

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

July 27, 2015

Vikki Wachino
CMS Deputy Administrator
Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Attention: CMS-2390-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

**Re: Comments on Proposed Medicaid Managed Care Regulations;
File Code CMS-2390-P**

Dear Ms. Wachino:

Justice in Aging is a national organization founded in 1972; we were known as the National Senior Citizens Law Center until our name change earlier this year. We advocate on behalf of older adults with limited resources; one of our principal goals is access to affordable health care. We have decades of experience with Medicaid, with a particular focus on long-term services and supports. Our recent work is heavily focused on managed care, both in Medicaid managed care programs and in the dual eligible financial alignment demonstrations.

We thank CMS for developing the proposed regulations for Medicaid managed care. As CMS has noted, Medicaid managed care has expanded dramatically in recent years, and the existing federal regulations fall short in numerous ways. We appreciate CMS's hard work in developing the comprehensive package of proposed regulations, and also appreciate the opportunity to submit our comments for your consideration.

We specifically appreciate CMS's plans to incorporate the 2013 guidance on managed long-term services and supports (MLTSS) into the proposed regulations. MLTSS is indeed a vital component of Medicaid managed care systems, and the guidance includes many important protections.

We believe that the following issues deserve particular consideration. In almost all of the items below, we have included both our discussion of the relevant issue, along with our recommended revisions to the regulatory language.

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For brevity, our narrative comments (but not our recommended revisions) generally refer to an “MCO” rather than listing multiple types of entities: an MCO (managed care organization, a PIHP (Pre-paid Inpatient Health Plan), a PAHP (Pre-paid Ambulatory Health Plan), and/or a PCCM (Primary Care Case Manager).

42 C.F.R. § 438.2 Definitions

Strengthening Definition of LTSS

We recommend that the definition of long-term services and supports (LTSS) be revised to more comprehensively address the benefits and purpose of LTSS. CMS’s proposed definition is too limited in speaking of LTSS as “supporting the ability of the beneficiary to live or work in the setting of their choice.” Our recommended language is not limited to “support” and also is not limited to the ability to live or work in a particular setting. Also, our recommended language corrects a grammatical problem: CMS’s proposed definition confuses work settings and residential settings, by including a list that seems to limit a beneficiary’s work settings to homes, residential settings, and institutional settings.

Recommendation

§ 438.2 *Long-term services and supports (LTSS)* means services and supports provided to a beneficiary ~~ies~~ of any ~~all~~ ages who ~~has~~ have functional limitations and/or chronic illnesses, with that have the primary purpose of supporting and advancing the beneficiary’s ability ~~of the beneficiary~~ to live and/or work, and to reside in a ~~the~~ setting of his or her ~~their~~ choice, which may include the beneficiary’s ~~individual’s~~ home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

42 C.F.R. § 438.3 Standard Contract Requirements

Requiring Coordination of Benefit Agreements in Order to Increase Access

We express our support for proposed subsection 438.3(t), which requires MCOs responsible for coordinating benefits for dual eligibles to enter into a Coordination of Benefits Agreement (COBA) with Medicare. We have been actively involved across the country with the dual eligible financial alignment demonstrations, and our experiences have shown that, when MCOs have not entered into a COBA, providers can face complicated and cumbersome billing requirements. Those complications unfortunately have led some providers to decline to serve dually eligible beneficiaries, creating significant access limits. We thank CMS for addressing this concern by establishing a uniform requirement across affected states.

Our recommended revision for this section slightly modifies subsection (o) to more comprehensively cross-reference the federal regulations governing community-based settings for persons receiving home and community-based services.

Recommendation

§ 438.3(o) *LTSS contract requirements*. Any contract with an MCO, PIHP or PAHP that includes LTSS as a covered benefit must require that any services covered under the contract that could be authorized through a waiver under section 1915(c) of the Act or a State plan amendment authorized through sections 1915(i) or 1915(k) of the Act be delivered in settings consistent with § 441.301(c)(4)-(6) of this chapter.

Prohibiting Discrimination (relating to several different regulations)

We thank CMS for adding and expanding provisions that protect beneficiaries from discrimination in enrollment and in delivery of services. We particularly appreciate that CMS directly addresses discrimination based on sexual orientation and gender identity, and requires culturally competent care for all beneficiaries.

