



State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NICHOLAS A. TOUMPAS
COMMISSIONER

July 24, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTENTION: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2390-P, Medicaid and Children's Health Insurance Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

I want to thank the Centers for Medicare & Medicaid Services ("CMS") for providing the State of New Hampshire's Department of Health and Human Services ("Department") with the opportunity to comment on the proposed rules to better align Medicaid managed care programs with those of Medicare Advantage plans and coverage offered through Qualified Health Plans ("QHP").

Like many states, the New Hampshire State Legislature, in June 2011, enacted Senate Bill 147 requiring the Department to employ a care management model for administering the N.H. Medicaid program. The Department's Medicaid Care Management ("MCM") program enrolls recipients into a managed care organization ("MCO") which manages their care with a "whole person approach" to providing services. Currently, our program is in Step 2 of its development which will move nearly all of N.H.'s Medicaid recipients into the MCM program, and will eventually include N.H.'s four home and community based waiver services and other long term waiver services.

Accordingly, the Department appreciates CMS' goal of creating more standardized practices across the states to manage health care delivery and beneficiary experience across different product lines, and appreciates the amount of work that has gone into developing these proposed rules. Our comments are being submitted from the perspective of implementing the changes resulting from the application of these proposed rules to Medicaid managed care and Fee for Service ("FFS") delivery models.

We begin our comments by discussing the overall administrative impact, and we recommend that given the potential scope of the impact, CMS should, at a minimum, consider a phased in approach for the new regulations. The proposed rules will extend a more rigorous regulatory structure to managed care, and require the states to submit an unprecedented amount of documentation to CMS. We note that in *isolation* the new reporting, oversight, and systems requirements associated with the entire notice of proposed rulemaking does not appear to be cumbersome; however, in their *entirety* they will significantly impact overall program costs and will result in the redirecting of MCO and State staff resources to monitoring processes rather than investing in direct care and care coordination.

Further, without additional CMS staffing, we are concerned that CMS is unlikely to have the ability to thoroughly review all of the documentation in a timely manner which will adversely impact the State's ability to effectively operate its program. A staggered timeline for implementation will help to address the administrative and fiscal impact associated with implementing these rules, and will give CMS time to more thoroughly develop its oversight framework and guidance to states. Finally, we recommend that

CMS reconsider requiring these administratively burdensome changes to be met by contract year 2017. The policy changes and reporting requirements will require analysis, dedicated staff resources, contract amendments, and programmatic changes which will require significant time and dedicated resources to implement. States have limited capacity and resources to carry out some of these changes, and may have to redirect resources from other efforts.

Part 431 – State Organization and General Administration

§431.500 Comprehensive state quality strategy.

The proposed rules require each state to develop and routinely update a comprehensive quality strategy for all Medicaid programs the state operates. The specific performance measures are yet to be developed by CMS, and each state's quality strategy will include measures developed by CMS as well as those developed by the state. While we understand the importance of assessing and measuring performance to strengthen and improve the quality of care delivered to Medicaid recipients, we note that compliance with the new changes will take time, and additional staffing and budgetary resources to develop, implement and monitor. Creating a Medicaid program wide quality strategy does broadly align with the Department's mission and vision; however, we are concerned about the challenges of meeting this requirement in too short a time span.

Assessing quality across all populations will be difficult to perform given the broadness of the different programs and the various competing quality approaches particularly with the lack of coordination between various federal agencies (*e.g.* CDC, HRSA, CMS and SAMHSA all have different quality approaches). Good quality oversight of the entire Medicaid program will require additional agency staff with the appropriate expertise and training to successfully monitor quality across all programs. We recommend CMS provide support to state staff for capacity building, similar to the recent CMS Adult Medicaid Quality Grants. Such support will allow states to hire and train staff to promote the expedient development of a comprehensive system. We believe CMS should allow an enhanced match for all state quality activities either directly to the states or through external quality review organizations to provide ongoing support for quality activities. Finally, we request CMS clarify that not all updates to the quality strategy will trigger a review of the strategy's effectiveness or trigger the extensive stakeholder consultation, as this may create an undue administrative burden.

Part 433 – State Fiscal Administration

§433.138(e) Identifying liable third parties.

