July 27, 2015

Mr Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P
PO Box 8016
Baltimore, MD 21244-8016

Dear Mr Slavitt:

On behalf of Altegra Health, I am pleased to submit the following comments in response to CMS-2390-P, a proposed rule that would modernize the Medicaid managed care organization (MCO) regulations to reflect changes in the usage of managed care delivery systems.

Altegra Health supports health plans operating in Medicaid managed care programs across the country. As such, it has a unique perspective regarding the operational feasibility of certain proposed reforms, as well as their impact on MCO beneficiaries. Altegra Health applauds CMS's effort to modernize the MCO regulations, including their alignment with Marketplace and Medicare standards. Altegra Health would like to submit the following recommendations, which are discussed in greater detail below:

- **Risk adjustment**: CMS should require states that risk adjust their health plan payments to make public their risk adjustment model and methodology and should require such states to accept supplemental risk adjustment data submissions based upon medical record reviews.
- **Quality rating system**: CMS should attempt to implement a quality rating system for Medicaid in a shorter time period than it has proposed, which Altegra Health believes is feasible.
- **Care coordination**: CMS should require MCOs to coordinate health care with social and community supports and services and should include such coordination in the medical loss ratio (MLR) numerator and in quality rating measures.
- **Encounter data submission**: CMS should require states to publish clear encounter data submission requirements and CMS should work with states to develop uniform national standards.

About Altegra Health

Altegra Health operates in all 50 states from 7 regional offices, as well as its headquarters in Miami Lakes, Florida, to provide a complete range of services to health plans, health plan members, and providers, including:

- **Risk adjustment and audit**: Risk analytics, encounter reporting, and chart audit/coding solutions
- **Quality performance**: HEDIS®/quality solutions; member healthcare communications
- **Engagement solutions**: Identification and assisted enrollment into government-funded healthcare programs, community assistance programs, and privately-funded programs through our My Advocate™ service

- **Advisory services**: Consulting services that improve performance for health plans and providers

Altegra Health works with some of the largest health plans and providers in the nation, including:

- **Payers**: More than 150 Medicare Advantage (MA), Managed Medicaid, and Commercial Market plans
- **Providers**: Hospital systems, provider groups & integrated delivery networks
- **Other markets**: Accountable Care Organizations (ACOs), health insurance marketplace, ICD-10 transition

The mission of Altegra Health is to help healthcare organizations and their members receive the financial resources and other benefits to which they are entitled, enabling quality care at the right time, leading to improved health at a lower cost, and overall, a better quality of life. Altegra Health utilizes health plan data and Altegra Health's proprietary predictive analytics algorithms to assist health plans in delivering integrated health-related interventions that are specifically tailored to their members. In carrying out this mission, Altegra Health is committed to maintaining the strictest regulatory compliance and data security for health plans and the members that they serve.

Risk Adjustment (§§ 438.5(g), 438.7(b)(5))

CMS proposes to define risk adjustment as a plan payment methodology that accounts for the health status of enrollees across Medicaid MCOs and distinguishes risk adjustment from acuity adjustments that modify payments based upon the health status of the total enrolled MCO population, as compared to a standard population. CMS proposes to require that, to the extent states risk adjust MCO payments, risk adjustment must be budget neutral. CMS also proposes to define prospective and retrospective risk adjustment and to establish documentation standards for each.

Altegra Health works closely with Medicaid MCOs to ensure that they maintain accurate risk scores for their beneficiaries and supports policies that strengthen risk adjustment programs. Altegra Health is one of a few entities with deep and longstanding experience in Medicaid risk adjustment. Altegra Health's proprietary technology and expertise assist MCOs in converting their source data and managing errors to facilitate timely and accurate submission to the states where Medicaid risk adjustment programs exist. Altegra Health's predictive analytics are utilized by MCOs to evaluate the documented health status of their beneficiaries and identify gaps between health status, provider documentation and reported quality scores and risk scores.

Altegra Health supports CMS efforts to standardize definitions for risk adjustment as part of the rate development standards. Altegra Health recommends that, in addition to the proposed regulations, CMS require that states make their risk adjustment methodology publicly available and accept supplemental encounter data submissions.

CMS Should Require that States Make their Risk Adjustment Methodology Publicly Available

Currently, over 30 state Medicaid programs utilize risk adjustment. States currently utilize one of six different methodologies, with approximately 63 percent of states utilizing the Chronic Illness and

Disability Payment System (CDPS) developed by the University of California-San Diego. However, each state implements and updates its risk adjustment system differently, customizing to state actuarial requirements such that even states utilizing the CDPS model implement it quite differently. In many states, the details related to risk model calculations are difficult to obtain by Medicaid MCOs and other entities that rely upon risk scores to manage their beneficiaries' care.

