



View Electronic Mail

July 27, 2015

Andrew Slavitt, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2390-P 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

Dear Administrator Slavitt:

The American Association for Homecare (AAHomecare) submits the following comments on the Centers for Medicare and Medicaid Services' (CMS) request for comments on the above captioned proposed rule. AAHomecare is the national association representing suppliers of durable medical equipment prosthetics, orthotics and supplies (DMEPOS). Our members include suppliers, manufacturers, and others in the homecare community that serve the medical needs of millions of Americans who require oxygen systems, wheelchairs, medical supplies, inhalation drug therapy, and other medical equipment and services in their homes. Our comments are explained in detail below.

Medical Loss Ratio (MLR)

AAHomecare recommends that CMS require all states to have a minimum MLR. Loss ratios allow states to compare a plan's claims administration and quality improvement costs with its administrative costs. Loss ratios are a key tool for assessing whether capitation payments adequately fund the reasonable costs of providing covered services. A state's or CMS' ability to perform this analysis is crucial to ensuring adequate capitation rates which in turn protect access to services for all beneficiaries.

If Medicaid Managed Care (MMC) plans are concerned that a minimum MLR would not capture costs for any nonmedical services they furnish to enrollees CMS should address these concerns by including the costs of these services in the numerator for calculating the MLR. Certain nonmedical costs like transportation and

social services are key to controlling and reducing the overall costs of furnishing medical services and may be legitimately considered as a component of determining the MLR.

Likewise, CMS can address safety-net hospitals' concerns that a minimum MLR would adversely affect their revenues by recognizing community support activities as a medical cost in the numerator for calculating the MLR. Safety-net hospital revenues can fluctuate as a result of outlier events requiring them to use a surplus in one year to offset losses from another year. Alternatively, a separate MLR could be established for safety-net hospitals.

Network Adequacy

AAHomecare recommends that states require MMC plans to maintain an up-to-date roster of suppliers and providers on their websites. Plans that fail to meet this requirement should be subject to penalties. We believe that the imposition of penalties is important to assure compliance with this standard. Our experience with exchange plans and Medicare Advantage plans shows that few plans actually maintain current rosters even when their contracts explicitly require them to do so. Many beneficiaries choose a plan because of the suppliers and providers in the plans' network. So, it is very important that plans maintain accurate supplier/provider lists, especially during the enrollment period. Any other rule would diminish continuity of care for enrollees.

AAHomecare also recommends that CMS expand the factors that states must consider in developing standards to assure the adequacy of their networks. We agree that each state needs the flexibility to define measures specific to their beneficiary and supplier/provider demographics. But it is also important that stakeholders, especially plan enrollees and suppliers/providers, participate in establishing the standards. The final rule should include a requirement that states engage in formal public notice and comment rulemaking to propose and finalize the standards.

We appreciate CMS' desire to give MMCs flexibility to create networks by allowing states to grant them exceptions to the rules for ensuring the adequacy of their networks. But without reasonable limitations on the number and type of exceptions a state can authorize, the exceptions have the potential to undermine the purpose of the rules. Keep in mind that adequate access to necessary timely delivery of services is crucial and permitting exceptions to these rules can diminish beneficiaries' access to appropriate services by limiting the number and types of suppliers/providers in a network. We recommend that CMS limit and closely monitor state's authority to grant MMC's exceptions from rules for establishing adequate networks.

Fraud and Abuse

AAHomecare supports measures for deterring and eliminating fraudulent suppliers and providers from the Medicare and Medicaid programs. We also believe the program integrity measures must be sufficiently tailored to minimize their impact on legitimate and law abiding suppliers and providers. So we recommend that CMS establish reasonable "checks and balances" under the fraud and abuse prevention rules. For example, the proposed rule requires the MMC plan to suspend payments to a supplier/provider if the state determines there is a credible allegation of fraud against him or her. This standard gives states an open ended ability to identify suppliers/providers as fraudulent without having to establish the probable accuracy of that determination. The proposed rule does not require states to have even minimal standards for establishing the credibility of allegations of fraud against a supplier or provider. We recommend that CMS require states to adopt procedural standards for these program integrity measures. We also recommend

that the proposed rule require states to move expeditiously to resolve allegations of fraud against a supplier/provider. This should include a supplier/provider's ability to appeal a payment suspension through a state's administrative process.

Rate-Setting

AAHomecare recommends that actuarial standards for setting capitation rates take into account suppliers' and providers' payments to their subcontractors. Large MMC plans permit suppliers and providers to furnish some services indirectly, using subcontractors. These downstream suppliers/providers receive only a fraction of the rate the contractor receives from the plan. We understand that CMS views these situations as matter of negotiation between the contracting entities, but CMS should also be aware that reimbursement for subcontractors can be very low, often to the point of jeopardizing enrollee access to services. We agree with CMS that rates must be sufficient to cover reasonable, appropriate and attainable costs in providing covered services. To achieve this, downstream suppliers and providers that furnish services to enrollees "under arrangements" should be included in rate setting formulas. We believe that CMS should consider establishing at least some threshold payment standards for subcontractors as part of the rate setting provisions.

Enrollment Protections

AAHomecare recommends that CMS require states to give the public formal notice and opportunity comment on any procedure they adopt for assigning beneficiaries to new plans. We agree with CMS that states must consider the goal of preserving "provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid" when assigning beneficiaries. These goals are best achieved by allowing the public to participate in establishing these rules.

We also recommend that the final rule stipulate that the 14 day notice period for beneficiaries enrolling in new plans is a minimum requirement. States should remain free to adopt a longer notice period as long as beneficiaries are not denied services in the interim.

Enrollment of MMC Providers

The proposed rule would impose a new requirement on states to enroll all network suppliers/providers of MMC plans, Primary Care Case Managers (PCCMs), and PCCM entities that are not otherwise enrolled with the state to provide services to fee-for-service Medicaid beneficiaries. We appreciate CMS' intent to ensure that "bad apples" do not escape detection by moving between plans. But this requirement will be very burdensome on legitimate suppliers and providers. We suggest instead that CMS modify this proposal to require states to register only suppliers and providers that are not already enrolled in the Medicare or state Medicaid program. Medicare does a very thorough job in vetting suppliers and providers so that requiring suppliers/providers to be enrolled in Medicare would adequately protect state funds and at the same time reduce the burden of registering on suppliers and providers.

Appeals and Grievance Procedures

AAHomecare recommends that the final rule stipulate clearly that federal rules requiring states to adopt procedures and timelines for beneficiaries or suppliers/providers to appeal plan decisions do not supersede existing state procedure and timelines if the state's processes are more generous than the federal rules. If a state already allows beneficiaries or suppliers/providers to make an appeal before exhausting the plan's internal appeal process or to file appeals after more than 60 days, states should not be required to adopt

the new rules. We also recommend that CMS require states to adopt explicit standards and deadlines for resolving fair hearings.

Financial Soundness of MMCs

We are aware that a number of MMC plans have encountered financial difficulties recently. For example, a large MMC plan in California is under conservatorship. This suggests to us existing state rules for establishing plans' financial soundness are inadequate. Poorly funded MMCs will strain the state's ability to assure adequate care for Medicaid beneficiaries. CMS should set stronger rules for measuring the financial viability of MMC plans. CMS should also require a state to be accountable for paying suppliers and providers when MMC plans vetted by the state encounter financial difficulties.

Thank you for giving us the opportunity to submit these comments. Please feel free to contact if you have any questions or if I can be of assistance in way.

Sincerely,



Kimberley S. Brummett
Vice President for Regulatory Affairs