Specific reference to discrimination based on sexual orientation and gender identity is important and necessary. LGBT beneficiaries have been the victims of widespread discrimination in the provision of health care. For example, as reported in *LGBT Older Adults in Long-Term Care Facilities: Stories from the Field*,¹ many LGBT individuals receiving long-term services and supports have faced harassment, a refusal to provide care, attempted discharge, and other discrimination directly affecting access to health care services. Responding to other surveys, transgender older adults report discrimination and sometimes complete refusal of care, even in emergency situations.²

In addition to the enrollment protection in proposed section 438.3(d)(4), we especially appreciate the requirement on states to ensure full access to covered services. We specifically support:

- Proposed section 438.206(c)(2) requiring delivery of culturally competent services.
- Proposed section 440.262 requiring states to have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, and ensuring that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs.
- Proposed section 457.1201(d)(3) prohibiting enrollment discrimination.

¹ Justice in Aging, *LGBT Older Adults in Long Term Care Facilities: Stories from the Field*, available at <http://www.justiceinaging.org/lgbt-older-adults-in-long-term-care-facilities-stories-from-the-field-2>.

² Services and Advocacy for GLBT Elders (SAGE), *Improving the Lives of Transgender Older Adults*, available at <http://www.sageusa.org/resources/publications.cfm?ID=13>.

42 C.F.R. § 438.10 Information Requirements

We appreciate the requirements for language access contained in the proposed regulations but believe that more specificity is needed. Clear enforceable standards would better ensure that limited English proficient (LEP) enrollees have genuine access to health care, in order to address the health disparities that confront many LEP populations.

Setting a Meaningful Floor for Translation Requirements

We appreciate that CMS proposes a definition of “prevalent language” but are concerned that the proposed regulation delegates the setting of specific translation standards to the states. We urge that the definition instead be precise and specific, setting a floor for state determination of prevalence. We recommend the “safe harbor” provisions in the LEP Policy Guidance for HHS Recipients (Aug. 8, 2003), which set the floor at 1,000 persons or 5%, whichever is smaller, based on the LEP population of the MCO service area. This standard would be consistent with the 5% floor used for Medicare Advantage plans (see 42 C.F.R. § 422.2264(e)), but will provide for more realistic language access than a percentage-only standard offers, especially for beneficiaries in densely populated areas. By itself, a percentage-only standard does not recognize the needs of the tens of thousands of persons who might be served by an MCO in a large metropolitan area.³

Recommendation:

§ 438.10(a) *Prevalent* means a non-English language determined to be spoken by a significant number or percentage of at least the lesser of 1,000 or 5% of potential enrollees or enrollees in the entity’s service area that are limited English proficient, ~~and~~ consistent with standards used by the Office for Civil Rights in enforcing anti-discrimination provisions in Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act.

...

(d) *Language and format.* The State must:

(1) ~~Establish a~~ Utilize the methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area.

³ The Medicare Advantage regulation, by relying solely on a percentage measure, has failed to provide adequate language access to any language group other than Spanish speakers. Besides Spanish, Chinese is the only other language for which translation is required under the Medicare regulation, and that requirement only applies to a handful of Medicare Advantage plans in the entire country. This very limited coverage is simply not consistent with Title VI requirements.

Interpreter Services in All Languages; Multi-Language Inserts

We recommend amending subsection (d)(2) to explicitly require that states provide interpreter services in all languages. Subsection (d)(4) appears to impose this requirement but the current wording of subsection (d)(2) creates ambiguity.

We also recommend adding a requirement for multi-language inserts in 15 languages. These inserts alert beneficiaries to their right to free language services and encourage them to use those services. The inserts are used in some states and in the Medicare Advantage and Medicare Part D programs, and have proven valuable both for beneficiaries speaking “prevalent” languages and also for those who will have access only through interpreter services.

Experience with Medicare Advantage has shown that, though many beneficiaries could use interpreters, relatively few actually request them. Including an insert in every state mailing is an efficient way of reminding beneficiaries to ask for language assistance. These inserts should be required not just for pre-enrollment written information for potential enrollees, but also should be included whenever an MCO sends a “vital” document, including but not limited to any document related to service denials or appeals.

Recommendation:

§ 438.10(d)(2): Make available [competent](#) oral [information in all languages](#) and written information in each prevalent non-English language. All written materials for potential enrollees must include [prominent](#) taglines in ~~each prevalent non-English language~~ [at least 15 non-English languages](#) as well as large print explaining the availability of written translation ~~or~~ [and](#) oral interpretation. . .

(d)(3)(i): All written materials for enrollees, including provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services, must include taglines in ~~each prevalent~~ [at least 15 non-English languages](#) as well as large print . . .

Defining Vital Documents

We recommend defining “vital” documents to be translated into prevalent languages, as including not only documents related to appeals and grievances, but also including specifically any denial or curtailment of services, any denial of a request for prior authorization, or any termination of services.