The proposed rules require state agencies to identify paid claims for recipients containing diagnosis codes indicative of trauma, injury, poisoning and other external causes for the purposes of identifying liable third parties. The Department complies with the ICD-9 codes required under the current rule and has completed the ICD-10 mapping of accident and trauma codes. We appreciate the rule's flexibility in allowing the State to determine the trauma codes; however, we note that the rule no longer identifies the range of codes (800-999) indicative of trauma. Since the regulation does not specify what codes to flag for claim review, what request would an agency need to make to waive the requirement under §433.138(l)? Would a waiver request involve waiving all of (e) and not specific diagnosis codes? Does CMS want agencies to submit, as part of their State Plans, the specific diagnosis codes identified as indicative of trauma for CMS approval? How will CMS validate the codes agencies designate as trauma codes? If CMS is not going to review the designated codes, how will agencies know that they have selected the appropriate codes? How will CMS assure the ability to conduct comparison analysis between states and identify best practices?

Part 438 – Managed Care

Subpart A- General Provisions.

§438.3 through §438.8 *Standard contract provisions; Special contract provisions; Actuarial soundness; rate development standards; rate certification submission; medical loss ratio (MLR) standards.*

The proposed rules add new requirements for MCO contracts such as increasing the level and time required for CMS to review and approve them, and creating a new approach to actuarial soundness. We appreciate that the changes will provide states with a clear template of the required structure and terms of contracts with MCOs. We note that compliance with the new requirements for CMS review and approval may delay negotiations and implementation of the MCO contracts which will create uncertainty for the State, MCOs and providers. Additionally, the process of changing the capitation rate annually to ensure actuarial soundness will have to begin at least 120 days before the rates are to take effect. Such a long lead time does not allow for states to be nimble in their management and oversight of MCO activities and performance under the MCO contract.

The Department agrees with CMS' goals of efficiency and transparency in the rate setting process; however, we are concerned that the new requirements will delay rate approvals and create unnecessary financial and programmatic uncertainty. Delays will adversely impact contract approvals and modifications, waiver extensions, and performance measurements. To avoid this outcome, CMS should establish a timeline for its review and approval of rates, and it should have a contingency plan for when review runs past the effective date for the MCO contracts.

CMS should collaborate with the states to outline a process for rate reviews. The framework should lay out timelines and expectations for both CMS and states around what occurs once rates are transmitted to CMS. It should be structured with the goals of achieving transparency, minimizing duplication of effort, and promoting efficient review. We recommend that CMS establish a clear process for its review of rates and institute a hold harmless policy for when CMS approval is delayed by allowing states to use the proposed rates until CMS approval is received. We also recommend that small rate changes should not trigger the need for new CMS approval as it restricts the ability of states to accommodate market shifts during a contract year.

The proposed rules require states to have a MLR at 85% and describe the requirements for the numerator and denominator of the formula. We believe states should have the flexibility to include non-medical services in the calculation of quality improvement activities in the MLR. The Medicaid population differs from populations covered by private insurance, and Medicaid service packages include benefits not covered by other insurers. The proposed rule states that quality improvement activities may be included in the numerator, and this is a step toward recognizing the unique nature of Medicaid and the population served. While the proposed inclusion of quality improvement activities is welcome, we believe the rule should give states flexibility to delineate which non-medical services are considered activities that improve health care quality. We also believe CMS should provide a minimum of 2 years after the rules' adoption for states to develop and implement MLR methodologies.

The proposed rule requires that any contract with a MCO including long term services and supports ("LTSS") as a covered benefit must be delivered in settings consistent with §441.301(c)(4). We seek clarification on this rule. The timeline for states to bring their settings into compliance with the HCBS rule is 2019. This proposal requires that LTSS benefits be delivered in a HCBS compliant setting by contract year 2017. Is this the intent of the rule? CMS should consider aligning timelines around HCBS settings across both regulations.

§438.3(u) Standard Contract requirements-Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease.

