with special needs and LTSS, based on the needs of the population served (“rather than on services covered under the contract.” CMS clarified that this exception only addresses exceptions relative to the provisions proposed in §438.208(c) (which are applicable to enrollees who require LTSS or have special health care needs) and told commenters to consult with their state for clarification regarding primary care provider assignment when acute medical care was covered by Medicare in that circumstance.

CMS acknowledged but declined to further address concerns about sharing of health records and stated that all state and federal data protection requirements must continue to be met.

Very importantly, CMS clarified that it is not a conflict of interest for MCOs to perform “comprehensive” assessments as required for MLTSS, and explicitly disagreed with other comments which would have prohibited MCOs from developing care plans as well as numerous suggestions to standardize assessment tools, assessment qualifications and other requirements at the federal level, leaving current state flexibilities in place. CMS states “The 2013 MLTSS Guidance prohibited managed care plan involvement in functional assessments conducted *prior to enrollment* for the purpose of determining initial eligibility for services. The assessments in §428.208(c)(2) are conducted by managed care plans *after enrollment and are assessments of their own enrollees.*” (*emphasis added.*) “We do not perceive the same conflict of interest in having MCOs, PIHPs and PAHPs assess individuals already enrolled in their plans to determine the appropriate care to be provided by the plan.”

CMS also clarified that care and treatment plans are required for MLTSS enrollees, but are at the state’s discretion for non MLTSS enrollees with special needs and further clarified differences in applicable requirements for each. They also clarify that such treatment plans should not rely solely on the initial screenings, as that screening would not have the same level of detail as MLTSS screenings.

As a result of public comments CMS made the following modifications to the final rule:

- In §438.208(b)(1), they added new text to require that enrollees receiving care coordination be provided the contact information for their care coordinator, stating that “enrollees who are assigned a care coordinator should know how to contact the coordinator for questions or issues about their coordination plan and that managed care plans must implement procedures to ensure that this information is provided to enrollees in a timely manner.
- In §438.208(b)(2)(iv), they are adding text to require coordination with community and social support providers.
- In §438.208(b)(3), they changed “assessment” to “screening”. CMS agreed that as proposed this was unclear given their use of “assessment” in §438.208(c)(2) and that “screening” better describes their intended meaning and is more consistent with standards for “initial health assessment” as applicable to MCOs participating in both Medicare and Medicaid. They further clarified that the intent in §438.208(b)(3) was for the managed care plan to



administer a survey type instrument to gather health needs related information from each enrollee, not to have enrollees receive a PCP visit within the initial 90 days. CMS encourages but does not require that screening tools include elements addressing social determinants of health.

- **§438.214(b). Credentialing and Re-credentialing Policy.**

(The SNP Alliance did not comment on this section but is including it because of interest in this topic.)

Final CMS Rule. (pages 582-583)

CMS notes that language relating to “uniform credentialing and re-credentialing policy needed to be clarified and indicated that policies are not meant to be identical but must be tailored by provider type of specialty to appropriately reflect criteria such as education, training, experience and or licensure or certification. CMS restates that LTSS providers, regardless of the type of service provided, must undergo the credentialing and re-credentialing process and notes that the criteria for credentialing may differ based on the type of LTSS provider.

- **§438.242(c) and §438.818. Health information systems, enrollee encounter data**

Original SNP Alliance Comment: 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.

CMS Final Rule: (pages 888-914)

As part of statutory requirements to align basic elements of MCO health information systems with the Affordable Care Act, CMS implements new standards for encounter data for all MCOs and states which are based on and linked to state requirements for T-MSIS. CMS states they will issue further initial guidance which will address at a minimum “MCOs’, PIHPs’, and PAHPs’ submissions to the state: enrollee and provider identifying information; service, procedure and diagnosis codes; allowed/paid, enrollee responsibility, and third party liability amounts; and service, claim submission, adjudication, and payment dates.” CMS clarifies this must include encounters and capitation data from sub-capitated providers.

CMS also adds a standard for states for reporting of enrollee encounters, requires that such data be validated for accuracy and completeness, and implements FFP deferrals and disallowances on states and MCOs for data that is not complete, accurate or timely. CMS states that advance notice of such actions will be provided to states and that they should notify MCOs of any actions. CMS states that retraction of capitations from a plan based on application of deferral and disallowances provisions should be addressed in its contracts.



