



January 14, 2019

Chris Traylor  
Acting Director  
Center for Medicaid and CHIP Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Acting Director Traylor,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on CMS's proposed revisions to the Medicaid managed care regulatory framework (CMS-2408-P). Medicaid Directors are pleased to see many of the issues states discussed with CMS throughout 2017 and early 2018 reflected in this proposed rule, and appreciate CMS's thoughtful consideration of state perspectives. While some policy areas would benefit from additional flexibility, this proposed rule represents a positive step towards streamlining Medicaid managed care regulations in a manner that promotes more efficient program administration.

More specific comments on CMS's proposals are below.

### **Network Adequacy**

#### **Removal of Mandatory Time and Distance Standards**

CMS proposes revising §438.68(b) to remove mandatory time and distance standards, instead requiring states to adopt a minimum quantitative standard for specified providers and for long-term services and supports.

NAMD strongly supports this revised approach to assessing network adequacy. NAMD and our members partnered with CMS throughout the latter half of 2016, after the release of the current managed care regulatory framework, to deeply explore the methods states use to ensure their managed care plans build and maintain the provider networks necessary to provide services to Medicaid beneficiaries. The product of this partnership was CMS's Medicaid managed care network adequacy toolkit, released in April 2017, which describes in detail



current state practices and model approaches to this important aspect of Medicaid managed care programs.

In the course of these toolkit conversations, states noted that while time and distance standards are a commonly employed method for monitoring provider networks, they are rarely the only method used, nor are they the most appropriate method in many circumstances. States also use provider to enrollee ratios, monitor the volume of beneficiary grievances and appeals and the reason for their initiation, assess the availability and timeliness of appointments, gauge the cultural competency of providers to address unique beneficiary populations, and several other strategies. States commonly use multiple strategies in combination to provide a more multifaceted look at beneficiary access and utilization in their managed care programs.

In proposing to remove mandatory time and distance standards, CMS acknowledges the reality of current state practice. While we recognize some stakeholders may desire a federal minimum standard in this area, the varied nature of state provider landscapes and the structure of each state's managed care program makes a blanket federal requirement less valuable in practice than in theory. We greatly appreciate CMS's extension of flexibility in this area.

### **Definition of "Specialist"**

CMS proposes revising §438.68(b)(1)(iv) to explicitly grant states the authority to designate what constitutes a specialist for purposes of setting network adequacy standards. We appreciate this change, as some states struggled to meaningfully apply the requirement to set network adequacy standards for specialists in their programs without clear understanding of whether they had the authority to define the term.

### **Information Requirements**

#### **Tagline and Large Font Requirements**

CMS proposes revising §438.10(d)(2) to require taglines to be included only on materials for potential enrollees that are critical to obtaining services, rather than all written materials. CMS also proposes removing the definition of "large-print font" and to adopt the "conspicuously visible" standard in §1557 of the Affordable Care Act, rather than mandating 18-point font.

NAMD supports this change. The 18-point font requirement is overly prescriptive and resulted in states and plans increasing expenditures for printed materials without a clear linkage to beneficiary need for such enhancements. The conspicuously visible standard allows plans to exercise more discretion in designing materials in a manner which clearly communicates appropriate information to beneficiaries in a way that is useful and actionable. We concur with



CMS's discussion of this issue in the preamble and view this change as supporting more diverse materials for beneficiaries, including pamphlets, brochures, and postcards.

### **Provider Termination Notices to Beneficiaries**

CMS proposes revising §438.10(f) to require plans to issue notices to beneficiaries of the termination of their routinely seen providers by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after plan receipt or issuance of the termination notice.

NAMD supports this change. We agree with CMS that the current requirement for plans to issue beneficiary notices within 15 calendar days of receipt or issuance of termination, without regard to the role that such actions may play in routine network negotiations between plans and providers, can cause unnecessary alarm for beneficiaries and give the erroneous impression that their providers will not be in their plan network.

### **Provider Directories**

CMS proposes revising §438.10(h)(3) to allow plans which have a mobile enabled electronic provider directory to print a paper version of the directory on a quarterly basis, rather than a monthly basis, and for any changes in provider networks to be reflected in the electronic directory within 30 days. Plans without mobile enabled electronic directories will continue to be required to print their provider directories each month.

