



Douglas A. Ducey, Governor

Thomas J. Betlach, Director

July 27, 2015

Nicole Kaufman  
Medicaid Managed Care Operations  
U.S. Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

**Re: Filed Code: CMS-2390-P: Arizona Comments to Medicaid Managed Care Proposed Rules as Published June 1, 2015**

Dear Ms. Kaufman:

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's single State Medicaid agency, sincerely appreciates the opportunity to provide comments to the proposed regulations concerning Medicaid managed care. The proposed rules represent the most comprehensive revision of the managed care delivery system in more than a decade, and Arizona is uniquely suited to offer an invaluable perspective to this effort. Although Arizona was the last State to opt into Medicaid, it has the distinction of being the first to adopt a statewide, mandatory managed care Medicaid program. Consistent with one of its founding principles, AHCCCS has operated as a public/private partnership predicated on competition, choice, and flexibility since 1982. We are grateful to share Arizona's insights gained from several decades of successful experience providing Title XIX services in a managed care setting to large and diverse populations across the State.

With more than 33 years of Medicaid managed care experience, AHCCCS serves as a model of the benefits of managed care, having achieved considerable recognition and national attention over the decades through the innovative practices, design, and flexibility of its comprehensive health care delivery system. In Arizona, Medicaid managed care was adopted across all populations and service areas, including long-term care services and supports (LTSS), behavioral health services and dual eligible beneficiaries. Many critics of managed care dispute the efficacy of this model for certain populations. We emphatically disagree. In fact, our results consistently demonstrate that individuals with the highest needs receive greater benefit from a health care system designed to support the individual in managing his or her health to achieve maximum potential.

A prime example of the benefits of managed care for high need populations is the Arizona Long Term Care System (ALTCS). ALTCS is the AHCCCS program for the elderly and for persons with physical, cognitive, or intellectual disabilities who are at immediate risk of institutionalization. In addition to presuming that Medicaid managed care programs cannot adequately serve this population, critics also

assert this model cannot adequately meet the needs of individuals enrolled in both Medicaid and Medicare – persons who are also referred to as “dual eligibles”. However, Arizona has successfully improved health care outcomes for these beneficiaries while lowering costs by aligning the two systems.

All AHCCCS managed care organizations (MCOs) are required to also offer a Medicare Dual Eligible Special Need Plan (D-SNP). When Avalere conducted a study comparing member experience in one of the ALTCS health plans with the experience of Fee-For-Service (FFS) dual eligibles, it found that members enrolled in the ALTCS plan for both Medicaid and Medicare exhibited:

- 43% fewer days spent in the hospital (per 1,000 months of beneficiary enrollment);
- 31% fewer in-patient discharges (per 1,000 months of beneficiary enrollment);
- 19% lower average length of stay;
- 21% lower readmission rate;
- 9% fewer Emergency Department visits (per 1,000 months of beneficiary enrollment); and
- 3% higher proportion of members accessing preventive/ambulatory health services.

The ALTCS health plans have also achieved tremendous gains in serving as a support to individuals to maximize their potential and remain in the community. Arizona, through the efforts of managed care working in partnership with the State, now identifies 84% of members in ALTCS as living and receiving services at home or in the community. For the fourth year in a row, Arizona was recognized by United Cerebral Palsy as having the best Medicaid system in the United States for individuals with intellectual and developmental disabilities (see *The Case for Inclusion Annual UCP reports*).

Managed care has also supported the development of a robust community-based behavioral health system that engages members, employs peer supports, and connects to employment and housing opportunities. To improve care coordination and better support members in accessing care, AHCCCS recently introduced an integrated health plan model for members with serious mental illness where physical health was incorporated into a traditional behavioral health plan. With the support of the MCO (known as Regional Behavioral Health Authorities or RBHAs), behavioral health providers are expanding their service array and engaging members in a new way, while strengthening their partnership with the RBHA.

These successes exist throughout the AHCCCS system. In large part, Arizona’s transformative accomplishments are attributable to the unique public/private partnership where MCOs are responsible for far more than payment of claims and performing prior authorization, an antiquated view of the MCO’s role held by those who misunderstand the nature of the partnership. As with the health care landscape, the role of the managed care entity is ever evolving. Today’s MCO must utilize modern, sophisticated data analytic tools to develop appropriate interventions for their members as well as timely conduct risk assessments to offer supports that keep members healthy. It is also imperative that MCOs think beyond “sick care” and move into population health where connections to supportive services are available to members, whether it is employment, housing supports, or other basic needs. MCOs are part of the fabric of communities; they collaborate with existing programs and are vital in maintaining the community-based system of care.

Today's MCO also recognizes that new arrangements with providers must be established. Value based purchasing is critical in furthering the concept of partnership in managed care so that it extends between provider and health plan as well. MCOs have the capabilities to support providers in adapting to the use of data analytics in their practices. In turn, MCOs can share in savings or support quality based payments that reward providers for the role they play in helping members achieve wellness, manage chronic disease and avoid costly, institutional settings. To this end, AHCCCS has launched several key initiatives aimed at altering the dynamics of health care delivery in positive ways. Distinctive strategies are underway in areas such as integration, care coordination, payment modernization, health information technology, and public-private partnership transformation which will drive innovation and improve both health care access and quality in our State. We invite you to learn more about these exciting developments by reading the information posted on the AHCCCS public website at <http://www.azahcccs.gov/shared/initiatives.aspx>

State flexibility is essential for the success of Medicaid managed care. States must be afforded discretion to craft the appropriate balance between oversight and flexibility. With the appropriate infrastructure, States are best able to leverage the capabilities of their private sector partners. The necessary infrastructure and accountability – from staff expertise, in-house actuaries, data analytics, adequate contractual terms, etc. – engender State trust in the partnership. In turn, trust fosters a culture of innovation within the partnership that otherwise could not be achieved when too many aspects of the relationship are burdened by government regulation or restraint.

Ultimately, the success of Arizona's managed care program has rested upon one other critical partnership – the State/Federal partnership. Therefore, it is crucial that these rules be developed as tools to support States in their efforts to achieve the aforementioned objectives while providing appropriate federal oversight, in the same way that Arizona has developed an infrastructure to monitor MCOs in a manner that protects members while maximizing the opportunities health plans offer to produce the best outcomes at sustainable costs.

Arizona supports CMS' objectives in modernizing Medicaid managed care regulations to improve health care outcomes, enhance beneficiary protections, and manage program costs. Arizona equally supports CMS' stated goals of Medicaid managed care alignment with other insurance programs, where appropriate and feasible, to promote administrative simplicity. While some proposed rules reflect common practice or offer opportunities for States, many of the provisions go too far, constraining State flexibility to foster innovation. Moreover, many of the proposals will impose considerable resource and budgetary burdens without corresponding benefit. Therefore, we sincerely appreciate the opportunity to offer our insights given Arizona's extensive experience in Medicaid managed care so that constructive revisions can be made.

In summary, our comments focus on opportunities to improve the rule to allow continued State flexibility and innovation while assuring our shared goals of high quality and efficient delivery of care to members. Broadly, we are concerned that by establishing so many significant federal standards and reporting requirements, these rules swing the pendulum in the State/Federal partnership too far away from an appropriate balance between Federal oversight and State flexibility. Although the Preamble

repeatedly refers to the flexibility afforded the States, the proposed regulations actually serve to diminish State flexibility and suppress opportunities for innovation. In our experience, reporting and documentation requirements must be meaningful; that is, CMS should ensure it focuses on those elements that are useful in determining whether States are providing appropriate oversight of their managed care contracts. The expanding CMS involvement in what are more appropriately State activities threatens the continued progress achieved by States. Federal regulation should not duplicate State oversight of managed care contractors. The overreaching, burdensome double-regulation of our MCO partners presents an increasing administrative and fiscal inefficiency at a time when both States and the Federal government simply cannot afford it, particularly when no clear benefits are derived, and the State currently performs such activities.

The considerable requirements mandated for readiness review submissions are one of many examples of such overreaching micromanagement in an area where States are currently afforded flexibility. CMS is certainly authorized to obtain any relevant documentation from States to determine whether MCO's can successfully fulfill the requirements of the health care delivery system. However, a more effective and efficient mechanism would be for CMS to address concerns about State oversight processes as they arise rather than through duplicative oversight by CMS and its creation of mandatory, significant additional operational reporting requirements. Given the substantive and procedural provisions of the proposed rule, it is likely that delays in contract implementation will occur which are unrelated to deficiencies detected through readiness reviews but which instead result from the challenges encountered by States in complying with the added level of burdensome administrative requirements. Adverse impacts to beneficiaries as well as ambiguity of contract effective dates and implementation deadlines are some of the unintended consequences of this proposed rule.

We are also deeply concerned about CMS's ability to provide sufficient oversight of these numerous new documentation and reporting requirements. Before imposing such significant requirements on States, it is imperative that CMS ensure it has adequate capacity for such oversight. Although we are committed to transparency with our federal partners, we must have a path to timely review and approval of required documentation. For example, Arizona has experienced significant delays in its rate review process with CMS during the past few years. Rates that were submitted in February 2015 for an April 1, 2015, effective date have still not been approved, and Arizona has not received feedback on these rates from CMS in over 3 months. These types of delays create significant operational and fiscal challenges and inefficiencies for States and are, quite simply, unnecessary. If CMS intends to impose significant new requirements upon States, then it must have adequate resources in place to complete timely review and approval. It is inappropriate to place both States and contractors in a position where both entities are assuming new risks and liabilities because of the inability of CMS to manage the substantial work that it has created. We articulate these and similar concerns in our comments.

Like CMS, Arizona supports alignment across health insurance affordability programs and recognizes its importance as members move between Medicaid and other payers. We also support alignment with Medicare where appropriate. In Arizona, contracted MCOs are also required to be Medicare D-SNPs, and this alignment enhances the efficiency of health plan operations and interface with members, especially in the delivery of services to our dually-eligible population. However, we believe it is

absolutely critical that any final regulation both allow for a sufficient operational transition time in those areas where alignment is desirable as well as recognize the unique nature of the Medicaid population and the needs of our members in areas where alignment may not be appropriate.