Recommendation:

§ 438.10(d)(3) Require each MCO, PIHP, PAHP, and PCCM entity to make its written materials, including at a minimum, provider directories, member handbooks, appeal and grievance notices, [denial and termination notices](#), and other notices that are critical to obtaining services...

42 C.F.R. § 438.54 Enrollment

Extending Enrollment Period from 14 Days to 60 Days

Under the proposed regulations, an enrollee would have as little as fourteen days to make a decision about managed care enrollment. If the enrollee fails to act within that period, she would be automatically enrolled into the default MCO.

We strongly disagree with this proposal: 14 days is far too little time, given the importance and complexity of the decision, and the fact that enrollees often rely on assistance from others in reaching a decision. In general, Medicaid beneficiaries have low health literacy and rely on non-print sources like family members, caregivers, advocates, and others for assistance in making health care decisions.⁴ Indeed, for that reason, the proposed regulations call for a robust beneficiary support system.

Accordingly, we recommend a minimum of a 60-day period to allow beneficiaries to make a choice prior to default enrollment. As explained above, obtaining necessary decision-making assistance may require multiple weeks. For example, in the recent transition of California beneficiaries into dual-eligible plans, the wait times for enrollment counseling exceeded five weeks.

Recommendation

§ 438.54(c) *Voluntary managed care programs.* ...

(2) A State must provide potential enrollees at least ~~14~~60 calendar days of FFS coverage to provide the potential enrollee the opportunity to actively elect to receive covered services through the managed care or FFS delivery system. If the potential enrollee elects to receive covered services through the managed care delivery system, the potential enrollee must then also select a MCO, PIHP, PAHP, PCCM, or PCCM entity.

(d) *Mandatory managed care programs.* ...

(2) A State must provide potential enrollees at least ~~14~~60 calendar days of FFS coverage to provide the potential enrollee the opportunity to actively select their MCO, PIHP, PAHP, PCCM, or PCCM entity.

Increasing Readability of Informational Notices

We support the proposed requirement for informational notices that explain the implications of enrollment decisions, whether enrollment is voluntary or mandatory. These notices should be written to be useful for the beneficiary population, so we appreciate that CMS is proposing that these notices comply with the information requirements of section 438.10. We recommend

⁴ America's Health Literacy, Why We Need Accessible Health Information, available at <http://www.health.gov/communication/literacy/issuebrief/#adults>.

that the regulations also require that informational notices undergo beneficiary testing and are written at a sixth-grade reading level. Beneficiary testing is imperative to ensure information is clear and comprehensible to beneficiaries.

Recommendation

§ 438.54(c) Voluntary managed care programs. ...

(3) The State must develop informational notices that clearly explain the implications to the potential enrollee of not making an active choice between managed care and FFS and declining the MCO, PIHP, PAHP, PCCM, or PCCM entity selected by the State, if relevant to the State’s managed care program. These notices must:

...

[\(iii\) be written at a sixth-grade reading level and undergo beneficiary testing.](#)

(d) Mandatory managed care programs. ...

(3) A State must provide informational notices to each potential enrollee that explain the process for enrolling in a MCO, PIHP, PAHP, PCCM or PCCM entity including the choice of MCOs, PIHPs, PAHPs, PCCMs or PCCM entities available, how to make the enrollee’s selection of a MCO, PIHP, PAHP or PCCM known to the State, and enrollee’s right to disenroll within 90 days from the effective date of the enrollment. These notices must:

...

[\(iii\) be written at a sixth-grade reading level and undergo beneficiary testing.](#)

Supporting Enrollees’ Ability to Make Decisions

Due to physical and cognitive limitations, many Medicaid beneficiaries need a representative to act for them in making enrollment decisions. If systems are not able to accommodate representative decision-making, these beneficiaries effectively lose their ability to make decisions, with the state becoming the default decision-maker.

To protect beneficiaries’ rights, additional accommodations are required. We recommend that the regulations require states to develop thorough policies and procedures that enable a representative to make enrollment decisions when the enrollee lacks the ability to make those decisions independently.

Recommendation

§ 438.54(b) General rule. The State must have an enrollment system for both voluntary and mandatory managed care programs. [The State must design its enrollment system so they the system does not unreasonably impede beneficiaries from receiving](#)

[assistance from family members and other trusted sources in executing enrollment choices.](#)

42 C.F.R. § 438.56 Disenrollment: Requirements and Limitations.

Allowing Enrollees to Change Their MCO During First 90 Days

Current law allows an enrollee to change from one MCO to another during the first 90 days in an MCO. The proposed regulations, however, would limit that right to the enrollee's first enrollment into a Medicaid MCO.