Medicaid MCOs also utilize risk adjustment to project resources necessary to support populations with varied health status, particularly vulnerable populations. The high degree of risk adjustment customization and lack of transparency makes it difficult for MCOs to understand and manage the risk adjustment system. Because risk adjustment is a critical component of managing and delivering quality care for vulnerable populations, Altegra Health encourages CMS to not only standardize definitions, but also require states to make the risk adjustment methodology publicly available as is the case with both MA and Marketplace risk adjustment programs. CMS should clarify that the documentation for the risk adjustment methodology submitted to CMS under proposed section 438.7(b)(5) will promptly be made public.

CMS Should Require State Risk Adjustment Methodologies to Accept Supplemental Submissions

Very few state Medicaid programs that utilize risk adjustment currently permit supplemental data submissions or corrections. Risk adjustment programs are dependent upon encounter data primarily derived from claims systems. For many reasons, claims systems may not provide the full details of risk-adjusting conditions for an individual Medicaid MCO beneficiary. Provider administrative systems may not accurately or completely capture all risk-adjusting conditions. Providers also may not accurately code the conditions. Additionally, electronic medical records, practice management and claims clearinghouse systems may restrict the number of diagnoses sent regarding a claim. Finally, provider contracts under which capitated fees are paid may not require providers to submit to Medicaid MCOs sufficient encounter data to calculate a risk score. It is important for both state and CMS analytics that data include a comprehensive view of beneficiary risk scores. Altegra Health encourages CMS to require states to implement a supplemental data program, utilizing medical record reviews to substantiate and correct insufficient risk score data. Because state risk adjustment programs are budget neutral, a supplemental submission program would not increase overall Medicaid expenditures, but would improve the accuracy of payment adjustments to MCOs.

Quality Rating System (§ 438.334)

CMS proposes to establish a new quality rating system in which all Medicaid MCOs would be required to participate. CMS believes the system would be refined over three to five years prior to its implementation. Altegra Health welcomes the creation of a rating system for MCOs and encourages CMS to implement it in a more expedited manner than the timeline that CMS proposes.

Altegra Health assists health plans in all market segments with the submission of quality data, quality care analytics, provider engagement and member engagement to facilitate quality ratings and related care management. Altegra Health's software has been certified by the National Committee for Quality Assurance (NCQA) for 11 consecutive years. Altegra Health provides analytics to support all types of quality programs, including the MA Five-Star Quality Rating System, Marketplace quality reporting, ACO submission and numerous state quality programs. In addition, Altegra Health's nurse clinical reviewers

are often contracted by MCOs and other entities to review medical records for evidence of quality metrics.

Altegra Health supports the proposal to develop standard quality ratings for Medicaid MCOs. Because many states already require MCOs to provide quality data and because MCOs that do business in either MA or commercial markets are already submitting quality data in those lines of business, Altegra Health believes it would be feasible for Medicaid MCOs to participate in a quality rating system sooner than the timeline CMS proposes. Quality rating systems are vital for beneficiary participation, and Altegra Health encourages CMS to adopt quality standards as soon as possible. Based upon Altegra Health's operational experience implementing quality reporting programs, it believes this is feasible and would be happy to serve as a resource to CMS as it develops this new national rating system.

Further, Altegra Health recommends that the quality rating system applies to all delivery systems including fee-for-service and other emerging delivery systems to ensure a comprehensive approach to quality reporting. Altegra Health also recommends that the quality rating system employ stratification based upon certain populations to ensure a fair and accurate evaluation of quality. For example, Medicaid MCOs serving beneficiaries with special needs should not be compared to those without special needs beneficiaries. Altegra Health has considerable experience serving low-income Medicaid MCO beneficiaries, as outlined in the next section, and recognizes the unique needs of this population and their effects on quality ratings.

Care Coordination Activities (§ 438.2089(b))

CMS proposes to clarify that the services that Medicaid MCOs may coordinate are not limited to healthcare services, and may include social services. Given the well-documented effects of social determinants on health,[1] Altegra Health recommends that CMS explicitly require MCOs to coordinate health care with appropriate community or social supports beyond merely permitting such coordination.

Altegra Health has deep experience in conducting coordination with social and community supports and has seen the dramatic impact coordination with these supports can have in improving beneficiary health. Altegra Health's COMMUNITY Link™ product guides low-income Medicaid MCO beneficiaries through an extensive database of more than 9,000 public and privately-sponsored community programs for which they may qualify. These programs address a variety of challenges to low-income beneficiaries such as transportation, nutrition assistance, medication co-payments, as well as utility or telephone assistance. Altegra Health proactively reaches out to beneficiaries utilizing multi-channel communications and a proprietary eligibility tool to identify programs that a beneficiary may qualify for in his or her geographic area. Further, Altegra Health provides advocacy and enrollment assistance to help beneficiaries access, enroll and continue to benefit from these programs. Altegra Health helps health plan members in all markets secure approximately $150 million in financial benefits through Community Link annually.