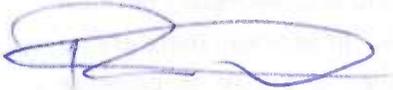
Finally, we strongly oppose the required 14 day FFS enrollment period (which is actually longer than 14 days when the advance mailing provisions delineated in the proposed rule are included). States have developed successful processes that assure informed member choice while still providing the benefits that managed care offers members, and this change is a significant step backward with profound negative implications for quality of care objectives. The mandatory FFS enrollment period represents an enormously disruptive policy shift that will impact hundreds of thousands of members each year, adversely affecting care coordination with potentially grave consequences to persons with chronic health conditions as well as to other high risk populations. For example, in March 2015 alone, 57,362 additional members would have been enrolled in FFS coverage due to this requirement. Members in Arizona's Medicaid program are satisfied with the current process as consistently demonstrated by the exceedingly low percentage of enrollees who changed plans after they were auto assigned: During March and April of 2015, less than 2% of the total number of enrollees changed plans. It is paternalistic to assume that members who choose a plan during the eligibility determination process do not do so in an informed manner. Moreover, imposing a mandatory FFS enrollment period is unnecessary because members are permitted to change plans within the first 90 days of enrollment. In addition, there are no provisions addressing enrollment of members who were previously enrolled in a plan to promote continuity of care. Regarding this point, data from March and April 2015 identifies that approximately 30% of enrollments involved Arizonans who had been enrolled in a plan within the previous 90 days. It is illogical, burdensome to members, and wasteful of taxpayer resources to require a FFS enrollment period for these individuals. While CMS may believe that this proposal will "assure the State's ability to conduct intelligent default enrollments into a managed care plan," what CMS has proposed is the creation of a system in which individuals are forced into "un-managed" care for a period of more than two weeks where tens of thousands of individuals a month, in Arizona alone, must be transitioned into a managed care plan. This proposal is anything but efficient and effective, and one has to question what problem it is that CMS believes it is attempting to solve. These provisions do not, as articulated in the Preamble, "assure the state's ability to conduct intelligent default enrollments into a managed care plan."

It is from this perspective that Arizona provides comments to the rules proposed by CMS to modernize Medicaid managed care. Our comments identify the most significant concerns presented by the proposed language of the rules themselves. They also outline Arizona's position regarding specific sections of the commentary in the Preamble. In some instances, Arizona found that the actual language of the proposed rules does not correspond with requirements and expectations for the State discussed in the Preamble. In other cases, CMS has affirmatively requested States to submit comments to options under consideration by CMS, whether or not reflected in the language of the proposed rules. Given the magnitude of the proposed changes (which implicate most aspects of the managed care delivery system), coupled with less than 60 days to submit responses, Arizona's comments outlined in the subsequent pages address only major areas of concern.

For all of the requirements included in the revised regulations, it is critical that CMS allow States sufficient transition time for implementation. Many of these requirements are operationally and resource intensive, and an appropriate transition time will mitigate the risks associated with implementation. A minimum phase-in period of 3 years from the effective date of the final rule will be necessary.

In preparing our remarks, Arizona thoughtfully considered the proposed rules, relying on our decades of unique experience operating Medicaid managed care programs. Because the rules touch on so many different aspects of the program, our comments are organized into seven key areas: (1) Quality; (2) Medical Loss Ratio; (3) Managed Care Operations; (4) Medical Management; (5) Grievance System; (6) Program Integrity; and (7) Enrollment. We look forward to future discussion and collaboration with CMS to develop regulations that will extend beneficiary protections, improve health outcomes, and manage program costs yet offer genuine flexibility to States so that they may operate successful Medicaid managed care programs that support innovation.

Sincerely,



Thomas Betlach  
AHCCCS Director

## SECTION 1: QUALITY

### § 438.68 - Network adequacy standards

Summary (b)(1) Requires States to establish “time and distance standards for the following network provider types: Primary care (adult and pediatric); OB/GYN; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to such time and distance standards.”

- **Recommendation:** This is a significant expansion of expectations for network adequacy down to ancillary and specialty providers. While it appears that there may be some flexibility for States to determine what provider types should be included, States should have the authority to determine network adequacy based on the needs of the populations served. In addition, States should have the ability to use standards other than time and distance. As States move to value-based purchasing, there may be factors other than time and distance that are appropriate to consider. For certain specialties in which only a handful of providers serve the entire State, time and distance standards may not be meaningful even if CMS permits the State to establish varied standards by provider specialty; other standards may be more appropriate in these cases. In addition, as technology evolves a time and distance standard becomes meaningless as healthcare is delivered remotely. For example, Banner Hospitals currently monitor the ICU units from a facility in Israel during certain times of the day.

Summary (d): Requires States to develop an exceptions process for use by MCOs, PIHPs, and PAHPs unable to meet the network standards and requires States to “monitor enrollee access to providers in managed care networks that operate under an exception.”

- **Recommendation:** CMS should give States the flexibility to consider other factors for granting exceptions for time and distance standards such as the willingness of providers to contract with the Medicaid program (MCOs), routine care patterns for members or communities, cost-effectiveness of service provision, the leveraging of technology in the delivery of care and other need variations determined by the State.
- **Recommendation:** Network requirement standards should recognize providers within each State and how individuals needing care have access to that provider/specialty, regardless of the payer source.

Summary §438.68 Requests comments on whether standards for behavioral health providers should distinguish between adults and pediatric providers.

- **Recommendation:** CMS should give States the flexibility to determine if differentiation between adults and pediatric behavioral health providers is needed, but should not require such differentiation

### §438.210 – Coverage and authorization of services

Summary (a)(5)(ii): Revises criteria for defining “medically necessary services” by requiring that such criteria meet the EPSDT requirements for beneficiaries under age 21 “to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found”.

- **Recommendation:** CMS should exclude EPSDT standards from the criteria for defining medically necessary services for persons age 21 years and older, or, alternatively, clarify that the expanded criteria applies only to persons under the age of 21 because the current drafting is unclear and ambiguous.

- The addition of the EPSDT requirements of 42 USC 1396d(r) to all Title XIX members is not supported by the Medicaid laws. Congress explicitly intended the EPSDT criteria defining medical necessity to apply exclusively to persons under the age of 21, and no counterpart of the EPSDT criteria for the general population is found in the Medicaid statute. For persons age 21 years and older, States have been afforded the discretion to define medical necessity as a matter of State law where States are provided flexibility to develop criteria according to their unique circumstances.
- The expansion of the definition of medical necessity for persons age 21 years and older to include EPSDT criteria will promote considerable litigation, will eliminate State flexibility and discretion consistent with the Medicaid statute, and will vastly increase costs of the Medicaid program.

#### **§438.214(b)(1) Credentialing and Re-credentialing**

Summary: Requires each State to establish a credentialing and re-credentialing policy that addresses all the providers, including LTSS providers, covered in their managed care program regardless of the type of service provided by such providers to emphasize the importance of a credentialing and re-credentialing policy for all provider types for the services covered under the contracts. Also requires each MCO, PIHP, and PAHP to follow the State policy but does not prohibit additional policies at the State or managed care plan level.

- **Recommendation**: States should have discretion in determining the categories of LTSS providers that should be credentialed and when alternative methods of assuring quality care and beneficiary protection are sufficient. There are no existing credentialing criteria that could be utilized to address entities and individuals that are not licensed by the State and may not be certified under current rules or requirements. This would increase the burden of credentialing particularly for providers such as habilitation, attendant care, self-directed providers, personal care, peer support, outpatient treatment centers, residential treatment centers, group homes, etc. which would impose a significant burden on the State and also serve as a disincentive for individuals to work in these types of positions, potentially creating access to care concerns.

#### **§ 438.330 - Quality assessment and performance improvement program**

Summary (a)(2)(ii): Allows States to apply for an exemption from the CMS-specified performance measures and PIP topics.

- **Recommendation**: CMS should provide State-flexibility regarding the development of Performance Improvement Projects (PIPs) rather than having CMS-standardized PIPs for the following reasons:
  - States are best positioned to determine the most appropriate areas to target for performance improvement, which may vary by State for a variety of reasons such as historical State performance.
  - As described in the proposed rule, the ability for a State to receive an exemption from a PIP would be at the MCO level rather than at the State level, which would further bifurcate the resources and focus of quality improvement initiatives. The rule also does not specify CMS action if an individual MCO or more than one MCO does not meet the performance targets established for the PIP by CMS.
  - If CMS-standardized PIPs are established, Arizona recommends that the following be considered as exemptions under the Rule: whether the State has previously implemented and achieved a statistically significant improvement in the measure or related measure that would impede its ability to recognize any additional statistically

significant change; the utilization/needs of the population being served in the state; resources needed for the interventions/activities; other State focused improvement priorities etc.

- **Arizona requests CMS to provide special consideration (e.g., an exemption) for programs that solely serve American Indian and Native Alaskan (AI/NA) populations from collecting and reporting on the PM and PIPs established in § 438.330 (a)(2). The majority of the providers that serve these populations are IHS/638 providers and States do not have the authority to enforce IHS/638 provider compliance with PIPs. In addition, States have limited detail data and limited capacity to collect data from this system due to IHS/638 billings practices. These unique challenges could present barriers to effective PIPs for these populations.**

Summary (a)(2) and (b): Requests comments on adding flexibility for States to change the way in which a measure is weighted in their quality rating methodology.

- **Recommendation: Arizona supports State flexibility in determining the weighting of specific measures in the quality rating system to align with state quality improvement goals.**

Summary (b)(5): At page 31150 of the Federal Register, CMS encourages States to incorporate surveys for beneficiaries receiving long term services and supports as part of the State's implementation of section 438.330(b)(5) regarding assessment of quality. CMS requested comments on the current use of such services and how they may best be used to improve the delivery of LTSS.

- **Recommendation: While Arizona supports the use of member surveys, the tools currently being tested (such as the TEFT) require the actual member to respond. Given the population served through an MLTSS program, a member's representative should be permitted to respond in order to address challenges in collecting results as well as the accuracy of the results. In addition, given the absence of standardized normed long term care survey tools the results of member surveys may be of limited value depending on the quality of the individual tool. Should CMS move forward with the recommendation, it should be optional or provide the State with the flexibility to select or create the tool.**

Summary (c) Allows States to elect to use an alternative or preexisting quality rating system in place of the rating system proposed by CMS, subject to CMS approval.

- **Recommendation: Arizona is concerned that only pre-existing rating systems developed by States would be considered for approval. The same approval expectation should be available to all States that choose to develop their own quality rating systems. Therefore, Arizona recommends that the final rule include specific language authorizing States to receive approval of alternative quality rating systems.**

#### **§ 438.334 – Medicaid Managed Care Quality Rating System**

Summary §438.334: At page 31153 of the Federal Register, CMS requests comment on the feasibility of adding flexibility for States to change the way in which a measure is weighted, while envisioning that the selection/methodology development process occur every 2 to 3 years.

- **Recommendation: Although Arizona agrees that it is important to ensure measures reflect current priorities and practices, an update every 2 to 3 years is too frequent, and Arizona recommends CMS maintain a more stable set of performance measures. The system development and implementation of new or additional measures is resource intensive and does not allow for adequate trending to determine ongoing system performance and**

improvement. Continual changes to measures limit the comprehensive development, implementation, and effectiveness of interventions.

