



July 23, 2015

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

RE: File Code CMS-2390-P

Dear Sir/Madam:

The Home Care Association (HCA) of New York State applauds the U.S. Centers for Medicare and Medicaid Services for recognizing that changes in the delivery of health care services covered by Medicaid necessitate revisions to the rules governing managed care. HCA makes the following additional recommendations to improve the delivery of such services for patients and providers.

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 300,000 Medicare and Medicaid patients in New York State. HCA's members include Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCP) providers, Licensed Home Care Services Agencies (LHCSAs), providers of various waiver programs, Managed Long Term Care plans, hospices and others. HCA's home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

Our comments are based on experiences of our members who provide a variety of skilled and non-skilled services to multiple populations in their homes and who have delivered services in a state that has shifted its home care and larger health system from Medicaid fee-for-service (FFS) to managed care since 2011.

Issues

Misalignment between Federal and State Regulations for Home Care

CMS's proposed rule needs to recognize the misalignment between any state and federal regulations, including the Medicare Conditions of Participation (CoPs), governing providers who operate in a managed care environment. The delivery of home and community-based services ("home care" services) in New York and some other states is

increasingly shifting away from the traditional Medicaid fee-for-service system. This means that services are moving from the authorization and oversight of the local social services departments and providers – for purposes of assessment, service planning and delivery, and care management – to the managed care plans, which are subject to different rules, procedures and norms in their execution of these functions.

The situation is compounded in New York, which separately regulates state-licensed home care services agencies (“Licensed Home Care Services Agencies”) in a distinct manner from Certified Home Health Agencies. New York also regulates managed care and managed long term care plans in a manner that allows plans to contract for and broker home care services across different types of agencies on an individualized provider basis, procuring one service from one agency, another service from another, and so on. This approach to delivery runs contrary to the consolidated, comprehensive home care model envisioned and regulated under the COPs.

This misalignment has been leading to duplication of procedures, services, administrative tasks for home care providers and managed care plans, increased costs, and confusion for staff and patients alike. Conflicting federal policies, regulations and operating procedures between these – i.e., provider-based versus managed care – delivery paradigms need to be addressed in any proposed federal changes to Medicaid managed care.

Recommendation

CMS should allow states to streamline, waive or otherwise align some federal regulations that contradict their own regulations pertaining to home care services delivered to managed care enrollees as long as the state can demonstrate that there will be no adverse effect on patient care. In addition, CMS should require states to clarify which rules their home care providers must abide by when there are conflicts, duplication or other instances of incongruity between federal and/or state regulations, and provider-based and managed care models.

Actuarial Soundness of Rates

While the proposed regulations cover the area of actuarially sound capitation rates by states for managed care plans, one glaring omission is actuarially sound rates for network providers. Although proposed section 438.6(4)(c)(iii) would allow states to require plans to adopt a minimum fee schedule for all providers that provide a particular service under the contract, this does not adequately address the issue of provider rates.

Recommendation

States should have to demonstrate that the rates paid by managed care plans to their home care and other providers are actuarially sound. When determining actuarially soundness, states should be required to include wage and benefit costs, including any mandated pay

levels for staff, overtime, workers compensation health insurance, vacation and sick time, etc.; health information technology; quality assurance; emergency preparedness; corporate compliance; recruitment, retention and training costs due to changes in the health care delivery system; and other areas.

In addition, states should be required to include these costs when establishing rates for managed care plans.

Disenrollment

Per 438.56(d)(2)(iv), consumers receiving long term services and supports (LTSS) may disenroll from a managed care plan in cases where, absent disenrollment, the enrollee would have to “change their residential, institutional, or employment supports provider based on that provider’s change in status from an in-network to an out-of-network provider. . . .” However, there is no option for a consumer to disenroll if his or her home care provider changes to out-of-network status.

Recommendation

HCA requests that this proposal clearly include circumstances where an enrollee’s home care provider changes from in-network to out-of-network, in addition to the circumstances already accommodating disenrollment. Enrollees develop strong relationships with their home care providers, and if the provider leaves the plan’s network, enrollees should be allowed (if they so desire) to enroll in another plan served by that provider to ensure continuity of care.