NAMD supports this change. Technological solutions such as electronic provider directories allow beneficiaries to access timelier information on providers in their network and save printing expenses for states and plans. We believe CMS's proposal to reduce printed directories to once a quarter for plans supporting mobile enabled electronic directories strikes a suitable balance between streamlining access to provider directory information in electronic and printed formats.

## **Actuarial Soundness and Rate Development Practices**

### **Cost Shifting to the Federal Government**

CMS proposes revising §438.4(b)(1) and adding a new §438.4(d) to make explicit in its actuarial soundness requirements certain prohibited practices which shift costs from states to the federal government. Specifically, CMS proposes prohibiting:

1. Using a profit, operating, or risk margin for any covered population or contract that is higher than such margins for the population or contract with lowest average FFP;

2. Using additional costs of required fee schedules or minimum levels of reimbursement above the costs of similar requirements for the covered population or contract with lowest average FFP; and
3. Using a lower remittance threshold for a MLR than the remittance threshold applied to the covered population or contract with lowest average FFP.

While we understand CMS's desire to ensure federal dollars are spent appropriately, we foresee potential unintended consequences emerging from this proposal. For example, states with primarily managed care delivery systems may have specialty contracts for a specific population, such as foster youth, with state statute setting the rate structure at the state's vestigial fee-for-service rates. This would lead to a low average FFP for this covered population and would make the state's fee-for-service rate structure the standard by which other contracts are judged, which may not be an appropriate standard. This could incentivize states to require increased rates in such contracts in order to allow for more appropriate rates in other covered populations that receive enhanced FFP, which appears contrary to the intent of the proposal.

Further, states which may have less experience in developing rates for a given population, such as a state newly expanding its Medicaid program, may have good reason to build in higher margins or assumptions to address uncertainty regarding actual experience. Restricting a state's ability to incorporate these types of assumptions into their rates could negatively impact the state's overall goals for the program.

We believe CMS's existing rate certification process provides sufficient oversight to ensure states set rates in a manner that does not spend federal dollars unnecessarily. Should CMS move forward with this proposal, we recommend clarifying in regulatory text that states may continue to have different margins, reimbursement levels, and remittance thresholds for higher FFP contracts when those differences are justified in data and actuarial experience. It is critical for states to retain the flexibility to set appropriate rates for covered populations, especially when the state operates multiple contracts which may focus on different populations with unique service needs.

### **Rate Ranges**

CMS proposes revising §438.4(c) to allow a new option for states in the rate development process. This option would allow states to set a rate range, primarily for purposes of supporting a competitive bidding plan procurement process, so long as the range meets specified conditions, notably having the lower and upper bounds of the range certified as actuarially sound and ensuring that the upper bound of the range does not exceed the lower bound by more than a multiple of 1.05. CMS proposes that states using this new option would not be able



to use the existing flexibility to adjust a specific certified rate up or down one-and-a-half percent. Lastly, states using the new rate range option would be able to select a rate within the range for their managed care contracts, but must provide a revised rate certification if the state seeks a mid-year adjustment to the rate.

We view this change as a positive step that reflects NAMD's desired flexibilities on this issue. As CMS notes in the preamble, several states utilize a competitive bidding process in their plan procurements. Under this approach, states may factor in a plan's ability to provide services with a rate on a lower end of an actuarially sound rate range into their selection criteria. The five percent rate range would support states leveraging such an approach.

We do note that mid-year rate adjustments may be necessary in the course of a contract year to correct underlying rate assumptions or other issues, and encourage CMS to ensure that its recertification process for selecting a new rate within a previously approved rate range is minimally burdensome for states.

### **Annual Rate Development Guidance**

We appreciate CMS's commitment at §438.7(e) to issue annual rate development guidance and clearly articulate the supporting documentation it expects from states in the rate development process. Timely rate development and certification is a cornerstone of well-functioning Medicaid managed care programs, and improvements in this area is a key focus for states. NAMD and our members look forward to continuing to work with CMS to further streamline this process.