**§438.358- Activities related to external quality review**

Summary: Adds another mandatory EQR-related activity to validate MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with the State standards developed in accordance with § 438.68.

- **Recommendation: Arizona does not support the recommendation of a fourth mandatory EQR-related activity. The recommendations in the Proposed Rule extend network adequacy monitoring and oversight by the State, including certification of individual MCO network adequacy, in submissions to CMS. Adding another layer of review is an unnecessary burden with limited benefit as well as a fiscal impact to the State.**
- **If this recommendation is included in the Final Rule, clarification is requested as to whether, like other mandatory EQRO activities, the State or another vendor contracted by the State may conduct the activity and provide the results of the activity to the EQRO for inclusion in the annual EQR report.**

**§438.362 - Exemption from external quality review**

Summary: Allows States to exempt a health plan from undergoing an EQR if the MCO has a current Medicare contract under Part C of Title XVIII or under section 1876 of the Act, and, for at least 2 years, has had in effect a Medicaid contract under section 1903(m) of the Act.

- **Recommendation: CMS should clarify whether any Medicare contract that the MCO has would apply (example: would New York-based Medicare results apply to Arizona Medicaid if owned by the same MCO).**

## SECTION 2: MEDICAL LOSS RATIO (MLR) STANDARDS/FINANCE

### §438.2 - Definitions

Summary: Modifies a number of existing definitions and adds new definitions.

- **Recommendation:** Arizona requests that CMS include a definition of "rating period" in this section, similar to the language in section 438.8(b): such as "a period of 12 months selected by the State, for which a MCO's, PIHP's, or PAHP's prospective capitation rates are developed and submitted to CMS as required by section 438.7." This will avoid confusion in the regulations between the period for which rates are being developed and the historical data period(s) being used in rate development.
- In addition to adding a definition for "rating period" in section 438.2, Arizona recommends that the definition of "MLR reporting year" in section 438.8(b) be simplified to state: "a period of 12 months, consistent with the rating period selected by the State."
- Arizona provides additional comments in Section 4 – Medical Management

### §438.3(a) (Standard contract requirements) in conjunction with 438.7 a (Rate certification submission)

Summary: 438.7(a) requires States to comply with 438.3(a) for rate certifications concurrent with the CMS review and approval process for contracts: States must submit to CMS for review and approval, no later than 90 days prior to their effective date, MCE rate certifications as well as proposed final contracts.

**Recommendation:** Arizona recommends adoption of a 45 day advance timeframe for submission of rate certifications to CMS and approval. Imposing a 90 day advance timeframe will add greater uncertainty in the accuracy and applicability of rates developed from past data that are intended to be applied to time periods considerably in the future. Arizona is committed to working with CMS to meet appropriate timeframes for rate submission to help ensure the process is more predictable with regard to the timing of approvals and effective dates.

Arizona believes 45 days is a more appropriate timeline for rate submissions as the shorter time period enables States to develop rates that more accurately reflect current conditions. A 45 day timeline for CMS review is sufficient, given that CMS has sought to articulate its expectations for rate submissions in its 2016 Rate Development Guide and in this proposed rule. We believe extensive negotiations are unnecessary when States have considered all elements required by CMS, provided the necessary information on rate development, and provided CMS with a certification from the state's professionally trained and licensed actuary, as required. The increased transparency described in other parts of the regulation should mean that CMS' review process could be completed in the 45 day timeframe. The proposed 90 day requirement for rate submission, when coupled with the necessary time to develop the rates, would result in States using data that is less timely. This raises concerns with accuracy of developed rates. AHCCCS Actuaries generally take 60 days or more to conduct their analysis and establish rates. For States to meet the proposed 90 day state submission deadline, the data used for rates will be over six months old by the time of the contract effective date, at a minimum.

Arizona provides additional comments on section 438.3 in Section 3 of this submission – Managed Care Operations.

### §438.3(u) IMD

Summary: States may make a monthly capitation payment to an MCO or PIHP for a member receiving inpatient treatment for mental disease in an inpatient hospital facility or sub-acute facility providing

crisis residential services, so long as length of stay in the IMD is no more than 15 days during the period of the monthly capitation payment.

**Recommendation:** Arizona disagrees with all IMD changes and believes States should be allowed to continue to use “in-lieu of” authority to cover IMD services, regardless of length of stay, when it is more cost effective and appropriate for the member for the following reasons:

- A 15 day per month limit is more restrictive than the current in-lieu benefit. Page 31118 of the Federal Register states CMS’ expectation that short term stays in IMD’s are “priced consistent with the cost of the same services through providers included under the state plan,” i.e., general hospital costs – in Arizona those rates are 93.5% greater than IMD rates, thus CMS’ change in its approach to valuing these services represents a material fiscal impact to the program;
- Page 31117 of the Federal Register states that “capitation payments may not be made if the specified conditions outlined in this section are not met and that a state would have to ensure that covered Medicaid services are provided on a FFS basis or make other arrangements to assure compliance.” While the costs of the in lieu of services can be included in capitation rates, subsection (u) prohibits a “monthly” capitation payment for any stays in excess of 15 days. If rates are built on the assumption of stays of 15 days or less, but an entire month of capitation is denied, an actuarially sound rate is not being paid for the non-IMD services provided to any member with a stay over 15 days.
- There are multiple operational impacts related to implementing a 15 day monthly limit, such as tracking days (which is difficult when encounters reported to the state are lagged). Tracking days of the IMD stay is made even more complex when a member changes MCOs mid-stay. Operational processes will have to be developed to disallow or recoup capitation for violations exceeding 15 day stays.
- In summary, for Arizona, three fiscal impacts were identified: increased cost to AHCCCS to value the cap rates at higher cost settings for IMD days; increased costs to AHCCCS to place members in higher cost settings after 15 days; and loss of revenue for IMD’s based on reductions in placements.

Should CMS not allow the continuation of the current “in-lieu of” authority, AHCCCS recommends a limited recoupment of the MCO capitation payment specific to the behavioral health portion of the IMD stay in excess of 15 days. Furthermore, if any limit is imposed it should be based on an amount, duration, and scope adequate to meet the needs of most beneficiaries such as a length of stay adequate to provide coverage for 80-90% of beneficiaries needing the service rather than the average length of stay. Finally, Arizona urges CMS to provide States with sufficient transition time, 3 years from the effective date of the final rules, to make the significant operational changes necessary as well as secure the increased funding associated with federal restriction.

If CMS adopts the rule as proposed, it imposes a quantitative treatment limitation on inpatient behavioral health services that the State would be required to include in its analysis of compliance with proposed 42 CFR 440.395 that appears as part of the NPRM published April 10, 2015, 80 Fed. Reg. 19418 (“Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations”). Arizona recommends that, if the State is required to offer more than 15 days in an IMD under that proposed regulation (assuming it becomes final), that the cost of the length of stay in an IMD greater than 15 days may be claimed under proposed 438.3(c) (“final capitation rates must be based only upon services covered under the State plan and additional services deemed by the State to be necessary to comply with the Mental Health Parity and Addiction Equity Act”).

#### **§438.4 - Actuarial Soundness**

**Summary:** Any proposed differences among capitation rates according to covered populations must not be based on the FFP percentage associated with the covered populations. The Language appears to suggest states cannot set a capitation rate for a population that has a unique FFP even when that population has unique characteristics that are appropriate for grouping for rate setting purposes. The Preamble (31120) further states ", we propose in paragraph (b)(1) to prohibit different capitation rates based on the FFP associated with a particular population."

- **Recommendation:** CMS should permit States to have different rates for populations that may have unique costs and needs, regardless of whether those populations have different FMAPs. Appropriately reflecting the costs of the populations is not a "cost-shift" to the federal government, as articulated in the Preamble, rather it may be an appropriate actuarial practice to differentiate the rates for a unique population. It is only a "cost shift" if the rates are inappropriately inflated for populations with higher FFP, which would be inconsistent with accepted actuarial practice and would be apparent upon CMS review of the rates.

#### **§438.5 - Rate development standards**

**Summary:** Describes the development and documentation of capitation rates paid to risk based MCOs, PIHPs, and PAHPs.

**Recommendation:** CMS should clarify that the actuary can use quarterly unaudited financials and that States can use a portion of the three most recent and complete years prior to the rating period as the base data if the actuary determines that the portion is the most appropriate. Arizona recommends that this should NOT require an exception as this is an accepted and appropriate actuarial practice.

#### **§438.6(c)(2)(ii)**

**Summary:** Requires contract arrangements that direct the MCO's, PIHP's or PAHP's expenditures under paragraphs (c)(1)(i) or (c)(1)(ii) to demonstrate in writing a number of standards.

- **Recommendation:** Arizona opposes the establishment of strict federal parameters around how States structure delivery system reform and value-based purchasing. These changes and the administrative burden associated with the federal reporting requirements will chill State innovation. In addition to stifling future innovation, this will adversely impact the State's existing value based purchasing (VBP) initiative. This rule suggests that VBP has to be available to all providers, rather than the MCOs determining the providers with whom they will enter into these agreements. This also requires uniform performance measures, which does not allow MCOs to account for unique contract terms, population needs or community or geographical issues. Initiatives, and hence performance measures, for a behavioral health provider, for instance, will differ from a primary care provider or hospital. MCOs and providers must have the flexibility to reach arrangements that make sense for the populations they serve. These burdensome requirements will significantly slow the pace of innovation in Arizona.

#### **§438.7 - Rate certification submission**

**Summary:** Requires all adjustments used to develop the capitation rates to be adequately described with enough detail so that CMS, or an actuary applying generally accepted actuarial principles and practices, can understand and evaluate a number of specific requirements

- **Recommendation:** Broadly, Arizona believes that these regulations and the just released CMS Rate Setting Guidelines are far too prescriptive in the level of detail required for CMS review and approval of rates. Actuaries are highly trained professionals that adhere to professional standards and requirements. CMS should establish a reasonable process for rate review that

respects the work of the actuaries rather than checking each and every calculation they perform. In addition, CMS should work with States on appropriate time frames for approval. For example, if CMS does not approve rates within 45 days of submission, the rates should be deemed approved.

- When this language is considered in conjunction with the Guidelines, the Guidelines provide more detail on this issue. Arizona is concerned with a statement in the Guidelines that begins "...changes in the program between the time period from which the data is obtained, and the rating period..." This language suggests that every program or delivery system change that occurred over the 3 years of the base data must be explained with every actuarial certification. In some years the State has experienced upwards of a dozen program changes. The language in the Guideline suggests that the State would be required to restate over 30 program changes with each new actuarial certification. This repetition is unnecessary because prior certifications (for the years in which the program change occurred) fully explain the rate adjustments.

