Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
Managed Long-Term Services and Supports ("MLTSS")	
• **Definition of LTSS:** Defines LTSS 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." Community-based services are intended to be largely non-medical in nature and focused on functionally supporting people living in the community (e.g, HCBS delivered through a section 1915(c) waiver, section 1915(i) or section 1915(k) SPAs, and personal care services). • **HCBS Setting Standards:** Requires state contracts with MCOs and PIHPs[+] that include LTSS to mandate that any covered services that could be authorized through a 1915(c) waiver or a SPA under 1915(i) or 1915(k) be delivered in settings consistent with HCBS settings rule. • **COB:** If state has COB agreement with Medicare, MCO/PIHP must enter into COB agreement with Medicare and participate in the automated claims crossover process. • **Assessments and Service Plans:** o Requires identification, assessment, development of service plans, and access to specialists for beneficiaries who need LTSS or have special health care needs. State determines whether to exempt PIHPs and MCOs that serve duals (i.e., MLTC and FIDA plans). o Assessment of enrollees who need LTSS includes any ongoing special conditions that require a course of treatment or regular care or monitoring. Assessment must use appropriate health care professionals or individuals meeting LTSS service coordination requirements of the State or the MCO/PIHP. o If State requires MCOs/PIHPs to produce a treatment or service plan for enrollees who require LTSS or with special health care needs, service plan must be developed by the enrollee's provider or individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with other health care professionals caring for enrollee; developed by a person trained in person-centered planning using person-centered process and plan for LTSS; approved by the MCO/ PIHP in a timely manner, if approval is required; and consistent with State quality assurance and utilization review standards. Service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when enrollee's circumstances or needs change, or at the request of the enrollee. o Treatment or service plans developed for those in need of LTSS must conform with the person-centered planning standards in § 441.301(c)(1) and (2), consistent with the HCBS final rule released in 2014. o Provides that service authorization standards should not disadvantage individuals with chronic diseases or in need of LTSS. o Adds to definition of "medically necessary" - "the opportunity for an enrollee receiving LTSS to have access to the benefits of community living."	CMS: Is the LTSS definition appropriate in scope?

Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
• **Network Access:** States must develop and enforce network access standards. ○ Requires plans that cover LTSS to meet additional network access standards appropriate for LTSS, recognizing that many services are provided outside of office or facility. ○ Must include time and distance standards for LTSS provider types that require enrollees to travel to the provider to receive services; and other standards for LTSS provider types that travel to the enrollee to deliver services. ○ May include, for individuals receiving LTSS in their homes, enrollee-to-provider ratios. Must ensure that network providers have capabilities to ensure physical access, accommodations, and accessible equipment. ○ Withdrawal or termination of a residential, institutional, or employment support provider from a plan network is a valid cause for LTSS beneficiaries to switch plans at any time. • **Beneficiary Support System:** Proposes federally-funded, LTSS-specific beneficiary support system. (see below) • **Critical Incidents:** Requires contracts with plans to include requirement to participate in state efforts to prevent, detect, and remediate all critical incidents. • **Quality:** ○ Requires plans to implement quality assessment and performance improvement program with MLTSS-specific quality standards, including mechanisms to assess the quality and appropriateness of care between settings and care provided to enrollees as compared to the enrollee's service plan. Must include performance improvement projects and measures that assess quality of life of LTSS beneficiaries and outcomes of the MCO/PIHP rebalancing and community integration activities for beneficiaries. ○ Requires state to include in its annual program review the results of any rebalancing efforts by the MCOs/PIHPs for individuals using LTSS. ○ Requires state to convene stakeholder group and requires plans to establish a Member Advisory Committee with representative sample of covered population to solicit direct input on enrollees' experiences. ○ Plans that serve only dual eligible beneficiaries would have the option of using the MA five-star rating system as their quality-rating system.	
Beneficiary Experience	
• **Networks:** ○ Requires States to regularly assess and certify health plan provider networks and time/distance standards including behavioral health, pediatric dental, and pharmacy. ○ Plans that cover LTSS would have to meet additional standards appropriate for LTSS.	CMS: Should CMS set minimum federal network adequacy standards and require states to adopt certain network adequacy enforcement strategies, such as secret shopper efforts?

Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
○ Requires plans to submit annual documentation of network adequacy.	
• **Beneficiary Support System:** ○ Requires states to create beneficiary support system, including: choice counseling, provider training on community-based resources and supports, assistance in understanding managed care, and targeted assistance with LTSS. Entities that provide choice counseling would be considered enrollment brokers and subject to conflict of interest restrictions. ○ LTSS elements must include access point for complaints, education on grievance and appeal rights, assistance in navigating grievances, appeals and fair hearings. ○ Services must be accessible by phone, in-person, and through the Internet. ○ Proposes federally- funded, LTSS-specific beneficiary support system.	
• **Membership Information** ○ Must notify potential enrollees about, their right to disenroll, cost-sharing requirements, and the plan's performance on quality indicators. ○ Information may be provided to enrollees and prospective enrollees electronically, provided that it is accessible, can be electronically retained and printed, and the plan informs enrollee that information is available in paper form without charge on request within 5 days. ○ Clarifies that provider directories, handbooks, appeal and grievance notices, and other notices must be translated into prevalent non-English languages, and that plans must notify enrollees and potential enrollees that alternative formats, auxiliary aids and written and oral interpretation are available free of charge. ○ Oral interpretation services for all non-English languages must be made available free of charge. ○ Requires provider directories to add provider's group affiliation, website, cultural and linguistic capabilities, and accessibility to people with physical disabilities. Paper provider directories must be updated at least monthly, and electronic provider directories must be updated no later than 3 business days after receipt of updated provider information. ○ Requires provision of plan formulary listing all covered medications and tier associated with each medication. ○ Formulary and provider directory must be available on plan's website in a machine-readable format, allowing data to be downloaded to make comparisons among plans. ○ Requires plans to make good faith effort to notify enrollees within 15 days of termination of provider that regularly cared for enrollee. ○ Requires plans to notify enrollees of any change in enrollee handbook that the State defines as significant, at least 30 days before the intended effective date of the change.	
• **Care Coordination/Authorizations/Transitions** ○ Requires initial health risk assessments within 90 days of enrollment, and regularly updated assessments and treatment plans for beneficiaries with special health care needs or LTSS needs. ○ Changes expedited authorization determination timeframes from 3 working days to 72 hours, consistent with MA and commercial plan standards.	CMS: Should plan coordination requirements encompass community and social support services?

Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
○ Requires States to establish policies for beneficiaries moving from FFS to managed care or changing plans, which must include continued access to services and current providers for a specified period, referrals to appropriate in-network providers, access to historical utilization data, and ability of members' new providers can access members' medical records. Services subject to transition of care standards include prescription drugs. No period of time specified for transitional services.	
Enrollment	
• Requires states to give beneficiaries at least 14 calendar days and appropriate notices to select a plan; coverage must be provided through FFS until the beneficiary makes a choice. Exception to 14-day period in rural areas with 1 plan or in which states have secured Section 1115 waiver. • Modifies definition of "rural" to apply county-based classifications used by Medicare Advantage, for purposes of expanding areas in which a choice of 2 plans will not be required. • Voluntary programs may employ "passive enrollment," in which states select a plan but the beneficiary may decline the plan selection. • Auto-assignment and passive enrollment must be based on existing provider relationship and relationships with providers that have "traditionally served Medicaid beneficiaries." If no provider relationship, must distribute enrollment equitably and may consider additional criteria. Must send confirmation of plan enrollment to beneficiaries within 5 calendar days of processing. • Beneficiaries may disenroll for cause at any time. May disenroll without cause 90 days from effective date, once every 12 months and upon imposition of intermediate sanction on plan. • Disenrollments for cause include, for enrollees who use LTSS, absence of enrollee's regular institutional, residential, or employment supports provider from network.	CMS: Should a longer enrollment choice period— such as 30 or 45 days— be adopted?
Grievances and Appeals	
• Aligns Medicaid grievance and appeals processes with those that exist for MA and commercial plans. • Requires enrollees to exhaust internal appeal before seeking fair hearing, but limited to only *1 level* of internal appeal. Imposes 60-day deadline for filing internal appeal. • Eliminates enrollee consent requirement before providers may appeal adverse determination, if state authorizes provider to serve as representative. • Shortens deadline for plans to respond to an appeal from 45 to 30 days; requires plans to respond within 72 hours to expedited internal appeals. Strengthens notice to enrollees if the plan extends time to respond to an appeal. • Provides enrollees with 120 days to request fair hearing after an internal appeal; request must be made within 10 days for aid	

Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
continuing. • Requires plans to provide, upon request and free of charge, basis for an adverse determination. • Notices must be accessible to individuals with disabilities and limited English proficiency. • Prohibits subordinates of those who made initial determination from participating in an appeal determination. • Requires plan to accept any information submitted in deciding appeal. • Requires continued authorization of services, through appeal and fair hearing processes, if appeal and fair hearing request are timely-filed, and the original authorization has not expired at the time of the appeal. If plan's determination is upheld, states may allow plans to recoup cost of services from beneficiaries.	
Delivery System Reform/Value-Based Payments	
• Permits states to direct plans to use state-specified value-based payment methodologies when contracting with providers and to align payment methods with multi-payer payment initiatives, such as PCMHs, health information exchange, and prevention efforts. States must use a common set of performance measures across all of the payers and providers. States cannot set the value or frequency of the payments nor link them to intergovernmental transfers. • Includes allowing states to make available, through plan payments, EHR adoption incentives to providers excluded from EHR incentive programs (long-term/post-acute care, behavioral health, community-based providers). • Permits states to require plans to set higher reimbursement standards for particular provider types (such as primary care) or for particular services or to offer higher rates to increase accessibility of services. CMS expects these initiatives to be linked to the state's comprehensive quality strategy.	CMS: How can CMS reinforce interoperability standards in future rulemaking and guidance?
Quality Improvement	
• Requires states to adopt a Medicaid managed care quality rating system modeled on the system for QHPs. • States may adopt an alternative quality rating system with CMS approval. • Plans that serve only dual eligible beneficiaries would have option of using the MA five-star rating system. • Requires CMS to specify quality assessment and performance improvement measures through the public notice and comment process. • Requires plans to be accredited by one of the CMS-recognized accrediting entities. States could review plans instead, provided they apply standards at least as stringent as those used by the accrediting entities. • External quality review would include compliance with network adequacy requirements, in addition to current requirements. • Requires states to adopt a comprehensive quality strategy to promote quality in both their fee-for-service and managed care	

Proposed Rule*	**CMS Questions/LANY Member Comments on CMS Questions and Other Issues**
programs.	
Program and Fiscal Integrity	
• Requires states to conduct screening and enrollment of providers in Medicaid managed care networks. • Requires states to review ownership and control information of plans and subcontractors and validate exclusion status monthly through federal databases. • Requires plans to submit to states the following data: encounters; compliance with the MLR; reserves against risk of insolvency; compliance with provider network adequacy; ownership and control; annual report of overpayment recoveries. CEO or CFO must certify the accuracy, completeness and truthfulness of data. • Every 3 years, states must conduct independent audit of accuracy of encounter and financial data submitted by plans. • Requires direct reporting by Compliance Officer to CEO and Board and establishment of Regulatory Compliance Committee on Board. • Requires prompt reporting to state of changes in enrollees' Medicaid eligibility (e.g., change in residency, income, death), changes in providers' eligibility to participate in Medicaid, improper payments, and potential fraud, waste and abuse. • Clarifies that plans may retain recoveries of overpayments and requires plans to establish a mechanism for providers to report and return overpayments within 60 days of identification. Plans must also report recoveries to state annually, with the state excluding such payments from rate development. • Prohibits plans from including in networks providers that have been excluded, debarred or suspended from federal health programs.	
Rates	
• **MLR:** ○ Requires plans to calculate and report MLRs beginning in 2017. ○ States may elect to mandate minimum MLR. If State elects, minimum MLR must be 85%. Authorizes, but does not require, States to recoup funds, if MLR is not met. ○ MLR numerator = incurred claims + quality improvement expenses. MLR denominator = revenue, including uncollected cost sharing, unless reasonable effort was made. Stop-loss reflected as adjustment to incurred claims. Fraud prevention expenses included in numerator and capped at 0.5% of revenue. Excludes network development, utilization management, claims processing costs, and administrative fees. ○ Provides "credibility adjustments" for plans with small enrollment that may have more irregular claims experience.	CMS: Is definition of activities that improve health care quality in 45 CFR 158.150 broad enough to encompass MCO/PIHPs activities related to service coordination, case management, and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS. CMS expects MCOs/PIHPs to include costs of appropriate outreach, engagement, and service coordination in this category.

