VNAA
Visiting Nurse Associations of America

July 27, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule for Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098

Dear Acting Administrator Slavitt:

On behalf of the Visiting Nurse Associations of America (VNAA), thank you for the opportunity to comment on these important regulations. Medicaid provides critical insurance coverage to millions of people, including seniors, people with disabilities and pregnant women and children. Modernizing Medicaid Managed Care and strengthening important federal regulations will help ensure that these beneficiaries continue to receive critical health services.

VNAA is a national organization that supports, promotes and advances mission-driven, nonprofit providers of home and community-based health care, hospice and health promotion services to ensure access and quality care for their communities. As safety net providers, VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicaid, Medicare, privately insured and uninsured patients. VNAA members provide high quality patient-centered care at home as well as offer support for family caregivers. They primarily serve the most clinically complex and vulnerable patients who will benefit from care delivered in their homes. But, because Medicaid, unlike Medicare, does not include a homebound requirement for home-based services, our members are on the vanguard of providing innovative and efficient care to a wide range of beneficiaries with different acuities and needs for care.

VNAA is pleased to provide comments on the provisions in the proposed rule that may impact home-based care providers and are needed to protect beneficiaries. Our mission-driven home health and hospice providers serve Medicaid patients, but face significant challenges due to low reimbursement, delayed payments, administrative burden, and the complex regulatory environment. This rule makes

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positive steps to address many of these concerns while still protecting beneficiaries' right to high quality care.

Below please find our detail comments. In summary, VNAA:

- Appreciates efforts to modernize the delivery of long term services and supports (LTSS) and encourages CMS to prioritize coordinated care delivered in the home.

- Supports the provisions of this rule that address network adequacy, actuarial soundness and reinvestment in services (MLR) with the goal of increasing beneficiary access to services. For beneficiaries, this means a choice of high quality providers in a reasonable proximity who are accepting patients in a timely manner.
- Supports efforts that require high quality and value from providers as well as increasing the role of coordinated care for Medicaid.
- Recognizes and supports the transformation of the federal and state Medicaid partnership.
- Underscores that Medicaid beneficiaries are different than enrollees in other insurance products and face more negative social and economic determinants of health. Medicaid must acknowledge these challenges and appropriately set quality measures and risk adjust to reflect these differences.
- Encourages the alignment of Medicaid with other federal and commercial insurance programs, in terms of policies, rules and quality reporting measures. Inconsistencies in policies and rules across MCOs, as well as between the state and the MCOs, can pose significant challenges for providers and result in duplication of effort and reporting.
- Strongly supports the steps included in this rule that require MCOs to adhere to Medicaid's unique protections, including a guaranteed benefit of medically necessary services such as home care and hospice and freedom of choice among MCOs and providers.

Please accept the following more detailed comments on the provisions that may impact home-based care providers and/or would impact beneficiary access to services:

Coverage and Authorization of Services (§438.210)

CMS proposes to modernize the language governing the coverage and authorization of services, establish more uniform standards for states and the MCO contracts, and protect beneficiary access to services.

VNAA Comment: All eligible beneficiaries should be able to access high quality care when they need it and in the setting in which they choose. To achieve this goal, it is critical that the real costs of caring for beneficiaries with multiple chronic conditions or those facing many social and economic challenges are calculated into the capitation rates paid to plans—and that plans are held accountable to use those funds for services for beneficiaries. This includes developing robust provider networks as well as appropriately paying providers for caring for high-risk patients and our specific comments below reflect this need. MCOs should be prohibited from placing any restrictions on the amount, duration and scope

of needed benefits, and states should be required to ensure freedom of choice for all beneficiaries, including those who live in rural areas.

Defining Long-Term Services and Supports (I.B.g.1)

CMS proposes to define LTSS services as: "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 provider-owned or controlled residential setting, a nursing facility, or other institutional setting."

VNAA Comment: The proposed definition does not mention the need for coordinated care. It is critical that skilled medical services for beneficiaries receiving LTSS are closely and continually coordinated with community-based and social services. VNAA recommends that CMS strengthen this definition by adding a specific reference to coordinated services and support for beneficiaries.

Beneficiary Support System (§438.71) / Coordination and Continuity of Care (§438.208(c))

CMS proposes to require that states provide beneficiaries with unbiased counseling and support to assist in choosing a managed care plan.

VNAA Comments: VNAA supports a strong state-run beneficiary support system that includes unbiased counseling services for enrollment in an insurance plan. These protections and supports are essential for all beneficiaries and their authorized representatives, particularly those seeking LTSS services. It is critical that the counseling be independent and free of conflict of interest.