The proposed rules permit a state to make a monthly capitation payment to a MCO for an enrollee receiving inpatient treatment in an institution for mental disease (“IMD”) as long as the length of stay is no more than 15 days during the month. The IMD payment exclusion was intended to prevent Medicaid funds from covering treatment at in-state psychiatric hospitals, but in application, prevents medically necessary inpatient services at non-state facilities for people whose addiction treatment or mental health needs require residential treatment.

While we appreciate CMS’ attempt to address the IMD payment exclusion, we are not convinced it applies to the Medicaid managed care model, and we note that FFP is still prohibited for an enrollee between the ages of 22 to 65 regardless of delivery system. (*See* §435.1009). We believe that all the proposed rule allows for is the payment of capitation by the State to the MCOs, but does not affirmatively permit MCOs to use that payment to pay an IMD for the services rendered since the payment exclusion still remains. CMS should clearly state that MCO payment of IMD stays can be incorporated into actuarial rate calculations.

Further, we believe the length of stay for an enrollee should be based upon medical necessity such as the criteria issued by the American Society of Addiction Medicine. The length of stay for an enrollee dealing with a substance use disorder (“SUD”) and/or mental health issue is variable and should be decided by the appropriate clinicians based on the enrollee’s needs. We believe limiting the length of stay based on fiscal reasons or with an arbitrary cap may result in enrollees being discharged prematurely resulting in increased recidivism and lack of stable care. We note that some individuals with a SUD will be using a substance at the time of admission and may require a longer stay than 15 or 30 days to detox.

We believe it is faulty to rely upon the Medicaid Emergency Psychiatric Demonstration as the basis for the 15 day cap because it did not deal with care being administered to those with SUD disorders. The report examined emergency psychiatric care and in its conclusion, states the “demonstration...will not provide information about treatment provided by IMDs through managed care plans” and it “does not address inpatient treatment for substance-related disorders...(T)he results apply only to adults with mental illnesses who are suicidal, homicidal or otherwise judged to be dangerous to themselves or others.” Has CMS considered excluding substance use disorder from the definition of mental disease for the purposes of determining if a treatment facility is an IMD? Has CMS considered allowing states to use §1115 waivers to cover services provided in IMDs in some circumstances? We recommend CMS consider other options rather than creating a carve-out for a capitation payment to MCOs.

The proposed rules attempt to clarify the “in lieu of” standard. We appreciate the flexibility the rules grant in allowing MCOs the ability to furnish care in alternative settings in lieu of covered State Plan services; however, CMS’ proposal appears to allow the MCOs to depart from any State Plan coverage limits or other limitations such as types of health professionals excluded under the State Plan. We prefer that MCO services be based upon the State Plan, and we believe that keeping the N.H. State Plan as the basis of the MCO benefit offering provides the public with transparency and provides the State with a guarantee that it will receive the matching federal Medicaid dollars.

§438.10 Information requirements.

The proposed rules require the states and MCOs to provide paper copies of all information within 5 days of the request including provider directories. We believe requiring paper documentation especially provider directories is burdensome and will increase administrative costs. Provider directories change daily and are very lengthy. We are curious about this requirement when the current focus is on making

information available electronically. We believe requiring paper copies of information already contained on a website should have a 20 day turnaround. We recommend CMS consider removing the requirement to provide paper copies of provider directories, and we recommend CMS specify which machine readable format will be acceptable for provider directories.

Subpart B- State Responsibilities.

§438.54 and §438.56 Enrollment; Disenrollment.

The proposed rules require 14 days of FFS coverage for all enrollees. While we certainly agree that enrollees should be free to choose a MCO plan, we are concerned that this could lead to confusion on the part of enrollees and providers, and we note that the rule does not affirmatively state that once an enrollee has chosen a MCO, the FFS coverage ends. New enrollees should be able to reap the benefits of care coordination provided by the MCO as soon as the enrollee chooses a plan.

The rules propose to allow enrollees who use Medicaid LTSS to have the option to disenroll from their plan, at any time, when a residential, institutional or employment supports provider exits the MCO's network. Providers often change networks and in the commercial market, patients must switch to another provider within their insurance plan's network or pay out-of-pocket for the out of network provider's care. While we appreciate that CMS wants to provide assurance of continuity of care to those receiving LTSS, we believe creating a for cause disenrollment in this instance does not meet CMS' goals of aligning Medicaid managed care with coverage in the market place.