#### **§438.7(c) - Rate Certification submission; 438.5(b)(5) - Rate Development Standards**

Summary: §438.5(b)(5) requires States, when developing rate standards, to take into account the MCO's, PIPH's, PAHP's past medical loss ratio in the development of the capitation rates, and consider the projected medical loss ratio in accordance with § 438.4(b)(7). Section §438.7(c) requires that the State, "through its actuary, must certify the final rate paid under each risk contract and document the underlying data, assumptions and methodologies supporting that specific rate."

- **Clarification:** CMS should clarify that the State's actuary is not certifying the assumptions underlying the rates. Otherwise, this requirement violates Actuarial Standard of Practice 49 which specifies "...the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual MCO."
- **Clarification:** Arizona is concerned with what may be conflicting requirements in sections 438.5(b)(5), 438.7(c)(1) and ASOP 49. Please confirm Arizona's understanding that the application of the MLR results for individual MCO's - as required by 438.5(b)(5) - to an average capitation rate for a specific population in a specific geographical service area would not trigger the requirement under section 438.7(c)(1) that rates must be "independently developed."
- **Clarification:** In addition to the MLR rates for individual MCO's, the actuary may also apply other MCO specific factors to a single, average rate established for a specific population in a specific geographic area such as risk adjustment and components of the rate that are competitively bid (such as administrative costs). Please confirm Arizona's understanding that the application of these factors to an average rate would not trigger the requirement under section 438.7(c)(1) that rates be independently developed for each MCO.

#### **§438.8 - Medical loss ratio (MLR) standards**

Summary: Establishes significant reporting requirements States must require through its contracts for each MCO, PIHP, or PAHP.

- **Recommendations:** Please change the date in (a) to ensure that the requirement for the inclusion of contract language relating to MLR should not take effect until at least 6 months after publication of the final rule or January 1, 2017 whichever is later.
- In addition to adding a definition for "rating period" in section 438.2, Arizona recommends that the definition of "MLR reporting year" in section 438.8(b) be simplified to state: "a period of 12 months, consistent with the rating period selected by the State."

- Arizona supports flexibility in 438.8(b) for the State to determine the 12 month period for the MCO to report the MLR. However, States must be able to select different 12 month periods by line of business or contract as not all MCOs are on the same contract year.
- Arizona supports section 438.8(e) which provides for the inclusion in the MLR numerator of incentive and bonus payments to providers. Similarly, Arizona supports the inclusion in the numerator of activities that improve health care quality which include care coordination/ case management/ service coordination/ community integration of individuals with complex needs and the cost of appropriate outreach and engagement.
- CMS should address the following discrepancy: the report in section 438.8(k) is based on the MLR reporting year. However, in (k)(xi) there is a requirement for the MCO to reconcile the report with their annual audit. It is more than likely that the annual audit will not be on the same twelve month period as the MLR reporting year.
- Arizona supports flexibility in 438.8(b) for the State to determine the 12 month period for the MCO to report the MLR. However, States must be able to select different 12 month periods by line of business or contract as not all MCOs are on the same contract year.
- Arizona supports section 438.8(e) which provides for the inclusion in the MLR numerator of incentive and bonus payments to providers. Similarly, Arizona supports the inclusion in the numerator of activities that improve health care quality which include care coordination/ case management/ service coordination/ community integration of individuals with complex needs and the cost of appropriate outreach and engagement.

#### **§438.54(d) - Managed Care Enrollment**

Summary: Adds a number of requirements for States that operate mandatory managed care programs.

- **Recommendation:** This requirement should be eliminated or, in the alternative, States that have years of operational experience with enrolling all members into managed care immediately upon eligibility determination, including enrollment back to the first day of the month of application, should be waived from this requirement. Simply put, this mandate is a step backward for States like Arizona with mature managed care programs where the MCO is responsible for care management and coordination at the earliest possible date. It is completely unnecessary.
- Arizona provides additional, more detailed and robust comments in Section 7 of this submission- Enrollment.

#### **§438.74 - State oversight of the minimum MLR requirement**

Summary: Requires States to annually submit to CMS a summary description of the report(s) received from the MCO(s), PIHP(s), and PAHP(s) under contract with the State under § 438.8(k) with the actuarial certification described in § 438.7. The summary description must include, at a minimum, the amount of the numerator, denominator, MLR experienced, the number of member months, and any remittances owed by each MCO, PIHP, or PAHP for that MLR reporting year.

- **Recommendation:** Section 438.5(b)(5) requires States to consider medical loss ratios when developing rates. As such, it is not necessary to coordinate delivery of the MLR report with the actuarial certification as proposed in section 438.74(a)(1). Arizona recommends that the MLR reports be submitted as part of the annual report required by section 438.66(e). In the alternative, CMS should clarify that section 438.74(a)(1) does not mandate consideration of a single, two-year-old MLR report when setting current capitation rates.

#### **§438.818 - Enrollee encounter data**

Summary: Allows FFP for expenditures under an MCO, PIHP, or PAHP contract only if the State meets a number of conditions for providing sufficient and timely enrollee encounter data to CMS

- **Recommendation:** CMS should work with States collaboratively to define standards for accurate and complete encounter data as referenced in subsection (b) as well as a procedure for allowing States to correct deficient submissions. Arizona is concerned that CMS intends to use error tolerances set forth in the current MSIS data dictionary particularly with regard to fields required for MSIS submission that are intended to capture information that the State cannot consistently and reliably obtain. Specifically, the current data dictionary requires the submission of beneficiary enrollment data concerning race and ethnicity. However, 42 CFR 435.907(e) provides that the State may only require information relevant to an eligibility determination. As such, while the State may request information regarding race or ethnicity, it cannot require such information. However, the MSIS data dictionary counts a value of “unknown” as a value that counts towards the error tolerance. The data dictionary also provides that files with any values in excess of the error tolerance will be rejected. It is unreasonable to subject the State to potential deferrals and disallowances based on its inability to provide self-reported, non-mandatory data. It is incumbent upon CMS to establish clear and reasonable standards of accuracy and completeness.

## SECTION 3: MANAGED CARE OPERATIONS

### §438.3 - Standard contract requirements

Summary: Adds regulatory flexibility to set forth procedural rules— namely timeframes and detailed processes for the submission of contracts for review and approval—in sub-regulatory materials, and add a new standard for States seeking contract approval prior to a specific effective date that proposed final contracts must be submitted to CMS for review no later than 90 days before the planned effective date of the contract. The same timeframe standard would also apply to rate certifications, as proposed § 438.7(a) incorporates the review and approval process of § 438.3(a).

- **Recommendation:** Arizona has had a longstanding partnership with CMS to meet appropriate timeframes for rate submission to help ensure the process is more predictable with regard to the timing of approvals and effective dates. Additionally, Arizona has a highly regarded reputation regarding rate accuracy. It is our opinion that the proposed 90 day requirement for rate submission, when coupled with the necessary time to develop the rates, would result in States using data that is less timely. The result is less than accurate rates. Actuaries generally take 60 days or more to conduct their analysis and establish rates. For States to meet the proposed 90 day State submission deadline, the data used for rates will be almost six months old by the time of the contract effective date, at a minimum. In our 33 year experience, 45 days is a more appropriate timeline for rate submissions. This timeframe also allows actuaries to react to and include recent events, program changes, legislative mandates and other matters. Actuaries cannot ensure accurate rates if the data upon which they are relying does not incorporate current conditions.
- This alternative timeline of 45 days for CMS review is sufficient, given that CMS has sought to articulate its expectations for rate submissions in its 2016 Rate Development Guide and in this proposed rule. We believe extensive negotiations are unnecessary when States have considered all elements required by CMS, provided the necessary information on rate development, and received certification from the State's professionally trained and licensed actuary, as required. The increased transparency described in other parts of the regulation should mean that CMS' review process could be completed in the 45 day timeframe.
- Arizona provides additional comments in Section 2 – Medical Loss Ratio Standards.

Summary: Cap Rates for SPA Services Only – Section 438.3(c) provides that the final capitation rates must be based only upon services covered under the State Plan and that the capitation rates represent a payment amount that is adequate to allow the MCO, PIHP, or PAHP to efficiently deliver covered services in a manner compliant with contractual standards.

- **Recommendation:** Arizona covers services granted by the 1115 Waiver in addition to the State Plan (e.g., HCBS), and those services are included in the capitation rates. Distinguishing between State Plan services and other waiver services for purposes of capitation rates is unnecessary and takes away from the purpose of managed care: to hold an entity accountable for managing the whole health of a member.

Summary: Dual Coordination of Benefits (COB) Crossover Process 438.3(t): Adds requirements for MCOs, PIHPs or PAHPs responsible for coordinating benefits for dually eligible individuals. In a State that enters into a COB Agreement with Medicare for FFS, an MCO, PIHP or PAHP contract that includes responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare must require the MCO, PIHP or PAHP to enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

- **Recommendation:** CMS should clarify that MCE's are exempt from the COB Agreement crossover fee to the same extent that States are exempt from the fee.

#### **§438.10 Information Standards**

Summary: Section 438.10(c)(3) requires States to operate a Web site that provides the content specified in paragraphs (g) and (h) of this section, § 438.68(e), § 438.364(b)(2), and § 438.602(g), either directly or by linking to individual MCO, PIHP, PAHP or PCCM entity Web sites.

- **Recommendation:** Arizona supports the option to permit States to link to the MCO website. Arizona has 14 contracted health plans and it would create a significant administrative burden to manage routine changes at the MCO level for the numerous information items that will need to be available on the websites. This is best managed by the MCO.

#### **Arizona provides additional comments in Section 7 – Enrollment**

Summary 438.10(c)(6)(v): Requires the State, MCO, PIHP, PAHP, and PCCM entity to inform enrollees that the information is available in paper form without charge upon request and provides it upon request within 5 calendar days.

- **Recommendation:** The 5-day requirement should be business days, not calendar days.

Summary 438.10(c)(4)(i): Requires States to develop and require MCO's to use in member information packets approximately thirty different terms relating to the managed care delivery system.

- **Recommendation:** This requirement is overly prescriptive and should be deleted. States should be afforded discretion to determine what terms it will use and how they will be defined to ensure that the relevant information is conveyed to enrollees in a clear, concise, and culturally competent manner.

Summary 438.10(h)(3): Requires that information included in a paper provider directory be updated at least monthly and electronic provider directories must be updated no later than 3 business days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information.

- **Recommendation:** Arizona objects to the unreasonably short 3 business day time period to update the electronic provider directory. Changes to information included in the provider directory occur continuously, and the administrative burden of complying with this timeframe is impractical, diverting resources from more important operational activities. Arizona recommends adoption of a monthly timeframe.