CMS requires that LTSS data be included and acknowledges the challenges involved due to lack of standardized coding; however, they point out that T-MSIS allows each state to maintain a list of non-standardized codes and the rule allows states the flexibility needed to work with MCOs and providers to ensure claims and encounters meet the needs of the program.

CMS requires use of a standard format but not a specific business transaction which they deem to be outside the scope of the regulation. They encourage managed care plans and providers to use standard, electronic transactions to the greatest extent possible as developed through an appropriate Standard Setting Organization with the broad input of all impacted parties. CMS states that the standardized formats required for states to submit encounter data to CMS is dictated by MSIS/T-MSIS and has been repeatedly communicated to states.”

CMS has reconsidered their proposal to include a requirement for encounter data to be made public. “While we proposed in §438.602(g)(2) that states would make all data submitted under proposed §438.604, including encounter data, available upon request or on the state’s website, we have decided not to require that encounter data be made publicly available in the final rule. After consideration of comments received on the proposed provisions of §438.602(g)(2), we believe that the proposed rule was overly broad in the types of information that would need to be on the state’s website or made available upon request. We are finalizing section §438.602(g) specifying the minimum list of the types of information to be made publicly available on the state’s website and are not specifying information that must be available upon request.”

CMS states that encounter data is to include pricing information and acknowledges that including this information for capitated providers is complex. They cite the importance of this information and request at least the amount of the capitation payment. CMS also discusses collection of different types of data, collection and documentation systems for VBP arrangements and suggests that these need to continue to be worked out by states, MCOs and providers, but does not intend relax the requirement for those situations at this time.

- **§438.330 Quality assessment and performance improvement program**

- **§438.334 Medicaid managed care quality rating system**

Original SNP Alliance Comment: 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.

Final CMS Rule:

Standards for MCO Quality Assessment and Performance Improvement Programs: (pages 663-701)

CMS updated state standards that require each MCO to establish and implement an ongoing comprehensive quality assessment and performance improvement program that meets CMS and state requirements and incorporates standard performance measures identified by the state and other data and functions required under the rule and performance improvement projects that focus on both clinical and nonclinical areas. MCOs must measure and report results of their performance to the state annually and states must review the impact of QAPI programs annually.

CMS removed the proposed requirement to implement a state review and approval process of each MCO involving standards at least as stringent as the standards used by a private accreditation entity recognized by CMS stating that it would ultimately be duplicative of other activities such as the QRS system, EQR reviews, data validation through T-MSIS and other quality initiatives. Instead it revised the state review process to include review of the accreditation status of each MCO, PIHP, and PAHP when entering into a contract with the state and on an annual basis thereafter, and revised the type of information available on the State's Medicaid website to include the accreditation status of each contracted MCO, PIHP and PAHP and accrediting entity when applicable.



MCOs must include MLTSS in QAPI programs, including mechanisms to assess the quality and appropriateness of care for MLTSS enrollees including assessments of care between settings and a comparison of services MLTSS members are receiving compared to those in their care plan. States are required to identify MLTSS measures related to Quality of Life, Rebalancing and Community Integration for MLTSS members in their lists of standardized measures. CMS notes that it is working with NQF on measurement related to dual eligible, HCBS, family and person centered care and other MLTSS related areas and on pages 692-693 outlines a number of efforts in progress on LTSS measure development.

MCOs must participate in critical incident detection, reporting prevention and remediation. States may choose to substitute MA QIPs for Medicaid PIPs for D-SNPs and FIDE SNPs serving only duals. CMS declined to apply this provision to plans serving Medicaid beneficiaries that are not dually eligible even if they serve a significant number of dually eligible members, they point out that nothing in the rule prevents them from choosing the same topic for both a QIP and a PIP. CMS also clarifies that substitution of a QIP for a PIP does not relieve states of requirements to require PIPs that involve both clinical and nonclinical areas which could include MLTSS and also notes that plans are required to measure LTSS performance under this section. CMS also states elsewhere that other oversight and quality requirements specific to home and community based waivers remain in place.

CMS finalized language allowing CMS to identify a common set of national QAPI or PIP topics, to which states can add others. Should CMS choose to specify performance measures and PIPs to be included in the state's standard measures they will provide additional guidance to states. CMS also finalized their proposal to allow states to request an exemption from nationally identified PIPs and measures.