Further, we are concerned that the requirement gives providers inappropriate power over LTSS networks and delivery in managed care, and it is duplicative of existing beneficiary protections. Specifically, it provides a pathway for LTSS providers to withdraw from a MCO network due to a preference for fee-for-service, which undermines state efforts to move to value based care. Under the existing rules, enrollees can switch plans when there is a lack of access to providers experienced in dealing with the person's unique needs. Finally, if enrollees return to FFS, we believe it will create a situation in which states must duplicate nearly every operation they are purchasing from the MCOs in order to assure access, quality and outcomes of services. Such a situation will increase the costs of operating the Medicaid program.

§438.62 and §438.208 Continued services to enrollees; coordination and continuity of care.

The proposed rules require states to have a transition of care policy to assure that enrollees do not experience severe health consequences when transitioning from FFS to managed care and between MCOs. The rule also requires the plan be contained within the quality strategy plan. Requiring the MCOs to allow transition with providers who are not currently in the MCOs network may require states to stipulate in their managed care contracts that payment for those services must be equivalent to what the providers are currently receiving as payment under FFS or with another MCO. We are concerned that stipulating MCO's participation does not mean the provider will accept the MCO rate. To assure continuity of care and provider choice by the enrollees, payment to providers should be the equivalent to what the providers are currently receiving to encourage providers to continue to perform services. We recommend CMS provide a template for the transition plan to allow states to define their own approaches and consider the diverse needs of the populations serviced. We note that development will take time, resources, and stakeholder involvement.

§438.70, §438.71, and §438.110, Stakeholder engagement when LTSS is delivered through a managed care program; Beneficiary support system; Member advisory committee.

The Department's MCM program is currently in Step 2 of its development which will move nearly all of N.H.'s Medicaid recipients into the MCM program, and will eventually include N.H.'s four home and community based waiver services and other long term waiver services. The Department believes the transition to managed care should not directly or inadvertently impair the quality of care experienced by long term care recipients, and has worked diligently to align the integration of LTSS services into the MCM program with local and national guiding principles, guidelines and recommendations. Accordingly, the Department adopted recommendations from national organizations such as the National Council on Disability and the National Senior Citizens Law Center.

The Department also integrated recommendations from N.H. stakeholders such as the MCAC, Granite State Home Health Association, N.H. Health Care Association, N.H. Association of Counties, Developmental Services Quality Council, Nursing Home Affiliates, and Brain Injury Association of N.H. Additionally, the Department conducted a deliberative planning process and will continue to use public forums after the implementation of its §1915(c) waiver. Because of this work, and the Department's use of CMS guidance in its development of Step 2, the Department believes the overall design of Step 2 will provide integrated services in a fashion that will offer opportunities for enrollees for active community and workforce participation to the extent desired and appropriate for each enrollee.

The proposed rules require states to develop and oversee a choice counseling program administered by enrollment brokers who will assist enrollees in the enrollment process and perform oversight of LTSS program data. Currently, the Department contracts with a vendor to provide choice counseling, but may need to provide additional contract funding if the scope of the current program is not expansive enough under the proposed rules, and the vendor may need more staffing to perform the new functions. We request CMS provide clarity regarding the enrollment broker oversight activities of LTSS program data. What data should the enrollment broker be reviewing? How often should the review take place?

The Department believes the proposed rules will require a new LTSS ombudsman position which will need to be created, funded and housed outside of the Department. The scope of the services the LTSS ombudsman will perform is significant, and we anticipate development must include objective and verifiable measures. We note that if the Department's current choice counseling program needs to be expanded and a new LTSS function added, both tasks will require time, increased staffing and budgetary resources, which will increase program costs.

Subpart C- Enrollee Rights and Protections.

§438.104 Marketing activities.

The proposed rules allow communication to an enrollee by a MCO participating in Medicaid managed care and also operating as a QHP in the marketplace. We believe this change will be helpful to enrollees who experience transitions between Medicaid and QHP eligibility. Periodic income fluctuations means some people with incomes near the federal poverty limit will migrate between Medicaid and the marketplace. We believe this change will reduce market churn. We agree allowing marketing by MCOs offering multiple products will be useful to some consumers in managing their health needs and will improve care coordination by minimizing disruption to care.