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• **Actuarial Soundness:** ○ Requires States to use MLR data in setting future rates to generate an anticipated MLR of at least 85 percent. ○ Rates cannot reflect costs of improper provider payments. ○ Rates cannot vary based on expected FFP for enrollment groups. ○ Rate cells must relate to particular populations; rates in each cell reflect anticipated claims and allocated non-claims expenses associated with that population, without cross-subsidization. ○ CMS is considering assessing whether rates allow sufficient provider payments to ensure adequate access to care. ○ Prohibits certification of rate ranges. ○ Specifies steps in setting actuarially sound rates, based on prior 3 years of utilization experience, budget neutral risk adjustment. ○ Updates risk-sharing requirements for state contracts with plans; requires linkage to performance. ○ Capitation payments minus withhold arrangements that are not "reasonably obtainable" must be certified as actuarially-sound. • **Institutions for Mental Disease (IMDs):** ○ Permits payments to plans for short-term stays (up to 15 days) in IMDs, if facility is inpatient hospital or a sub-acute facility providing crisis residential services, despite prohibition on federal Medicaid payments for such care.	CMS: What methods can States use to evaluate whether capitation rates are sufficient to support adequate provider networks? CMS: Should risk sharing incentive arrangements continue to be limited to 5 percent capitation rates? Does this limit inhibit performance incentives? CMS: How would an actuary determine whether a withhold is reasonably obtainable? CMS: Should MLR be used to determine upper and lower bounds of risk sharing?
Prescription Drugs	
• Allows states to authorize plans to use their own formularies with only a subset of the section SSA-required drugs. Clarifies that any drugs or classes excluded from the formulary must be covered by the state on a FFS basis. • Requires plans with drug coverage to respond to prior authorization requests within 24 hours and to provide a 72-hour emergency supply of drugs that require prior authorization. • Requires plans to provide non-formulary drugs, if there is a "medical need" for the drug, and it is within plan's contract. • Requires reporting of drug utilization data to the state within 45 days of the close of each quarter. • Requires plans to conduct drug utilization review for appropriateness, medical necessity, and risk of adverse effects.	
Marketing	
• Medicaid plans may jointly market their Medicaid products and QHPs without violating the Medicaid marketing restriction on the sale of private insurance. • Includes social media as marketing materials that must receive state pre-approval. • Includes email and texting within the prohibition on cold-calling.	
State Monitoring	
• Expands state monitoring to include claims management, MLR reporting, encounter data reporting, marketing, program integrity, provider network management, and delivery of LTSS.	

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• Provides standards for readiness reviews for new plans, and existing plans offering new benefits, new eligibility groups, or services in new geographic areas. Must include desk review and on-site review, and must cover specified operational areas.	
CMS Contract Approval and Oversight	
• Requires plans to submit annual financial audits and preserve 6 years of records, including appeal, grievance, and MLR records. • Requires States to submit rate certifications for CMS approval, including required documentation, due 90 days prior to the effective date of the rates. • Requires States to provide sufficient and timely encounter data to CMS. • Authorizes CMS to withhold federal funding to states for managed care expenditures, if the State's contract does not meet minimum requirements or if rates are not actuarially sound.	
Subcontractors	
• Requires plan subcontractors to comply with laws, regulations, sub-regulatory guidance, and contract provisions; and grant state and federal oversight entities the right to audit, evaluate, and inspect records, equipment, and facilities, for the later of 10 years from the final date of the contract period or the date of completion of any audit.	

* Summary of provisions draws from "CMS Proposes Overhaul of Medicaid and CHIP Managed Care Rules," Manatt, Phelps & Phillips, LLP, June 1, 2015.

+ "PIHP" refers to Pre-Paid Inpatient Health Plan or a partially-capitated plan that covers hospital or institutional care.