VNAA recommends that CMS explicitly state that nothing in this proposed rule would prohibit states from contracting with community-based providers to provide support and health insurance counseling to beneficiaries. We note that many providers, including home health agencies, have served as navigators as part of the state and federal Marketplaces and have served beneficiaries in an unbiased, fair, and professional manner. In addition to their experience as navigators, home health providers have significant experience working with beneficiaries and their caregivers to improve health insurance literacy and navigate the complex maze of insurance coverage. They also excel in coordinating with community-based services to provide beneficiaries with a strong support system.

While the rule speaks to assistance in choosing a plan, experience in both Medicaid and Marketplaces points to the need for ongoing assistance so that beneficiaries can continually make the best use of their insurance. VNAA encourages CMS to modify §438.208(c) to ensure that beneficiary supports for people seeking LTSS are continuous and ongoing over the term of enrollment in the plan. In order to best serve the ongoing needs of beneficiaries, VNAA recommends that CMS codify the requirement that states provide training to plans and providers on available community-based resources. As trusted, integrated members of care teams, home health providers are in an excellent position to provide training to other providers and MCOs about what services are available and how to integrate them into the care plan.

Person-Centered Processes: §438.208(c)/ Care Coordination Activities (438.208(b))

This rule proposes for MCOs to make their best effort to complete an initial health risk assessment within 90 days of enrollment for all new enrollees, including an evaluation of community-based resources.

VNAA Comments: We strongly support an initial, comprehensive needs-assessment of a beneficiary's medical and non-medical needs upon enrollment. A study conducted by the Visiting Nurse Service of New York (VNSNY) and VNAA and published in *Health Affairs* found that resource use among home health patients varied significantly based on patient characteristics.[1] This research found that patients with poorly controlled chronic conditions such as diabetes and congestive heart failure, those who have severe pressure ulcers, and those who have limited assistance from caregivers in managing functional impairments and medical procedures were particularly resource (and cost) intensive. A comprehensive assessment of medical and non-medical needs will help plans identify and better support beneficiaries from the time of enrollment.

Due to the importance of the initial health risk assessment, VNAA strongly recommends that MCOs be required to conduct such an assessment for each enrollee and that the process includes a home visit. A home visit would provide critical contextual information to assist in the development of a comprehensive plan that enrollees can implement given their circumstances.

Finally, MCOs should be required to use the information collected to develop robust person-centered care plans. All providers contracting with the plan must be required to follow the determined plan of care. To be successful, this will require strong health IT infrastructure to enable sharing of the plan of care across providers as well as provider and health plan education on the full spectrum of medical and social services required to manage the beneficiary's health.

Network Adequacy (§438.68)/ Assurances of Adequate Capacity and Services (438.207)/ State Monitoring Standards (§438.66)

States must develop and enforce network adequacy standards for specific provider types to ensure that beneficiaries have access to services covered under the state plan. For LTSS providers who travel to the enrollee to deliver services, including home-based care providers, the state must use standards beyond time and distance.

VNAA Comments: VNAA agrees with CMS' proposal to require that states set standards to ensure beneficiaries' timely access to covered services, with a specific focus on LTSS services. At a minimum, CMS should include timeliness and whether or not the provider is accepting new patients, in addition to time and distance standards. VNAA also recommends a criterion that measures consumer choice of provider. Plans should be required to ensure that a sufficient number of in-network providers are willing to serve all patients, including those who are complex and potentially costly. This may be achieved by

[1] Rosati, R. et al. "Medicare home health payment reform may jeopardize access for clinically complex and socially vulnerable patients," *Health Affairs* June 2014.

requiring a minimum number of mission-based providers and/or providers whose case mix is above a minimum threshold. It is important to note that in order to retain high quality providers as in-network Medicaid providers, provider reimbursement must be set appropriately, payments to providers must be made in a timely manner, and states and plans must reduce the administrative and reporting requirements on providers.

Rate Development Standards (§438.5)

CMS proposes to conduct oversight of state capitation rates to plans.

VNAA Comments: VNAA reiterates the importance of appropriate rate setting. Our members' experience shows that state rates to plans are often inadequate, resulting in underpayments to network providers or excessive downward pressure on utilization to the point of patient harm. We underscore the need to base trend factors and risk adjustment on current data and data based on the actual experience from the same or similar population cohorts. Medicaid beneficiaries, who often face multiple social determinants of health, may present significantly different costs than patients in the commercial market. We also recommend that states be required to conduct routine evaluation of plan payment rates to providers to assess payment adequacy.

Qualified Providers (§ 438.68(b)(2); §438.207(b)(1))

Plans must document that they maintain a provider network adequate for the geography and anticipated number of enrollees.