Subpart D- MCO, PHIP, and PAHP standards.

§438.68, §438.206, §438.207 and §440.262 Network adequacy standards.

The proposed rules for network adequacy standards attempt to align Medicaid standards to coverage provided by Medicare Advantage plans and private insurance standards. Without adequate access to

providers, enrollees cannot receive the preventive care and treatment necessary to achieve positive health outcomes and improve quality of life. We note that “network adequacy” is different from “access”. Data which shows a MCO network as adequate may not completely address whether recipients are having problems accessing the care they need or perceive they need or whether there is a demand for the service. We believe data requirements are useful for tracking and comparison, but may not provide enough information on access because they do not address whether providers are actually taking new patients, have available appointments or deliver good care.

We encourage CMS to develop standards addressing access to providers in MCO networks. We believe methods to measure enrollee timely access like secret shoppers, and surveys provide more useful information than a reliance solely on network filing data. We note that the use of secret shoppers is sometimes viewed negatively by providers, and that surveys are time consuming and costly. Accordingly, CMS should consider an enhanced match to states who choose to use these methods. We note there will be additional costs to the State to have the EQRO perform network adequacy monitoring, and an increased cost to the State to track and monitor all exceptions granted under the rules.

With regard to recipient access to providers under FFS, CMS proposed a new rule which requires the states to promote access and to ensure that all recipients have access to covered services in a manner that meets their unique needs. While we believe it is important for the State to have flexibility to determine the appropriate standards for access given the specific geographic and provider availability constraints, we request clarity on this rule. What process does CMS want states to use to evaluate access under FFS? What data elements should the states be using? How does CMS envision states will promote access, and what criteria will CMS be using to evaluate whether the states are promoting and ensuring access adequately?

§438.208(c)(3)(ii) *Treatment/service plans.*

The proposed rules state when a MCO produces treatment or service plans for enrollees who require LTSS services, the plans must be developed by a person trained in person centered planning using a person-centered process. We request clarification on this requirement. Is the rule requiring treatment plans to be developed by individuals certified in Person Centered Counseling? Attainment of certification will require training by a qualified trainer. If the rule requires this, we note that the logistics of training staff who write plans within a certain time period must be aligned with the number of staff who require training and the number of trainers. Does CMS want attestation by the State or MCO? Does CMS want the State to credential the persons developing the treatment plan? Does CMS want the states to track whether each treatment plan was developed by persons with the certification? We note that credentialing and tracking the requirement will increase the need for staffing and will increase administrative costs.

§438.242 *Health information systems.*

CMS requested comment on how it might provide guidance to states on standards related to health information exchange. The Department supports the principal that all individuals, their providers and payers, should have consistent and timely access to health information in a standardized format that can be securely exchanged. To that end, CMS should consider supporting the use of managed care contracts to promote the adoption of health information technology through the use of appropriately allocated enhanced 90/10 HITECH in the managed care capitation payments. Examples of promotion the MCOs could undertake are enhanced provider payments for high performing users of health information technology as part of MCO payment reform efforts, proportional funding of state wide health information exchanged organizations, and MCO system development activities which promote adoption of health information technology or use of health information exchanges.

Subpart E-Quality Measurements and Improvement; External Quality Review.

§438.330(c)(4) *Quality assessment and performance improvement program – LTSS performance measurement.*

The proposed rules require the states to incorporate any LTSS balancing performed at the managed care plan level into the quality assessment program review. CMS estimates an annual burden of one hour for the assessment of rebalancing efforts. We disagree with the proposed annual burden as we believe balancing requires both MCO and agency staff to perform the following tasks: data query, data review, data scrubbing, data correction, financial report preparation, financial report review, correction and generation of the final report. Each task, without encountering any problems, will take an hour to perform. We request CMS revise its estimate on the annual burden.