#### **§438.14 –**

Summary: Adds requirement for MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs)

- **Recommendation:** Arizona recognizes that the proposed language largely repeats the statutory requirements of section 1932(h) verbatim. Nevertheless, Arizona would like to note that, pursuant to waiver authority under Section 1115, the State has successfully addressed the issue of access to IHCP by excluding the services of IHCP from the scope of services in its contracts with MCO. Under Arizona's Demonstration Project, American Indians are free to move between managed care enrollment and a FFS delivery system that provides access to all IHCPs. Arizona also shares this claims data with MCOs so that the information can be leveraged for care coordination and care management purposes.

**Summary:** CMS is seeking comments on the potential barriers to contracting with managed care plans for IHCPs and what technical assistance and resources should be made available to States, managed care plans, and IHCPs to facilitate these relationships. Such resources might include an I/T/U contract addendum, similar to those created for the QHPs and organizations delivering the Medicare Part D benefit.

**Recommendation:** While there are a few off-reservation I/T/Us that have contracts in place with MCOs, most IHS/638 facilities and other Tribal providers do not. There are various governmental requirements that differ for each Tribe. This would cause complicated arrangements and processes for networking with MCOs (e.g. credentialing, transportation, right of entry agreements). State survey agencies lack the legal authority to mandate reviews for the purposes of determining an on-reservation IHS or 638 facility's compliance with licensure standards (which is required even though issuance of a license is not). Neither do they have the authority to investigate complaints regarding on reservation facilities without the consent of the Tribal government. In Arizona, this could require each MCO or the State to negotiate agreements with each of the recognized Tribes that operate 638 facilities or that have I.H.S. facilities on reservation. In addition, the exemption from the requirement that a provider hold a State license is limited to those services described in the facility's 638 agreement with I.H.S. However, the description of covered services in the 638 agreement does not always align with the description of Medicaid covered services. Furthermore, facilities are not prohibited from providing services other than as described in the 638 agreement some of which might be Medicaid covered services. As such, some services may be exempt from Medicaid requirements for licensure (those listed in the 638 agreement) while others may not. Finally, the State is not always adequately informed of changes in the scope of the 638 agreements or when such agreements are suspended or terminated. An additional barrier is the divergent payment methodologies employed by the State and MCO's. The proposed regulation requires that the MCO pay non-participating IHCPs at a "rate not less than the level and amount of payment that the MCO ... would make for services to a participating provider which is not an IHCP." However, those payment levels and amounts can be very different from the All Inclusive Rate that the State pays the IHCP on a per visit basis. Finally, many IHCPs will likely have to make major system modifications to submit claims in the format required by MCOs. Arizona's process is far more streamlined and respects the direction provided from Tribes during consultation. CMS should conduct extensive tribal consultation before making these changes.

- If CMS should move forward as proposed, the following barriers have been identified:
  - IHS/638 facilities would be unable to receive the AIR through the MCOs.
  - IHS/638 facilities would have to bill multiple entities instead of the one entity that all payments are funneled through for Medicaid American Indian members. These facilities would not have the government to government relationship with the MCOs that they have directly with the State.
  - IHS/638 facilities would be subject to far more restrictive prior authorization requirements with MCOs than they do now and would not have staff or systems in place, adversely impacting the timeliness of service delivery to members who already have disproportionate health disparities when compared to other Medicaid populations.
  - IHS/638 facilities would be subject any rate cuts that may occur.
  - The State general fund would see a significant impact due to the loss of pass through funds because MCOs would be unable to claim the pass through. The Medicaid agency must make a direct payment to the IHS/638 facility to claim this.

#### **§438.66 - State Monitoring Requirements**

**Summary:** Establishes an extensive monitoring system for managed care programs and requires States to conduct readiness reviews of MCE's before the effective date of new or modified managed care programs. The readiness reviews must be started at least 3 months prior to specific enumerated factors and must be completed and submitted to CMS with sufficient time for CMS to approve the contract or contract amendment under 438.3. Adds numerous standards which trigger the State's responsibility to conduct readiness reviews.

- **Recommendation:** CMS should not require States to submit readiness reviews to CMS as part of its contract approval process as described in subsection (d)(2). As CMS acknowledges in the Preamble, operational oversight of MCOs is a State responsibility. Duplication of oversight from CMS by "reviewing the findings, discussing any possible issues and arriving at a mutual understanding of expectations" is not an appropriate function for CMS. Arizona is concerned that CMS is not appropriately resourced to conduct these activities. If CMS insists on this level of micromanagement, specific timelines should be established including CMS response time within 30 days of submission and a deemed approval if that response time is not met. The timeframe for submission of readiness reviews and contract amendments are not aligned. Arizona also suggests, due to administrative burden, the on-site reviews for readiness be optional. In the current age of advanced electronic capability, on-site review should not be needed for many activities. Arizona finds that on-site review of MCOs is unnecessary and requiring such would add an unnecessary burden to all parties. In addition to requiring readiness reviews prior to implementing a managed care program and when a specific MCE has not contracted with the State, CMS also proposes that readiness reviews be conducted at least three months before the State adds new benefits, populations, or geographic areas to the scope of its contracted MCE's. Such changes can occur frequently and may only require minor operational changes that do not warrant an extensive readiness review process. Readiness reviews for contract amendments should only be required when the change is material. For example, expansion of eligibility groups - (d)(1)(iii) – expansion of benefits – (d)(1)(iv) – and expansion of GSA's – (d)(1)(v) – may be minor or may represent major changes to the scope of the contract. Therefore, if CMS does not revise the rule to make all readiness reviews optional, AHCCCS recommends that CMS eliminate the proposed requirement for mandatory readiness reviews when those changes are not substantial, allowing States discretion to determine if such readiness reviews are valuable. Arizona is concerned that conditioning contract approval on submission of readiness reports to CMS will result in contract implementation delays and delays of effective dates of new contractor responsibilities. Any requirement for the submission of readiness reports to CMS should be for purposes of providing notification to CMS, not as a prerequisite to contract approval.

#### **§438.66(e) - State Monitoring Requirements**

**Summary:** Requires States to submit reports to CMS, no later than 150 days after each contract year, for each managed care program administered by the State, regardless of the authority under which the program operates.

- **Recommendation:** Because this report contains multiple requirements, Arizona suggests a due date of 180 days after the end of the contract year. Additional clarification is requested on the timeframe of required data as certain data to be reported (i.e. encounters) has a lag time of around six months. Arizona currently submits a report to CMS on an annual basis, after the end of the plan's contract year, but it does not include all of the requirements now prescribed in this rule. With these additional proposed requirements, CMS should provide States with additional time to complete the reports.

#### **§438.104 - Marketing activities**

Summary: The definition of “marketing” in subsection (a) excludes communications from a QHP to Medicaid beneficiaries even if the issuer of the QHP is also the entity providing Medicaid managed care; amends the definition of “marketing materials;” and adds a definition for “private insurance” to clarify that QHPs certified for participation in the FFM or an SBM are excluded from the term “private insurance” as it is used in this regulation.

- **Recommendation:** Arizona supports language that explicitly permits an entity (or related entities) from marketing QHP products to Medicaid enrollees as the transition from public assistance to subsidized coverage through Exchanges. Such marketing has potential to reduce confusion to enrollees and to facilitate continuity of care. Arizona recommends that the language be clarified to read “Marketing does not include communications to a Medicaid beneficiary from an MCO, PIHP, or PAHP that also offers a qualified health plan either through the MCO, PIHP, or PAHP or another entity under common ownership.” Arizona also requests that the Secretary confirm Arizona’s interpretation that the definition of marketing of QHP under section 438.104(a) is consistent with and permissible considering the definition of marketing in the Health Information Privacy Rule, 45 CFR 164.501, which similarly excludes from that definition of “marketing” communications describing “a health-related product ... that is provided by ...the covered entity” including the “replacement of ... a health plan.” However, while there is benefit for a member’s continuity of care, CMS should consider requiring Medicaid managed care entities to market related QHP products in a way that clearly distinguishes the Medicaid product from both the QHP and for any related Commercial Plan (for example requiring distinct plan names and logos.

#### **§438.206 - Availability of services**

Summary: 438.206(c)(3) requires each MCO, PIHP, and PAHP to ensure that network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

- **Recommendation:** Arizona supports the objective to ensure services are provided in a non-discriminatory fashion and acknowledges that State Medicaid programs have certain obligations regarding nondiscrimination. However, Arizona requests clarification of the scope of this obligation. Specifically, proposed 438.3(f) requires that the State’s contract with managed care entities “comply with” applicable State and Federal anti-discrimination laws. We are concerned that this provision may be interpreted to impose an obligation on the State to investigate and make findings regarding complaints arising from conduct at the managed care entities. State Medicaid agencies have neither the expertise nor the legal authority to conduct formal investigations or make such findings. Those responsibilities are assigned by law to other State and Federal agencies. We do not question the State Medicaid agency’s responsibility to make appropriate referrals to those agencies or to take appropriate contract action with respect to managed care entities that engage in a pattern of non-compliance.
- Similarly, Arizona recommends that section 438.206(c)(3) - obligating MCE’s to ensure network provider compliance with access standards – should be deleted as duplicative of obligations already imposed on providers as the result of the Americans with Disabilities Act. Like the State, MCE’s are not equipped or legally authorized to conduct investigations or to enforce civil rights provisions.

Summary: At page 31147 of the Federal Register, CMS requests comment on approaches to measuring enrollee's timely access to covered services and to evaluating whether managed care plan networks are compliant with such standards set forth in 438.206(c)(1).

- **Recommendation: Arizona suggests that CMS leave all options open to the State and MCOs. Arizona employs all of these at different times and based on specific issues. Here again, States understand best what the concerns unique to their States are, which then drives the correct approach.**

Summary: At page 31172 of the Federal Register, CMS acknowledges that CHIP serves a child-focused population and seeks comment on whether additional standards for additional pediatric providers, for example children's hospitals or child and adolescent behavioral health providers, should be included in section 457.1218.

- **Recommendation: Standards are best determined by the State in consideration of its membership, geography and needs. Factors, such as limited number of children's hospitals in a given area (or none available in a GSA), creates issues that cannot be managed through uniform federal standards.**

#### **§438.208 - Coordination and continuity of care**

Summary: CMS requests comment on including an additional standard relating to community or social support services including linking enrollees to services through organizations such as Protection and Advocacy organizations, Legal Aid, Aging and Disability Resources Centers, Centers for Independent Living, Area Agencies on Aging, or United Way 311 lines. Given the historically high rate of utilization of these services by the Medicaid population, Medicaid managed care plans have experience in facilitating and coordination access to these services. This language would acknowledge existing industry practice. We request comment on this approach and on any potential costs associated with this addition.