Many commenters cited the need for alignment or harmonization with other requirements, but cited many other systems and measure suggestions. Commenters also suggested risk adjustment and stratification appropriate for the differences in populations served. CMS agreed that alignment and risk adjustment is important and state they will look for those opportunities should they decide to implement a national QAPI or PIP system and take these into account during the public notice and comment period. They also noted that measures reported to the state and the EQRO must be specific to the Medicaid managed care population and requirements.

MMC QRS or State Alternative (pages 701-717)

CMS is adopting a requirement that states contracting with MCOs, PIHPs, and PAHPs develop and implement a MMC QRS. States must issue a quality rating annually for each contracted MCO. States may adopt either the MMC QRS developed by CMS or an alternative MMC QRS, and must implement such MMC QRS within three years of the date of a final notice published in the Federal Register (expected to be in 2018.) The rule provides that CMS will develop a MMC QRS, through public notice and comment that aligns with the summary indicators of the Marketplace QRS.

After feedback from many commenters that the MA 5 Star Rating system would not be appropriate for many Medicaid populations, CMS is not finalizing the proposed option for states to default to the MA Five-Star Rating system for those plans that serve dual eligible beneficiaries only. They will coordinate with other CMS components operating quality ratings systems in order to develop performance measures appropriate for enrollees needing LTSS, children, dual eligible beneficiaries, persons with special health care needs, and individuals with low socioeconomic status, as well as



adjustments to the methodologies to account for these populations and measures. CMS did not comment on whether plans offering D-SNPs in combination with Medicaid would be subject to two separate QRS systems. (page 703.)

States may adopt an alternative MMC QRS, contingent upon CMS approval, that utilizes different performance measures and/or applies a different methodology from the CMS QRS, provided that the “ratings generated by the alternative MMC QRS yield information regarding MCO, PIHP, and PAHP performance which is substantially comparable to that yielded by the MMC QRS.” CMS also includes requirements for a state public engagement process prior to submitting a proposal for, or modification to, an alternative MMC QRS and requirements for applications to CMS for approval of alternative MMC QRS.

CMS clarified that they are not proposing that states define their percentile distributions based on aggregated data across states and that each MMC QRS will use state level data that will provide comparisons across plans within a state. They also anticipate that the system will reflect risk stratification and other methodological adjustments for socio economic risk factors and other social determinants of health.

Comprehensive State Quality Strategy (pages 719-741)

CMS made a number of substantial changes to this section. CMS dropped its proposed Comprehensive State Quality Strategy applicable to both managed care and FFS and incorporated a number of elements into sections applicable to the managed care system (438.340, formerly 438.204), but not to FFS. They added a new element at §438.340(b)(3)(i) of the final rule to describe quality metrics and performance targets used to measure performance. They also added a reference to the description of a state’s transition of care policy consistent and an element focused on identifying, evaluating, and reducing health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable, as §438.340(b)(6). CMS also retained a requirement requiring states provide specified demographic information to MCOs, PIHPs, and PAHPs for each Medicaid enrollee at the time of enrollment.

- **§438.400-424 Grievance System**

Original SNP Alliance Comment. 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.

Final CMS Rule: (pages 31-91)

CMS changes the name of the section to Grievance and Appeals, requires that plan level be exhausted prior to SFH, retains the alignment of timeframes for plan level appeal timeframe of 60 days to align with MA, and allows for an additional 120 days to file SFH, but plan timeframes for decisions would be shortened to 30 calendar days also to align with MA. CMS emphasizes having a standard system across the nation as much as possible. They also add provision of an optional external medical opinion. They reconsider dropping requirements for providers to have written permission prior to appeals submission on behalf of enrollees, retaining that requirement.



Page 501. CMS also modifies 438.210 related to continuation of benefits after appeal to say that benefits must be continued through the conclusion of a timely filed appeal even though authorized time limits have expired and that policies on recoupment of benefits are left to states but cannot differ between FFS and managed care.

- **§438.602-§438.608. State Responsibilities, Data Certification, and Program Integrity**

Original SNP Alliance 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.

Final CMS Rule: Page 394. CMS agreed that the proposed rule was overly broad in the types of information that would need to be on the state's website or made available upon request. They are modifying §438.602(g) to narrow the information that must be made publicly available on the state's website as follows: the MCO, PIHP, PAHP or PCCM entity contract; data required by §438.604(a)(5); the name and title of individuals included in §438.604(a)(6); and the results of any audits under paragraph (e). Page 834. CMS also clarifies that they do not mean for actual encounter data to be put on the website.

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