### **Quality Rating System (QRS)**

#### **"Substantially Comparable" State QRS Information**

While CMS is not altering its overall requirement that state-developed QRSs generate substantially comparable information to the federal QRS, CMS does propose revising the requirement at re-designated §438.334(c)(1)(ii) to state that this information must be substantially comparable to the extent feasible to ensure meaningful comparison across states, taking into account differences in state programs such as covered populations, benefits, and stage of delivery system transformation.

Generating meaningful comparisons across states will not be a simple undertaking. Variation in covered populations, local health care market dynamics, participating plans, the structure of state managed care programs, and a host of other factors impact quality outcomes. We appreciate CMS acknowledging the roles of these various factors in developing the federal QRS, but continue to question how the substantially comparable standard will be implemented.



NAMD looks forward to working with CMS in future rulemaking on the QRS to more fully explore these issues and chart a workable path forward that appropriately balances state variation with the desire to have federal insights into the quality of state managed care programs.

### **Minimum Performance Standards and Alignment with Other Programs**

At §438.334(b) CMS proposes that the federal QRS and any state QRS must include a set of minimum performance metrics. The federal QRS will align, to the extent possible, with the Qualified Health Plan QRS in the exchanges, with the Medicare Star Ratings System, and with the Medicare-Medicaid Plan Financial Alignment Initiative Star Rating strategy. NAMD has reservations about moving forward with these specific performance metrics, given the substantial differences in population characteristics across these programs.

That said, we do encourage CMS to consider how the QRS and its work in the Medicaid Scorecard initiative may intersect and support one another. The collaboration between states and CMS on the Scorecard is helpful for thinking through more complex aspects of quality, and we see benefits in having those conversations inform the development of the federal QRS.

Again, we look forward to future QRS-specific rulemaking to more deeply explore these issues.

### **No CMS Pre-Approval of State QRS Development**

CMS is removing the requirement that states must have CMS pre-approval of their QRS development plan, but must make documentation and available to CMS upon request. We appreciate that this change will allow states to initiate work on their own QRS earlier than under previous regulations, though there could be challenges if states invest heavily in their own approach and learn late in development that their QRS does not meet CMS's substantially comparable standard. We request CMS consider allowing, at state option, some degree of pre-approval of a state's QRS design to ensure any discrepancies are addressed early in the development process.

### **Documenting Risk Sharing Arrangements and New Options for Directed Payments**

#### **Inclusion of All Payment Arrangements in the Contract**

CMS clarifies at §438.6(b)(1) that states must include all applicable risk-sharing mechanisms (reinsurance, risk corridors, stop-loss programs, etc.) in the contract and rate certification documents, and that such mechanisms may not be added or modified after the start of the applicable rating period.



We recognize that documenting risk-sharing mechanisms in the contract is good practice for effective contract management, and support CMS's intent in that regard. However, in practice mid-year modifications to these arrangements may be necessary to reflect actual experience throughout the contract year, address unanticipated issues emerging in the year, or to correct errors in the construction of the mechanism.

We encourage CMS to consider striking a balance between appropriate documentation of payment arrangements in the contract and providing states with the flexibility to make appropriate changes to these arrangements in a manner which supports overall stability and integrity of the state's managed care program.

### **New Directed Payment Options**

CMS proposes adding two new directed payment options at §438.6(c)(1)(iii). These include a new option for states to set their state plan fee schedule as the plan's minimum fee schedule, which does not require additional approval from CMS, and for states to require their plans to adopt a market-based rate (such as the Medicare rate or commercial payer rate).

NAMD fully supports these additional directed payment flexibilities. We particularly appreciate CMS not requiring the state to seek approval for plans adopting its state plan rates, as such rates are reviewed and approved by CMS through the State Plan Amendment (SPA) approval process. We agree with CMS that an additional approval of a state plan rate in the managed care context would be duplicative of both state and federal resources. Additionally, this state plan rate option further maximizes the process efficiency gains being achieved by the productive partnership between states and CMS in separate work streamlining the SPA approval process.

The option for states to direct a market-based rate coincides with state delivery system and payment reform efforts to promote multi-payer alignment. We support CMS providing states with this option as a default tool.