- **Recommendation: This is already Arizona's current practice, and we support the addition of this new standard as it is in the best interest of the member.**

## SECTION 4: MEDICAL MANAGEMENT

### §438.2 - Definitions

Summary: Broadens the definition of “health care professional to include “providers of services other than medical services, such as long-term services and supports, would be included in this definition.”

- **Recommendation: The definition for “health care professional” should not include providers of all services other than medical services. In these proposed regulations, a health care professional can render coverage and medical necessity decisions. See section 438.210. Non-medical, unlicensed persons and paraprofessionals, such as providers of personal care services and NEMT providers, cannot render these types of decisions. Arizona also recommends that CMS include pharmacists in the current definition of healthcare professionals.**
- Arizona provides additional comments in Section 2 – Medical Loss Ratio

## SECTION 5: GRIEVANCE SYSTEM

### §431.244 Hearing Decisions

Summary: Retains the three working day requirement (from the date the State receives the case file and information from the MCE) to take final administrative action for expedited matters.

- **Recommendation:** Arizona supports CMS's decision not to modify the three working day timeframe applicable to the State in 431.244(f)(2) because it is difficult to offer a hearing consistent with the requirements of due process and for the State to take final administrative action within the existing time frame. It has been the State's experience that, in practice, half of enrollees request delays of hearings for expedited matters for the convenience of the enrollee or the enrollee's witnesses.

### §438.400-Statutory basis and definitions

Summary: Adverse benefit determination in 438.400(b)(5) includes "the failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (b)(2) regarding the standard disposition of grievances and standard disposition and resolution of appeals."

- **Recommendation:** The State does not believe it is appropriate to include late dispositions of a grievance or appeals in the definition of adverse benefits determinations nor does doing so provide any meaningful additional beneficiary protections. Classification of untimely dispositions as an adverse benefit determination triggers a responsibility on the part of the MCE to issue a notice that conforms to 438.404 advising the enrollee that it has failed to resolve the grievance or appeal in a timely manner. In turn, under the proposed regulations, this initiates a process that allows 30 days following an appeal of the untimely resolution for the MCE to review its failure to timely resolve the grievance or appeal, 120 days for the enrollee to determine whether to request a State Fair hearing, and up to 60 days for the State to conduct a hearing and take administrative action on the hearing decision. This is a nonsensical means of resolving complaints regarding the untimely resolution of either grievances or appeals. A logical and reasonable solution would be to permit the enrollee to request a State Fair Hearing on the denial, suspension, or termination of a requested service notwithstanding the MCE's failure to issue a notice of disposition of the original adverse benefit determination. However, with respect to untimely grievance determinations, there is little practical sense in offering direct access to a State Fair Hearing at all. It is difficult to imagine what meaningful relief the State could order through the administrative hearing process to address complaints regarding "aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested."

### §438.402- General Requirements.

Summary: Eliminates the current requirement of 438.402(b)(1)(ii) that providers must obtain the enrollee's written consent in order to file an appeal. With regard to 438.402(c)(3) concerning filing requirements, the Preamble at page 31104 clarifies that written appeals and grievances include online requests. CMS seeks comments requests regarding States' implementation of online systems and whether online systems should be mandatory.

- **Recommendation:** Arizona opposes the amendment of 438.402(c)(1)(ii) which removes the requirement that a provider obtain the written permission of an enrollee to file an appeal on behalf of the enrollee. The right to seek review of an adverse beneficiary determination is personal to the enrollee. Section 1932(b)(4) clearly requires that provider must be acting on behalf of the enrollee. The State should be allowed to verify that the provider is acting with the authorization of the enrollee through a written statement from the enrollee. This insures

that administrative resources are not wasted on an appeal that the enrollee does not desire, or requested without clear authorization from the enrollee, and may be driven by the provider's self-interest. In Arizona's experience, providers have filed appeals on behalf of AHCCCS members without written consent where additional information has disclosed that members were unaware of the appeal, did not wish to pursue the appeal, and the provider filed the appeal due to financial considerations and not based on the interest of the member. The possibility of duplicate appeals (one by member and one by provider) may also result because the provider is not required to obtain the member's consent. Should the proposed language be adopted, Arizona anticipates a substantial increase in appeals initiated exclusively due to provider financial considerations. If the proposed language is adopted, administrative oversight will be necessary to identify appeals arising from conflicts of interest.

- Arizona does not maintain an online system that permits enrollees to file grievances or appeals or that permits enrollees to access the status of grievances and appeals. Neither does Arizona require MCE's to maintain such an online system. Arizona needs to address several challenges as part of an implementation of online appeals. First, if not implemented in a thoughtful, deliberate and well-coordinated manner, operation of an online system at both the MCE level and the State level could increase enrollee confusion regarding where to file and who is responsible for handling the grievance or appeal. In addition, online access poses security and privacy issues that will need to be addressed by the State and/or MCEs that have not already established secure online communications compliant with State and Federal standards. Establishment of an online system increases the risk of costly breaches of the online system and potential adverse impacts to enrollee privacy. Any future requirement for an online system should include a minimum of three years of lead time for implementation and be funded with enhanced Federal Financial Participation.

#### **§438.406-Handling of grievances and appeals**

Summary: Expands the decision making exclusion for grievances and appeals to include "subordinates of individuals involved in any previous level of review or decision making" as an additional level of member protection. 438.406(b)(2)(iii) expands information that decision makers must consider for grievances and appeals to align with "disclosure standards applicable to private insurance and group health plans" to include all comments, documents, records and other information from the enrollee or the representative, irrespective of whether the information was initially submitted or considered in the original determination. Proposed 438.406(b)(5) specifies that the MCE must *furnish*, without cost to the member, the case file and any new or additional evidence relied upon in connection with the adverse benefit determination prior to the resolution timeframe. The current rule requires that the MCE provide the member with the *opportunity to examine the case file*.

- **Recommendation:** Arizona recommends retention of the current decision maker exclusion and does not support expansion of the exclusion to the subordinate level. With more than one and one half million members in MCEs, Arizona has not received complaints from beneficiaries dissatisfied with the existing structure, design, or protections. The substantial costs associated with hiring new staff and restructuring existing processes to comply with the expanded safeguard, without demonstrated need, is unreasonable and unnecessary.
- Arizona recommends retention of the current rule where the MCE is required to provide the information *only* upon request by the enrollee or representative. Under the current process and regulatory requirements, this material is easily accessible to enrollees upon request, and the information is provided without charge. Despite the million plus members in MCEs and a robust and experienced grievance system, Arizona is unaware of situations where members have not timely received information they have requested during the grievance and appeals

process. To the extent a concern is identified, it is more efficiently addressed on a case by case basis. Significant administrative costs will be needlessly incurred by MCEs if they must automatically provide material to enrollees that may not be of interest or value to them, particularly given the lack of indication that the current process is unresponsive to members.

#### **§438.408 Resolution and notification: Grievances and appeals.**

Summary: Revises timeframes for MCE's to decide expedited appeals, imposes new requirements for notice standards for extensions, and mandates a 120 time period for enrollees to file a request for State fair hearing. 438.408(b)(3) modifies the expedited resolution timeframe from 3 working days to 72 hours. 438.408(f)(2) removes the Agency's discretion in establishing timeframes for enrollees to request a hearing (currently, not less than 30 nor more than 90 days) and mandates that enrollees be afforded a 120 day filing timeframe from the date of the MCE's notice of resolution.

- **Recommendation:** Arizona supports alignment of grievance and appeals process with Medicare. Since all of our plans are D-SNPs, maintaining separate processes for the two lines of business is inefficient for MCOs. However, States and MCOs should be given sufficient time to transition to the new time frames for the expedited resolution due to the significant operational difficulties associated with the change (e.g., building staff infrastructure for MCEs when the appeal is filed on a Wednesday, Thursday, or Friday).
- Arizona opposes the proposed amendment of 438.408(f)(2) to expand the time for requesting a State Fair Hearing from a range of 20 to 90 days to a fixed 120 day period. First, the State questions CMS premise that 120 days is necessary to “give enrollees more time to gather necessary information, seek assistance for the SFH process and make a request for a SFH.” Prompt resolution of appeals is in the mutual interest of all parties. It is not unreasonable to require an enrollee to provide prompt notification of the enrollee's desire for a SFH, and, if an enrollee believes that more time is necessary to prepare for hearing, the enrollee may request continuation of a scheduled hearing. This is a common practice that has not resulted in any adverse consequences to enrollees. Additionally, it has been the State's experience that there are significant issues that arise with retroactive coverage which are exacerbated by extending the request for hearing timeframe to 120 days. Direct reimbursement of the member is difficult, if not impossible, for the MCE to encounter as a covered service. Frequently, if the enrollee has paid out-of-pocket pending the appeal, the health care provider is reluctant to reimburse the enrollee and accept the MCE's contracted rate (if there is one). This problem is multiplied if the enrollee received services from an out-of-network provider, a provider not registered with the State Medicaid program, or a provider debarred from the Medicaid program. While these issues exist under current regulations, extending the time for a decision to pursue a SFH intensifies these difficulties with little appreciable offsetting benefit to the enrollee. Additionally, the expanded request for hearing time frame implicates treatment decisions because the time period between filing the authorization request and completion of the hearing process would be lengthened by 3 months in Arizona's program. The member's condition and health status may deteriorate due to the extended time period in completing the administrative hearing process, making treatment more costly if the health condition is exacerbated by the delay. Furthermore, due to the extended timeframe for completion of the hearing process and the expanded 120 day filing timeframe, members may be enrolled with different MCEs when the Hearing Decision is issued, presenting issues regarding MCE liability for coverage and payment
- For clarification, Arizona recommends that the proposed reference to 438.10 in 438.408(d)(1) and (2) point more specifically to the language and format requirements of 438.10(d).

**§438.420 - Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending**

Summary: Although the language of proposed 438.420(c)(4) has not been revised, the Preamble at page 31139 recommends continued services *without interruption* throughout the appeals process *regardless* of authorization or services. 438.420(d) adds the requirement that in order for MCE's to recoup costs of services from members, the ability of the MCE must be specified in contract AND the recoupment practices must also be consistently applied within FFS and managed care systems. CMS affirmatively requests comments to the proposed revisions to 438.420.