VNAA Comment: VNAA encourages CMS to retain the provision that MCOs submit regular documentation to the state to demonstrate that it complies with offering the full range of services, including LTSS, that are adequate for the anticipated number of enrollees. We encourage these data to be submitted by provider category so that, for example, it is possible to see how many home health providers are available to beneficiaries in a specific area.

Provider Discrimination Prohibited (§438.12)/ Provider Selection (§438.214)

Plans are neither required to contract with all providers nor with more providers than necessary to meet the needs of its enrollees. However, plans are prohibited from discriminating against providers who serve high-risk patients or patients who require expensive treatments.

VNAA Comment: VNAA reiterates the need to ensure that plan networks are adequate to ensure timely access to services for beneficiaries. States must have the ability to assess plan networks and to require plans to contract with additional providers in order to fulfill their obligations.

Special Contract Provisions Related to Payment (§438.6(c))

The regulations would permit states to require plans to contract with providers on a value basis or participate in other payment and delivery system reform initiatives. States would also be permitted to set a fee schedule or minimum reimbursement standards to which the plans would be required to adhere (though individual providers could still negotiate higher rates).

VNAA Comments: VNAA supports a move towards value-based purchasing to the extent the models used are developed with consideration of the full set of services needed by beneficiaries and the unique characteristics of the Medicaid population. For example, performance measures must align with program and beneficiary goals and characteristics and be appropriately risk-adjusted. We specifically support requirements that states demonstrate that incentive payments are based on the delivery of services and are being used to meet the goals of the program. VNAA also recommends that federal approval and oversight of Medicaid value-based purchasing include a review of network adequacy, specifically of the providers included in the value-based purchasing (VBP) program to ensure timely access to services.

In designing reimbursement for value-based payments, we strongly encourage state-based reimbursement floors to be adjusted to reflect the acuity of the patient and be set at a rate not less than Medicare rates for the same service or bundle of services. Current Medicaid reimbursement rates for home health (and other services) are often below the true costs of providing the services.
The cost of providing the same bundle of home health service may vary greatly from the commercial market, and will vary based on an individual patient's needs and situation. As previously noted, a recent VNSNY-VNAA study demonstrated that VNAAs non-profit members see patients with much higher acuity and number of chronic conditions than other home health providers and "average" payments would dramatically underpay.

Finally, we encourage CMS to require states to provide oversight and approval of measures selected for value-based purchasing programs implemented by the plans. States should be required to ensure that only validated measures are used and that measures across types of providers align to create like incentives. Our members' experience has been that MCOs have little experience using OASIS data for purposes of measuring performance. We strongly encourage CMS to specifically point to this existing source of data as a starting point for measuring performance of home health agencies. MCOs and agencies should work together to incorporate new measures and data sets as they become available and are validated.

Medical Loss Ratio (§438.8)

A medical loss ratio (MLR) is a standardized tool to assess the proportion of premium revenue a plan spent on clinical services and quality improvement. CMS proposes that states calculate managed care capitation rates taking into account an MLR of no less than 85%.

VNAA Comment: VNAA supports an 85% MLR and a strong reinvestment on clinical services and quality improvement.

Quality Strategy (§431.500; §431.504)

The rule extends a comprehensive written quality strategy to all state Medicaid programs, including LTSS, to monitor the delivery of quality health care to Medicaid beneficiaries. The proposed rule focuses on transparency, alignment with other systems of care, and consumer/stakeholder engagement.

VNAA Comments: VNAA supports the development of a written quality strategy and looks forward to participating in the robust public engagement process as CMS develops its Medicaid quality rating system. It is critical that programs be aligned so that providers, plans, and the state can collect and report a unified data set, easing the reporting requirements on all participants. VNAA urges the consultation of a wide variety of beneficiary and stakeholder groups in the development of the written quality strategy and specifically calls on CMS to include home-based providers to be part of this process. While the Marketplaces and Medicare Advantage can provide a strong foundation for a quality strategy, there will be factors that are unique to Medicaid beneficiaries and the providers who serve them. For this reason, we encourage a robust discussion on the social determinants of health and how they are measured in the quality strategy.

Beneficiary Choice of Plan (§438.52)

The rule reiterates current policy that states must ensure beneficiaries have the choice of at least two plans with an exception for residents in rural areas. The rule changes the definition of "rural" for purposes of this provision and may increase the geographic areas where beneficiaries would only have one plan in which to enroll.

VNAA Comments: VNAA has significant concerns with increasing the number of geographic areas covered by only one health plan. With only one option for coverage, beneficiaries may have significant access problems. They also would not have the ability to shop around for the benefit package or network that best suits their specific health care needs. The principle of beneficiary "choice of provider" is violated if their provider is not in-network with the only plan. VNAA recommends that all Medicaid beneficiaries be offered a choice of two or more MCOs. Where this is not possible, beneficiaries should be able to choose any willing provider on a fee-for-service (FFS) basis.