### **Multi-Year Directed Payment Approvals**

CMS proposes to codify in regulation at §438.6(c)(3) its existing guidance on multi-year directed payment approvals. We support CMS incorporating its sub-regulatory guidance on multi-year approvals into regulatory text.

Delivery system and payment reform work requires significant time and resource commitments from states, plans, and participating providers. CMS's steps to provide all these parties with certainty that a reform initiative – and its associated payment structures – will be durable across multiple years is recognized and appreciated by Medicaid Directors.



### **Pass-Through Payment Transition Period for New Managed Care Programs**

CMS proposes at §438.6(d)(6) to allow a three-year transition period for pass-through payments made to hospitals, physicians, and/or nursing homes when new services or populations are transitioned from fee-for-service into managed care. This transition period does not alter the current planned phase-down for such payments in existing managed care programs.

NAMD supports the creation of this transition period as a logical mechanism for allowing states the option to pursue managed care. Transitioning new populations and services into managed care requires thoughtful deliberation, with sufficient time for providers, beneficiaries, and plans to adjust to new delivery system dynamics. Depending on the nature of the change, smaller providers may need several years to adjust business processes and ensure financial viability going forward – particularly if the provider is reliant on pass-through payments in Medicaid fee-for-service. This transition period will support states seeking to create new or expand existing managed care programs by continuing to make such payments.

### **Grievances and Appeals**

#### **Adverse Benefit Determination Notifications**

CMS proposes at §438.400(b)(3) to clarify that a denial, in whole or in part, of a payment for a service because the claim does not meet the definition of a clean claim (no NPI, missing administrative information, etc.) is not an adverse benefit determination, and does not trigger beneficiary notice requirements.

NAMD supports this change. Some states interpreted CMS's prior rulemaking around adverse benefit determinations to include claims denied for administrative reasons (such as incomplete claims submissions) for which the beneficiary was not financially liable, causing unnecessary confusion and concern. We appreciate CMS clarifying that this is not its intent.

#### **Flexibility in Fair Hearing Request Timelines**

CMS proposes modifying §438.408(f)(2) to allow states to set the timeline for beneficiaries requesting a fair hearing to be no less than 90 days and no more than 120 days from the date of the plan's notice of resolution. We appreciate the flexibility for states to set a fair hearing timeline that best meets their needs.

### **Institutions for Mental Disease (IMDs)**

CMS declined to modify its policy on Medicaid managed care plans providing up to 15 days per month of admission in IMDs in lieu of other covered services. NAMD continues to believe this





policy poses operational challenges for states and creates barriers to medically necessary treatment for beneficiaries with behavioral health needs.

We recognize that both CMS and Congress have provided alternative pathways for IMD coverage in recent years. CMS has developed 1115 demonstration waiver constructs for substance use disorder (SUD) and serious mental illness (SMI), and Congress created a state plan option to provide opioid treatment in IMDs which will be available in October 2019. These flexibilities are greatly appreciated, and we anticipate states making use of them.

However, the 15-day limit continues to create inappropriate incentives for timing IMD admissions around basis of payment rather than the medical needs of an individual. Further, CMS's expectation that states recoup portions of a per-member-per-month (PMPM) payment to their plans when the limit is exceeded creates unnecessary operational burdens for states and financial uncertainties for plans. While CMS has noted in guidance that states may make pro-rated payments for Medicaid services provided to individuals when they are not in an IMD, this does not address the underlying operational challenges. Additionally, the 15-day limit creates additional challenges for states in complying with mental health parity requirements.

We continue to believe that a medical necessity standard is the most appropriate path forward for IMD coverage in a managed care context. NAMD can work with CMS to convene a group of states for a further discussion of data demonstrating the necessity of this approach.

NAMD wishes to thank CMS again for its thoughtful consideration of state perspectives on these crucial managed care issues. We look forward to continuing our work together to further improve the Medicaid program.

Sincerely,

A handwritten signature in blue ink that reads "Judy Mohr Peterson". The signature is written in a cursive style.

Judy Mohr Peterson  
Med-QUEST Division Administrator  
State of Hawaii  
President, NAMD

A handwritten signature in black ink that reads "Kate McEvoy". The signature is written in a cursive style.

Kate McEvoy  
State Medicaid Director  
State of Connecticut  
Vice President, NAMD