---

[1] *See*, *e.g.*, Laura McGovern et al., Health Affairs Health Policy Brief, *The Relative Contribution of Multiple Determinants to Health Outcomes* (2014), *available at* http://www.rwjf.org/content/dam/farm/articles/articles/2014/rwjf415185; John Walton Senterfitt et al., Los Angeles Cnty. Dep't of Pub. Health, *Social Determinants of Health* (2013), *available at* http://publichealth.lacounty.gov/epi/docs/SocialD_Final_Web.pdf.

In addition, Altegra Health provides multiple services that help improve health outcomes for Medicaid MCO beneficiaries by connecting them with care management support solutions. SMART Connect™ utilizes remote, multi-channel technology to provide on-going, interactive, personalized tools, enabling beneficiaries to better manage chronic conditions and stay connected with their MCO and primary care provider. SMART Appointment Scheduling™ utilizes live advocates to assist beneficiaries in securing provider appointments. Providers receive valuable health history information in advance of the appointment and beneficiaries receive recommended screenings and additional education to enhance the provider-patient conversation.

This beneficiary-level interaction has resulted in improved adherence to care plans, which improves care for health plan members. SMART Connect has been successful in receiving responses from approximately 80 percent of the members to whom it reaches out. The average impact of automated communications is between 3–12 percentage points of improvement in compliance levels. For instance, if mammogram rates are currently 65 percent for the health plan, the post-call rate can be expected to be between 68-77 percent. Additionally, members are overwhelmingly supportive of the information and interventions that SMART Connect provides.

Based upon its interactions with Medicaid MCO beneficiaries, Altegra Health encourages CMS to include community or social support services in the care coordination requirements. Community-based services are well received by beneficiaries and can provide relief to economic or other challenges of daily living that create barriers for beneficiaries accessing the health care system and maintaining their care plan. In short, when beneficiaries receive support, they can better maintain their health.[2] For the same reasons, Altegra Health supports CMS's proposal to include care coordination services as a quality-improving activity in the Medicaid MLR numerator. Additionally, Altegra Health recommends that access to care coordination services be an explicit factor in Medicaid MCO quality ratings.

Encounter Data Submission (§§ 438.242(c), 438.818)

CMS proposes to impose new requirements on the accuracy and completeness of encounter data submissions and threatens to withhold federal financial participation if such submissions are incomplete or inaccurate. Altegra Health supports requirements for encounter data submission, which it believes are achievable, but urges CMS to require states to publish complete and easily accessible submission requirements to facilitate this process. CMS should also work with states to create uniform national encounter data submission standards.

Altegra Health currently assists health plans in formatting data for submission to CMS for the MA Encounter Data System (EDS), for EDGE data servers in the Marketplace, and, in many states, for state Medicaid MCO encounter submission. As with risk adjustment, each state has different encounter submission requirements and formats. Documentation for requirements in some states is sparse and difficult to obtain. This makes compliance difficult for MCOs and is especially challenging for multi-state

[2] *See* MaryBeth Musumeci & Erica Reaves, Kaiser Family Found., *Medicaid Beneficiaries Who Need Home and Community-Based Services* 3 (2014), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8568-medicaid-beneficiaries-who-need-home-and-community-based-servcies.pdf.

MCOs and entities such as Altegra Health that support encounter data submission across many states. In order to improve compliance, the submission requirements should be more transparent and uniform.

Although states may have a poor record of submitting encounter data to CMS, Medicaid MCOs are very familiar with encounter data submission requirements and, when required (as is already the case in MA, the individual and small group market, and some Medicaid programs), can successfully meet requirements by accessing support from one or more numerous industry resources. Full compliance from MCOs for encounter submission is achievable. Altegra Health supports the additional requirements and encourages national standards that would create consistent requirements among the states, easing the burden for multi-state plans and entities that support Medicaid MCO encounter submission. Altegra Health also recommends that CMS require states to create thorough documentation and publicly release encounter submission requirements in a method that is easily accessible for MCOs and other entities supporting encounter submission.

Conclusion

Altegra Health appreciates the opportunity to comment on CMS-2390-P. If you have any questions or would like further information about any of the issues addressed here, please do not hesitate to contact me or Tim Jones, Director, Federal & State Government Relations, at 1-877-461-0415, or by e-mail at tim.jones@altegrahealth.com.

Sincerely,

Kevin C. Barrett
President & CEO