- **Recommendation:** Arizona opposes the proposal to require uninterrupted services throughout the appeals without consideration of service or authorization limits as suggested in the Preamble for 438.420(c)(4). It is worth noting that this proposal is not discussed in the Preamble discussing Subpart F or in the language of the proposed rule itself. Mandating continued services beyond the service limits or those specified in the service authorization throughout the entire appeals process conflicts with service delivery models based upon medical necessity, principles of cost effectiveness, efficiency, utilization review functions, and rate setting.
- In light of the concerns regarding uninterrupted services without regard to service limits/authorizations, Arizona recommends that 438.420(b) be modified to add the following two additional conditions:
  - (3) the services were ordered by an authorized provider and continuation of the services is consistent with the amount, duration, and scope ordered by the authorized provider.
  - (6) continuation of the services beyond the period covered by the original authorization do not exceed quantitative limits for the service described in the State plan unless the appeal explicitly contests whether the quantitative limit has been reached.
- Arizona recommends that similar language be added to (c) regarding the duration of continued benefits.
- Arizona opposes the proposed language in 438.420(d) that requires consistency in FFS and MCE recoupment policies. Although it is not routine for the Agency or MCEs to actually recoup costs, mandating a uniform approach for all MCEs and FFS does not promote flexibility and eliminates Contractors' discretion to tailor processes to their needs- regardless of the proposal to eliminate restrictions for continued benefits. If continuation of benefits is available without interruption regardless of authorization timeframe/service limits, then recoupment of costs will be mandatory, likely resulting in greater burdens for members and additional administrative processes for Contractors.
- Arizona requests clarification of the final sentence of 438.420(d) indicating that "practices" of MCEs recoupment of the cost of services provided pending an appeal must be "consistently applied" across managed care and FFS. Both the proposed language of 438.420(d) and 431.230(b) provide that the MCE or State "may" institute recovery of the costs. This implies that the both the State and MCEs have the discretion to make decisions on a case-by-case basis whether the cost or recovery outweighs the value of the recovery that can be expected. The State has never interpreted the discretion in 431.230 or the current version of 438.420 to mean that the State and MCE only have the choice of collecting all costs from all beneficiaries or no costs from any beneficiaries. The possibility of recovery of the cost of benefits provided pending an appeal is an appropriate deterrent to frivolous appeals; however, States and MCEs should clearly be provided the discretion to actually pursue recovery when cost effective.

#### **§438.424 - Effectuation of reversed appeal resolutions**

Summary: For denials and terminations reversed on appeal or through the hearing process, mandates provision/authorization of service no later than 72 hours from the date MCO receives notification of reversal. The Preamble at page 31107 solicits comments regarding reasonableness of 72 hour timeframe for MCO to provide/authorize services. 438.424(b) limits discretion of MCO to recover monies for services provided during appeal when "denial" is upheld in accordance with State policy and regulations.

- **Recommendation: As stated in comments to proposed 438.408, States should be given sufficient time to transition to a 72 hour timeframe for authorization or provision of a service.**
- **Arizona opposes the limitation regarding recoupment of costs as discussed in comments to proposed 438.420(d).**

## SECTION 6: PROGRAM INTEGRITY

### §438.602 - STATE RESPONSIBILITIES

Summary: Replaces the basic rule in its entirety and creates a new section that contains all responsibilities associated with program integrity, including monitoring of contractor compliance, screening, enrollment and revalidation of providers, review of ownership and control information, conducting federal database checks and periodic audits, receiving and investigating information provided by whistleblowers, posting certain information on the State website or making it available, upon request, implementing contractor safeguards, and implementing restrictions with regard to entities located outside the United States.

- **Recommendation:** States should not be required to post data as proposed. The display of disclosure information is inappropriate, potentially in conflict with the Social Security Act and the Internal Revenue Code, and increases the risk of identity theft and fraud. Proposed section 438.602 conflicts with the federal Health Privacy Information Rules found at 45 CFR Part 164. Specifically subsection (g)(2) requires the State to post to its web site or make available on request “the data submitted under section 438.604.” In turn, section 438.604(a) lists several data sets that contain confidential or sensitive information. Subparagraph (1) lists “encounter data in the form and manner described in section 438.818.” Section 438.818(a)(1) requires the State to submit “enrollee encounter data reports that must comply with the [HIPAA] security and privacy standards and must be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system.” Based on the current MSIS data dictionary (see <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/msis/downloads/msis-data-dictionary.pdf>), the required submission includes claims level data that is replete with data elements that are considered protected health information under 45 CFR 164.514. Under the Privacy Rule, it is permissible for a State Medicaid agency to share protected health information with CMS without individual authorizations for a number of reasons including CMS’s role as a health oversight agency. See 45 CFR 164.512(d). However, there is no provision in the Privacy Rule that permits the disclosure of this information to the public as required by proposed section 438.602. Nor would that be desirable from a policy perspective. Similarly, section 438.604(a) requires the State to submit - and section 438.602(g) requires to State to make publicly available - the data on the basis of which the States certifies the actuarial soundness of managed care rates. Under 42 CFR 438.5(c) that data includes “all validated encounter data.” If it is the intention of CMS that this data be de-identified as required by 45 CFR 164.514 prior to public display, section 438.602 should state that. Even if that is the intention, Arizona objects to this requirement for several reasons. First, Arizona receives between 10 to 12 million encounter records from managed care entities every month. The sheer volume of data would be overwhelming to the general public. Second, even the redacted data would be a series of records containing data – most of which are numeric codes such as NPI’s and CPT’s - that would be incomprehensible to the general public. Third, it is administratively inefficient to require every State Medicaid program to display this information rather than to have CMS provide summary information by State since CMS will receive the data as part of MSIS or its successor. In addition, section 438.604(a)(6) requires the State to submit – and section 438.602 would require the State to display – information on ownership and control described in section 455.104 regarding managed care entities. That federal regulation requires the disclosure of the name, date of birth, and Social Security Number of every person with an ownership or control interest and every managing employee as well as the tax identification number of any corporate entity with an ownership or control interest in a managed care entity. It is the State’s position that the display of this information is inappropriate,

potentially in conflict with the Social Security Act and the Internal Revenue Code, and increases the risk of identity theft and fraud. It would be more beneficial for CMS to provide summary information by State since CMS receives the data as part of MSIS or its successor and it could do so in a standardized format so that it is user friendly.

Summary: 438.606(a): Eliminates the option for MCOs to delegate attestation of data submitted to State; the attestation must be made by the CEO or CFO. Subsection (b) requires attestation to be made only after the entity has conducted a reasonably diligent review of the data. Subsection (c) requires that the attestation be submitted concurrently with the data.

- **Recommendation:** Arizona recommends that the regulation not be amended or that the requirement for attestation concurrent with submission of the data be modified. Encounter data containing tens of thousands of records are submitted by MCOs to the State on a daily basis. It is not practical to expect that the CEO or CFO can personally attest to a reasonably diligent review of the data with each file submission. At a minimum, the proposed rule should be modified to permit a retrospective attestation on a less frequently basis or upon request of the State so long as the attestation is provided before the data is used by the State for rate setting.

#### **§438.608 - PROGRAM INTEGRITY REQUIREMENTS UNDER THE CONTRACT**

Summary 438.608: Program Integrity Requirements under Contract. The term “subcontractor” is used throughout the proposed regulation.

- **Recommendation:** The proposed regulation should clarify that term “subcontractor” has the same meaning as defined in 42 CFR Part 455 or, if a different meaning is intended, the term should be defined for purposes of this provision to clarify whether it applies to an MCO’s subcontractors as referenced in 438.230, network providers, or both.

Summary 438.608(a)(1)(vii) Establishment and implementation of procedures: Adds specific details regarding procedures for internal monitoring and auditing as well as reporting compliance problems. In addition, it opens the possibility for MCOs to coordinate suspected criminal acts with law enforcement entities. Also proposes to apply these requirements to PAHPs and subcontractors.

- **Recommendation:** The parenthetical in the rule referring to a MCO, PIHP or PAHP’s “coordination of suspected criminal acts with law enforcement agencies” is unclear and should be deleted or its relation to the rest of the provision should be clarified. In addition, this language could be construed to require the MCO, PIHP or PAHP to coordinate its investigation or correction of internal compliance issues with law enforcement agencies rather than the State Medicaid agency, which would undermine the State Medicaid agency’s oversight authority. The goal of quickly addressing potential criminal violations is addressed by the prompt reporting/referral provisions of proposed 42 CFR 438.608(a)(2) & (a)(7), and the State Medicaid agency’s obligations under 42 CFR Part 455, Subpart A to conduct investigations and refer certain cases to the Medicaid Fraud Control Unit. The omission of the parenthetical language would also preserve States’ flexibility with regards to the investigation of criminal activity.

In the alternative, if CMS desires to write regulation language designed to achieve the goal of more effective coordination among managed care entities, the State and MFCU (as documented on page 31130 of the Preamble), CMS could add a clause to proposed 42 CFR 438.608(a)(1)(vii) requiring “cooperation with the State Medicaid program integrity unit and the State Medicaid Fraud Control Unit as directed in the State’s contract with the MCO, PIHP, or PAHP.” The OIG’s ability to coordinate diminishes when the MCOs are reporting and coordinating directly with law enforcement agencies, including MFCU, resulting in an inefficient system wide. Under CMS’s proposal, the SMA will have to then coordinate with 16 plans, approximately 1,500 referrals annually, approximately 800 cases annually, and a large range of federal and state law enforcement and other types of entities. OIG has found that a centralized reporting mechanism allows the state to track referrals, cases, recoupments and impose penalties as needed. By example, there may be instances in which the criminal activity reported by one MCO may involve another MCO(s) or other providers that are contracted with several MCOs, this increase the possibility of conflict of interest amongst our contractors; and the best interest of the state may not be served. OIG has a concern that in some instances in which an MCO will have a case against a provider, they will not have the information regarding other contracts in place with other MCOs, nor will the other MCOs know about the case and its implications. Finally, the OIG houses the provider registration section responsible to gather all information related to network and FFS providers. For several reasons the provider enrollment information is guarded at OIG and it is not open for the public or MCOs. This information is critical to access when looking at potential cases and referrals.

Summary 438.608(a)(2) prompt reporting of improper payments: Requires MCOs to promptly report all improper payments identified or recovered, specifying the improper payments as a result of potential fraud, to the State or law enforcement.

- **Recommendation:** The provision that refers to reporting is comprised of various factors. In order for the MCOs to report the overpayments derived from fraud, waste, and abuse, they must first identify such overpayment, determine the appropriate FWA status, and then proceed with the recoupment. The reporting piece is just a consequence of the first elements mentioned. CMS should reevaluate this provision to clarify that the States will have the ability to determine those processes in which a case is identified for potential overpayment, the process in which the actual recoupment will be based, to include the frequency and content of the report of overpayments under fraud, waste and abuse to the SMA. In addition, Arizona recommends that the subsection should end by replacing the term “the State or law enforcement” with “the State and the State Medicaid Fraud Control Unit as directed in the contract between the State and the MCO, PAHP, PIHP.” This affords flexibility to the State in the design of effective systems for the identification and elimination of fraud, waste and abuse.