§438.66, §438.330, and §438.334 *State monitoring requirements; Quality assessment and performance improvement program; Medicaid managed care quality rating system.*

The proposed rules require the states to have a monitoring program for all managed care operations. The Department and its MCM quality program strives to enhance the health and well-being of enrollees in managed care and provides oversight of MCM program operations through data driven quality assurance and improvement activities. The Department currently has a robust MCO monitoring standard and performs such as activities as readiness reviews, and quality monitoring beyond clinical data. However, we are concerned with the some of the new requirements.

The operational steps the Department must take to comply with the increased level of documentation are administratively burdensome. We are concerned that complying with the new documentation requirements coupled with the increased level of CMS oversight will undoubtedly slow timelines and create additional operational costs. Further, the requirement for readiness reviews 90 days prior to all go-live dates could be problematic because much of operational readiness cannot be developed that far in advance. We recommend CMS consider requiring a preliminary review at 90 days focusing on reviewing issues and actions over the 90 day period, and concluding with a final readiness review at 30 days before the go-live date.

The proposed rules require a new annual program assessment report. We note that this will initially be a significant challenge for the State to perform, and we believe CMS should consider issuing a template, table of contents or other clear articulation of expectations, timeframes, and content for the report. If left unstructured, significant time and resources will be needed to complete a comprehensive report to satisfy various diverse stakeholders. We are also concerned that the report will be duplicative of other reporting requirements. These include the submission of rates, quality strategies, contracts, EQRO reports, data compliance plans, etc. Accordingly, we recommend that CMS clearly articulate what information states are expected to provide, and CMS should seek to minimize duplication.

The proposed rules will create national performance improvement project (“PIP”) topics and measures which will provide comparators and allow best practices to emerge. We believe the national PIPs will provide specific insight into how each state is doing in comparison to other states, and may provide economies of scale for MCO quality efforts. However, they may reduce the State’s flexibility to address local priorities and may constrict quality improvement efforts. We believe the states, in general, and N.H. specifically, will need to engage strongly in the measure selection process. When CMS begins the process to develop nationally required PIPs, it should choose PIPs that are broadly applicable in all kinds of states, are clearly important issues for improvement, can be aligned with other payers, and can have an impact. Additionally, consideration should be given to projects that improve population health. To

provide flexibility, CMS could develop a menu of high priority topics, allow states to choose from them, and offer technical assistance to states around the implementation of them.

The proposed rules allow for CMS to develop a managed care quality rating system after a robust public engagement process. While laudable, a quality rating system with significant public input will take years to develop and may still fall short of being meaningful to all stakeholders. The rules allow states to submit their own rating system; however, there are no clear criteria on what CMS will require for approval. We recommend CMS develop a toolkit or use one type of national rating system, and we prefer that states not be permitted to change the way measures are weighted because to do so would not provide meaningful information to enrollees or the states.

The proposed rules state that CMS may specify performance measures for calculating quality ratings after it conducts a public notice and comment process. We propose that CMS consider the following measures when developing its performance measures:

- Measures should be broadly applicable to all states and ideally the private sector as well. Where measures are not applicable or meaningful in a state, there should be a waiver process.
- Measures should be comparable across the states. For instance, common exclusions should be required to ensure limited bias in the data (*e.g.* measures should explicitly state an exclusion/inclusion for Medicare duals, and individuals with commercial insurance as primary coverage for measures that Medicare or commercial cover.)
- Measures should be based on administrative data to the fullest extent possible and to measures that are required for certification by national groups.
- Measures should be validated for the populations studied and should measure detail in the public domain. Technical assessment should be available to resolve measurement concerns with uniform application of decisions to all Medicaid programs.
- Measures should be tailored to Medicaid program and populations (*e.g.* HEDIS measure review after mental health hospitalization must include members in an IMD even if Medicaid is not paying the claim).
- Measures should be broadened beyond clinical quality and member satisfaction in the child and adult core sets and should include operational measures.
- Measures should include social determinants of health such as housing, primary language, and education.
- Measures should not include FFS population calculations when the eligible population is small enough (we recommend 5% threshold).

Subpart F – Grievance System.

§438.402(c)(1)(ii) General requirements.