Transition of Care

Under proposed 438.62(b), the state must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to managed care or transition from one managed care plan to another when an enrollee, in the absence of continued services, would *suffer serious detriment to their health or be at risk of hospitalization or institutionalization*. Also, the transition of care policy must allow enrollees to have access to services consistent with the access they previously had, and permit the enrollees to retain their current provider for a period of time if that provider is not in the managed care plan’s network.

We believe that this is insufficiently protective of the consumer and that the transition of care should also apply to any enrollee who is receiving home care services and is mandated to enroll into a managed care plan. The “forced transition” of the consumer carries risk necessitating continuity of care provisions, without also having to meet the proposed additional “medical risk” standard, and regardless of whether the service provider is in the plan’s network.

Recommendation

When consumers receiving home care services under Medicaid FFS are required to enroll into a managed care plan, they should be allowed to receive the same level and type of services from their current provider for at least 90 days without having to demonstrate the proposed standard of “*serious detriment to their health or be[ing] at risk of hospitalization or institutionalization.*” In addition, plans should be required to reimburse providers for at least the same amount as the providers were receiving under FFS.

State Monitoring Requirements

The proposed rule (438.66) lists many areas that states must monitor for their managed care plans including appeals and grievance systems, claims management, medical loss ratio, marketing, program integrity and others. Two additional areas needed are timeliness of claims paid for LTSS services and adequacy of rates paid to LTSS providers. In New York, we have found that there have been long delays by many plans in paying for LTSS and this has adversely impacted the financial solvency and operations of providers. In addition, the rates paid to LTSS providers have not been adequate enough to meet the providers’ costs in delivering care, including wage and labor mandates, necessary infrastructure expenses, and staff compensation.

Recommendation

States should be required to monitor the timeliness of claims paid by plans for LTSS and the adequacy of the plans’ rates for such services. The plans should have to demonstrate that they meet “prompt pay” requirements, and that the rates paid to their contracted home care providers take into account the costs incurred by LTSS providers outlined in the “Actuarial Soundness of Rates” section.

Grievances and Appeals

Section 438.408 (f)(1) seems to require an enrollee to first request an internal plan appeal before being allowed to utilize the state fair hearing process. If this interpretation is correct, we point out that this is contrary to New York law.

Recommendation

CMS should clarify if the proposed rule is intended to require Medicaid managed care enrollees to utilize the plan’s internal appeal process before the state fair hearing process, and, if so, how this is to be reconciled with states that have conflicting practices.

Aid Continuing

While the preamble (page 31139) indicates that the proposed rule would eliminate the link between the duration of continued benefits pending appeal and the original authorization period, section 438.420(b)(4) includes a provision that one of the requirements under which plans must continue the enrollee's benefits is that "the original period covered by the original authorization has not expired."

HCA seeks clarification on this provision and notes that New York currently allows for aid continuing even if the original authorization period has expired.

State Responsibilities and Provider Screening and Enrollment

The proposed rule [438.602(b)] would require that states must screen, enroll and validate all network providers and separately require that all network providers be enrolled with the state as Medicaid providers [(438.608(b)]. We presume that the managed care plans could be designated by the state to screen its network providers.

Recommendation

Medicaid managed care plans – rather than the state – should be the entity responsible, and accountable for screening their network providers, rather than mandating a separate state-conducted screening and validation process.

Additional Areas

Two additional areas not addressed in the proposed rule are: uniform billing codes and identifiable contacts in managed care plans for resolving issues with providers.

Uniform Billing

New York home care providers who bill managed care plans have found that plans use their own set of codes for billing LTSS, and while there is some overlap, each plan still uses a multitude of codes. This necessitates lots of resources by providers to ensure that they use the correct code and resources by plans to address provider coding issues. CMS could rectify this resource-intensive task by requiring plans to use uniform codes for similar services. New York State has just passed legislation that requires uniform billing codes and we suggest that this be a federal requirement.

Plan Contacts

New York home care providers have also encountered many instances where they need to contact a managed care plan about a reimbursement, clinical or other patient issue and

encounter difficulties in obtaining the appropriate person. We recommend that plans be required to post and update contact information for their contracted providers. This would save time and other resources by both providers and plans.

Thank you for the opportunity to offer our comments on the proposed rule. If you have any questions or need additional information, I can be reached at (518) 810-0662.

Sincerely,

A handwritten signature in black ink that reads "Andrew Koski". The signature is written in a cursive style with a small superscript "e" at the end of the last name.

Andrew Koski
Vice President, Program Policy and Services