As small nonprofit providers, VNAA members will also be dramatically impacted. By increasing the number of geographic areas covered by only one plan, small providers may be limited in their ability to participate in Medicaid. In order to serve Medicaid beneficiaries, providers will have to go in-network with the one (and only) Medicaid plan offered—regardless of the terms of the contract. There will be no ability to use market forces to negotiate different reimbursement.

Plan Provider Directories (§438.10(h))

The rule would require states to ensure that a robust set of plan information is available to beneficiaries, including provider directories with more information than was previously required.

VNAA Comments: VNAA supports comprehensive and regularly updated provider directories. We also support that provider directories, along with all plan communications, be accessible to all beneficiaries. VNAA recommends that LTSS services be separated into categories, including a special mention of home health. We strongly recommend that plans be required to provide information for both beneficiaries and providers on how to contact the plans.

Managed Care Enrollment (§438.54)

States may either mandate or make voluntary enrollment in managed care. The rule would require states to provide enrollees with at least 14 days of traditional, fee-for-service coverage, during which the potential enrollee could select to participate in managed care (in a voluntary scenario) or choose a plan (in both mandatory and voluntary scenarios). In cases where an individual does not select a plan, the state would be required to choose a plan for the beneficiary.

VNAA Comments: VNAA supports these provisions so long as the state has an effective beneficiary support system that includes external, unbiased choice counselors to help beneficiaries and their caregivers make informed choices.

Disenrollment: Requirements and limitations (§438.56(d)(2)(iv))

If a state does not allow an enrollee to switch plans at any time, the rule would require states to let enrollees disenroll and switch plans if the enrollee's MLTSS provider leaves their network and, as a result, the enrollee would experience a disruption of services to their residence or institution.

VNAA Comments: VNAA recommends language to clarify that "MTLSS provider" could include a home health provider so that a beneficiary would be allowed to switch plans if their home health provider leaves the network.

Coverage and Authorization of Services (438.210)

The rule prohibits plans from implementing utilization controls (e.g., prior approval or stringent medical necessity definitions) to disadvantage beneficiaries with ongoing chronic conditions.

VNAA Comments: VNAA supports the provisions of this proposed rule which are critical for vulnerable beneficiaries who need home health services. We also support updating the time frame on medical necessity determinations of benefit coverage within 72 hours (as opposed to 3 working days) in the case of expedited appeals. The rule makes clear the process for notifying beneficiaries and caregivers the outcomes of medical necessity determinations but does not provide guidance on how members of the care team will be notified. VNAA recommends that CMS issue a clear and detailed process of notice for providers about the outcomes of these decisions.

Advancing Health Information Exchange

CMS proposes to allow states to require MCOs to participate in delivery system reforms such as health information exchanges. States would also be permitted to provide incentive payments to providers for the use of health information technology, including home health agencies.

VNAA Comments: LTSS providers, including VNAA members, were not eligible for the Meaningful Use Incentive programs. VNAA strongly supports the provisions of §438.6(c), which allows states to choose to make incentive payments available to providers who were not eligible for HITECH to further the goals of value-based purchasing. VNAA also requests that, in addition to this Medicaid proposal, CMS work to expand the Meaningful Use Incentive Program to provide funding to LTSS providers, to provide

additional technical assistance to small LTSS providers, and to encourage vendors to build products that focus on the needs of vulnerable and home-bound patients.

VNAA also supports aggressive implementation of electronic tools that allow for care coordination and real-time data sharing. We support the integration of community-based and patient/caregiver-generated data into electronic health records. These elements are critical to advancing value-based purchasing and patient-centered care.

Stakeholder Engagement when LTSS is Delivered through Managed Care (I.B.6.h)

The rule would require states to create and maintain a stakeholder advisory group that consists of beneficiaries, providers and other stakeholders to discuss the design and implementation of the MLTSS program.

VNAA Comments: VNAA recommends that CMS modify this provision to include an illustrative list of the type of stakeholder organizations who must be invited to participate in the state-level advisory groups, and that home-based providers should be on that list. It is critical that the stakeholder group be representative of the whole community and must include a wide range of providers, including those who work in beneficiary homes.

Thank you for the opportunity to comment on this proposed rule. VNAA supports this move to modernize Medicaid's relationship with MCOs. Please contact me at msmith1@vnaa.org or 571-527-1529 if you have any questions.

Sincerely,

/s/

Molly Smith
Vice President, Policy and Innovation