Summary 438.608(a)(7): Prompt referral of FWA: Requires MCOs to promptly refer all potential cases of fraud to the State Medicaid Program or the State Medicaid Fraud Control Unit (MFCU).

- **Recommendation:** In the Preamble at 31130, CMS clarified its position that States with an MFCU may choose, as part of the State’s contracts with MCOs, PIHPs or PAHPs, to stipulate that suspected provider fraud be referred only to the MFCU, to both MFCU and the State Medicaid program integrity unit, or only to the State Medicaid program integrity unit. Arizona

requests that CMS make this clarification explicit in the rule as the proposed language suggests that a MCO, PIHP or PAHP could choose where it refers suspected cases of fraud. Such a clarification would allow State Medicaid programs with established and proven mechanisms to combat fraud waste, and abuse, continue to manage their programs rather than disrupt systems that already work, potentially creating confusion and having cases fall through the cracks. In Arizona, the collaboration between the State Medicaid agency and the MFCU allows for the centralization of all investigations and referrals avoiding potential duplication of efforts and reducing the administrative burden when coordinating multiple MCO cases and referrals. CMS should eliminate this possibility for the MCOs to directly refer cases to MCFU, and allow the States to determine if and when cases should be directly referred to the MFCU to avoid duplicative processes and miscommunication which will lead to a number of inefficiencies in the system.

Summary 438.608(b)(3)(i): Requires MCO and subcontractors to report enrollee returned mail. Similarly, sub (ii) requires reports of enrollee change in income.

- **Recommendation**: Arizona requests that these provisions be deleted. In the normal course of conducting business, it is unlikely that an MCO would receive reliable information regarding the income of an enrollee. With respect to reports of mail returned to the MCO, the proposed regulation implies that CMS expects the State to take some action with respect to such a report from the MCO. However, it is unclear what CMS expects the State to do with this information. Loss of contact is not in and of itself a basis for taking any action with respect to eligibility or enrollment. Arizona assumes that CMS would expect the State to validate that the address is no longer valid; that is, whatever action CMS expects the State to take should not be based exclusively on mail returned to the MCO. In many instances, the enrollee may have moved within the GSA or the State which would have no impact on enrollment or eligibility. Requiring the state to initiate a review of eligibility based on every piece of mail returned to an MCO imposes an administrative burden that doesn't seem to be counter-balanced by any advantage to the Medicaid program.

Summary 438.608(d) treatment of recoveries: Allows MCOs to retain recoveries.

**Recommendation** States should have the flexibility to determine other incentives or contract provisions that allow plans to retain recoveries. In addition, the States should have the flexibility to develop a shared savings approach that could be more cost effective and remain administratively advantageous for the States to manage. CMS should provide clarification to include language regarding the federal government and or the States retaining the appropriate share of the overpayments the government recoups.

Summary 438.608(d)(2)Overpayments: Requires each MCO, PIHP, and PAHP to require, and have mechanisms for, network providers to report and return overpayments to the MCO, PIHP or PAHP within 60 calendar days of their identification. Rather than the MCO, PIHP, or PAHP returning the overpayments to the State, CMS proposes that plan contracts specify that the MCO, PIHP, or PAHP should retain overpayments recovered from providers. States would then be expected to take such recoveries into account in developing future actuarially sound capitation rates based on information provided by the plans. States would be required to collect reports from MCOs, PIHPs, or PAHPs about their recovery of overpayments.

- **Recommendation:** The proposed rule raises concerns regarding the impact of such recoveries on plan capitation rates, particularly given the proposed rule's attention to actuarial soundness and rate setting. The proposed language of this provision notes that overpayments occur for several reasons, the process of FWA being just one of them. In Arizona, these overpayments are to be reported within 60 days upon discovery. However, under program integrity and due to FWA determinations, the overpayments are always an exclusive task of the OIG. States should have flexibility to incorporate language into their contract regarding the implementation of processes for recoupment of overpayments as suggested in the Preamble. The regulatory language should be clarified to give the States the authority and flexibility to implement such recommendation.

## SECTION 7: ENROLLMENT

### §438.10 - Information requirements

Summary: Adds significant prescriptive requirements and timeframes for beneficiary communications, including how enrollee materials and notices are written. Additionally, many terms are not defined leaving them open to interpretation. State Medicaid programs are also required to list provider group affiliations, websites and office accessibility in the Provider Directory and timelines for updating the Directory.

- **Recommendation:** The proposed requirements are administratively burdensome for State agencies. Requiring tag lines for all written materials in at least 18 point font in each prevalent language poses increased costs. Regarding the Directory, a number of MCOs contract with different providers and are already required to post and update this information on each of their websites. Requiring state Medicaid agencies to update their website within 3 business days of any changes creates unnecessary administrative burdens when MCOs have the most available and up to date information about the providers with which they contract. MCO's are in the best position to be responsible for keeping such information updated.

Arizona provides additional comments in Section 3 of this submission –Managed Care Operations.

### §438.52 – Choice of MCOs, PIHPs, PAHPs, PCCMs and PCCM Entities

Summary: Changes the rural area exception for the purposes of choice requirements.

- **Recommendation:** Arizona supports the modification of the definition of rural for the purposes of determining whether MCO choice must be offered. We agree that the intent of the rural exemption is to recognize challenges unique to rural areas, and that the current definition of rural excludes areas in many states that are very clearly rural, or even frontier, in nature by any definition except the current Metropolitan Statistical Area classification. Our research confirms that the Medicare county definitions would, in Arizona, more appropriately reflect the rural areas in the State, and we strongly support this change.
- CMS should also consider, however, whether there should be additional flexibility around choice requirements for programs that serve smaller populations such as MLTSS plans. In those cases, even some areas categorized as “Metro” areas may not have sufficient program enrollment to ensure multiple plans are financially viable and can maintain sufficient networks. At a minimum, CMS should continue to consider waivers of choice in these circumstances.

### §438.54 - Managed Care Enrollment

Summary: Requires that members receive 14 days of fee-for-service to provide an opportunity to select a health plan, rather than auto-assignment into a plan. Auto-assignment would be permitted only after a minimum 14-calendar-day time period of fee-for-service coverage during which beneficiaries can make an “active choice” of their managed care plan. Also proposes standards for consistent informational notices to beneficiaries and use of default enrollment processes. For CHIP, the proposed rule sets standards for States that assign a child to a plan when the family does not pick one.

- **Recommendation:** Arizona strongly opposes the requirement for 14-day FFS coverage before enrollment in an MCO due to the profound negative implications for quality of care. States have had successful processes that assure informed member choice while still providing the benefits that managed care offers members immediately. This is a hugely significant policy shift that will impact hundreds of thousands of members in Arizona every year, adversely affecting care coordination with potentially grave consequences for persons with chronic

health conditions as well as other high-risk populations. For example, in March 2015 alone, 57,362 additional members would have been enrolled in FFS coverage for more than two weeks each under this provision. Members in Arizona's Medicaid program are satisfied with the current process as shown by the extremely low percentage of members who changed plans after they were auto assigned: During March and April of 2015, less than 2% of the total number of enrollees changed plans. CMS should not require the 14 day FFS coverage for the following reasons:

- This mandate is a step backward for States like Arizona with mature managed care in place since its inception. CMS did not provide any data or information to quantify and justify why this proposed rule was established. In Arizona, the MCO is responsible for prior periods which help them manage quality of care for new beneficiaries. It is paternalistic to assume that members who choose a plan upon enrollment do not do so in an informed manner and it is frankly unnecessary, given that members can change plans within the first 90 days of enrollment.
  - As proposed, there would be increased burden on State agency staffing and operations for already scarce resources. There are significant operational burdens in processing authorization requests for services, reviewing and processing claims, and grievances in a temporary FFS program. This also significantly increases the number of appeals and claim disputes for all issues that would arise during an expanded FFS window. Additionally, having a FFS period for every member would require significant increase in administrative costs to process FFS claims, prior authorization, etc.
  - There is no provision to address returning members who were previously enrolled in a Medicaid managed care plan to promote continuity of care. Data from March and April 2015 shows roughly 30% of enrollments were Arizonans who had been enrolled in a plan within the previous 90 days. It is nonsensical, disruptive to the member, and wasteful of taxpayer resources to require a FFS enrollment period for these individuals.
  - Arizona disputes that this process would provide sufficient benefit to the member to outweigh the significant administrative costs associated with this requirement. In fact, the requirement places an undue burden on members with complex physical and behavioral health care needs, including pregnant women, by delaying the care coordination and other benefits that they would otherwise receive immediately through an MCO. It is also confusing for members to completely shift how services are received, and it additionally results in an unnecessary transition of care between FFS and the MCO that will have negative consequences for members and providers.
  - In reality, the 14 day choice period is in effect a mandatory fee-for-service window of at least 17 days when the three day mailing period is included. For beneficiaries who select a plan on the 17<sup>th</sup> day, much longer FFS periods can result from delays as the request is processed, needlessly depriving the beneficiary of care management.
- **Arizona provides additional comments in Section 2 – Medical Loss Ratio Standards**

#### **§438.56 - Disenrollment: Requirements and limitations**

Summary: Clarifies the statutory 90-day disenrollment-without-cause protection and State obligations surrounding the disenrollment process.

- **Recommendation:** The proposed rule should not allow for disenrollment when a residential, institutional, or employment supports provider exits the network without any limits. For example, if a particular home health agency exits the network, members may not need to disenroll because many times home health aides leave one agency to work at another agency

still in the MCO's network and available to the member. If a provider is termed due to FWA or quality of care concerns, that is not a reflection of MCO performance and should not trigger choice. CMS should clarify that enrollment in Long Term Care is not disenrollment from acute due to health status. CMS should also clarify that electronic methods such as telephone calls and e-mails can be used to inform members of their annual enrollment. Finally, States with Waivers from this requirement should be able to maintain them.

#### **§438.71 - Beneficiary support system**

Summary: Provides for additional beneficiary supports for both potential enrollees and those changing plans. Requires States to furnish support using multiple platforms—phone, Internet, in-person, and auxiliary aids, as needed.

- **Recommendation**: CMS should not prescribe the details on how States should develop a beneficiary support system. Arizona has over 142 Community Partner Organizations throughout the State that already assist beneficiaries with many of the proposed elements. Additionally, State Medicaid agencies are responsible for the administration and oversight of its operations and requiring the proposed beneficiary support system would cause unnecessary administrative burdens and costs. Furthermore, some enrollees may not want choice counseling in the first place. CMS should amend the language to reflect that choice counseling can “be made available” rather than “provided to.” Should CMS require States to perform outreach, it should clarify the definition or scope for outreach. Finally, as it relates to LTSS, section (e)(2) implies required contact with all LTSS members rather than assistance upon request. CMS should clarify if “additional resources” are the same as the provider training resources.