The proposed rule will allow providers to appeal an adverse benefit determination without the written consent of the enrollee. We believe providers should only be permitted to file an appeal on an enrollee's behalf if they have express written consent of the individual. While an enrollee may find it appropriate to seek assistance from a provider in initiating an appeal, enrollees should provide written consent, and be aware of the steps the provider is taking on the enrollee's behalf. Without this safeguard, there is a potential for providers to initiate appeals without an enrollee's knowledge and which may not be in an enrollee's best interest.

Subpart H- Additional Program Integrity Safeguards.

§ 438.600 Program Integrity.

The proposed rules require the states to increase monitoring of subcontractor compliance with the managed care contract, and require states to screen and enroll all MCO network providers whether they are ordering, referring or furnishing services. The states must also review ownership and control disclosures submitted by MCOs, and subcontractors, and must confirm identities of all parties by using the Social Security Administration's databases. The purpose is to prevent "safe havens" for providers excluded from traditional Medicaid; however, the proposed rules do not address the disparate federal databases and processes the states must use to conduct provider screening and enrollment. CMS should consider streamlining the mechanisms and tools. For instance, CMS could use batch matching, provide baseline standardization or set up a single portal where states can access real-time information in the databases.

We note that to conduct searches using the Social Security Administration's databases, the State must require all parties provide a social security number. Accordingly, we recommend CMS affirmatively state in the rules that a social security number is required for the searches. (*See* §455.104(b)(1)(ii)). We believe without this affirmative statement some individuals will refuse to provide a social security number which will hamper the State's ability to determine whether the party qualifies as a prohibited relationship and should be barred from participation in the Medicaid program. We are also concerned the enrollment requirements could be seen as administratively burdensome particularly by specialty, subspecialty and out of state providers which may inadvertently impact access.

Subpart J- Conditions for Federal Financial Participation (FFP).

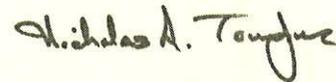
§438.807 and §438.818 Deferral and/or disallowance of FFP for non-compliance with Federal requirements; Enrollee encounter data.

The proposed rules allow CMS to defer or disallow FFP under a MCO contract when CMS finds the contract noncompliant or finds the capitation rates as developed and described in the rate certification noncompliant. CMS should establish a timeline for its review and approval of rates, and it should have a contingency plan for when review runs past the effective date for the MCO contracts. As we stated previously, CMS should clearly articulate that delays in approving rates by CMS should not result in the disallowance or deferment of FFP.

The proposed rules require states to submit to CMS, within 90 days of the effective date of the rule's adoption, a detailed plan to ensure states submit valid and timely encounter data to CMS, and it allows for states to use the external quality review activity to validate the data. If a state is unable to provide data that CMS considers compliant, then CMS will defer or disallow FFP for all or part of the MCO contract. We understand the need to get accurate encounter data, and we have included in our MCO contracts language to ensure that each MCO reports records of items and services even when the MCO has its own capitated arrangement with a provider. However, we believe the 90 day requirement to submit the detailed plan is unreasonable given that CMS has yet to describe the frequency of the submissions and the level of detail that it will require. We recommend CMS develop a template for the plan, and we believe states should have 90 days after CMS releases a template. If no template is provided by CMS, States should have 180 days to submit the detailed plan. Further, we believe CMS should not withhold FFP for incomplete encounter data, but should collaborate with the State in understanding and addressing key challenges in collecting and reporting encounter data.

We appreciate the opportunity to comment on these proposed rules to better align Medicaid managed care programs with those of Medicare Advantage plans and coverage offered through QHPs. We appreciate both the thorough efforts of the drafters to be comprehensive, and the willingness of CMS to review questions and comments on the proposed rules. The State has many questions and concerns regarding the effect of the proposed rules on our Medicaid programs. Accordingly the State encourages CMS to continue dialogue with state Medicaid programs to clarify intent and respond to questions such that whatever rules are finally approved, the impact on our clients is positive and does not result in untoward outcomes due to administrative burden or lack of clarity.

Sincerely,



Nicholas A. Toumpas
Commissioner

cc: Sylvia Matthews Burwell, Secretary, US DHHS
Her Excellency, Governor Maggie Hassan
The Honorable Kelly Ayotte
The Honorable Jeanne Shaheen
The Honorable Frank Guinta
The Honorable Ann Kuster