We urge that CMS continue current protections. An enrollee's ability to change MCOs, without being required to prove a "good cause" rationale, is an important protection that should not be limited to the first MCO. For example, if soon after enrollment to an MCO, an enrollee experiences poor quality of care or a breakdown in provider relationships, she would be well served by a simple right to disenroll, rather than staying in the MCO or being forced to prove a "good cause" reason for disenrollment. We recognize that the ability to switch from one MCO to another may cause some administrative burden for MCOs and the state, but that burden is outweighed by the potential harm of a beneficiary remaining enrolled in an MCO that does not meet his care needs.

Recommendation

§ 438.56(c) *Disenrollment requested by the enrollee.* If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, PCCM and PCCM entity contracts must provide that a beneficiary may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the beneficiary's ~~initial~~ enrollment into a MCO, PIHP, PAHP, PCCM or PCCM entity, or the date the State sends the beneficiary notice of the enrollment, whichever is later.

42 C.F.R. § 438.62 Continued Services to Enrollees

Continuing Services and Supplies During Transitions

We thank CMS for its attention to issues arising when a beneficiary transfers from fee-for-service Medicaid to an MCO, or from one MCO to another. We recommend that a state's transition care policy be required to ensure that a beneficiary retains access to both services and providers during a transition. In situations with inadequate transition protections, we have observed significant disruptions from enrollees' inability to access (for example) durable medical equipment, medication, transportation, and medical supplies.

The proposed regulations require only that the enrollee be able to retain the provider for a “period of time.” To make this protection more substantive, we recommend a minimum continuity of care period of at least six months. Our experience with LTSS beneficiaries indicates that any lesser period is likely insufficient.

We also recommend that the enrollee’s “new” MCO be required to work with the enrollee to smooth out transitions that occur as a continuity-of-care period expires. Otherwise, a continuity-of-care period may just delay — rather than prevent — care disruptions.

Finally, we recommend that the regulations be modified to guarantee that an enrollee never be required to move from one nursing facility to another, or from one assisted living facility to another, as a consequence of enrolling in a Medicaid MCO. Forced moves can be traumatic and negatively affect health; a move to a particular MCO should not require that the enrollee essentially be evicted from her residence.

Recommendation

§ 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 a MCO, PIHP, PAHP, PCCM or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM or PCCM entity 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.

(1) The transition of care policy must include the following:

(i) The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider [of all Medicaid-covered services or supplies](#) for [at least six months](#) ~~a period of time~~ if that provider is not in the MCO, PIHP or PAHP network.

[\(A\) The MCO, PIHP or PAHP must contact the beneficiary before the end of the continuity of care period about the process that will occur to transition the beneficiary’s care at the end of the continuity of care period. This process must include engaging with the beneficiary, the beneficiary’s caregiver \(if available\), and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.](#)

[\(ii\) A beneficiary who is a resident of an out-of-network Medicaid contracted nursing facility or assisted living facility prior to enrollment shall not be required to change facilities upon enrollment into an MCO, PIHP or PAHP.](#)

~~(ii)~~ [\(iii\)](#) The enrollee is referred to appropriate providers of services that are in the network.

~~(iii)~~ (iv) The State, in the case of FFS, PCCM, or PCCM entity, or the MCO, PIHP or PAHP that was previously serving the enrollee, fully and timely complies with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM, or PCCM entity in compliance with Federal and State law.

~~(iv)~~ (v) Consistent with Federal and State law, the enrollee's new provider(s) are able to obtain copies of the enrollee's medical records, as appropriate.

~~(v)~~ (vi) Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the enrollee's

42 C.F.R. § 438.68 Network Adequacy Standards

Ensuring Adequacy of Sub-Networks Organized Around Provider Groups

We are pleased that the proposed regulations provide minimum standards for LTSS network adequacy, and require MCOs to ensure that their network providers are culturally accessible and provide physical access, accommodations, and accessible equipment.

To improve the efficacy of the network adequacy standards, we recommend that the concept of a "network" be expanded to include sub-networks within an MCO's overall network. MCOs often limit enrollees to services and providers affiliated with a particular provider group. Thus, for many enrollees, access to services can be determined less by overall network adequacy, and more by the adequacy of the network offered by the provider group. Accordingly, for network adequacy standards to be useful, they must address not just overall networks, but also any sub-networks in which enrollees find themselves

Recommendation

§ 438.68(b)(3) *Scope of network adequacy standards.* Network standards established in accordance with paragraphs (b)(1) and (b)(2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas. [Network adequacy standards must be applied to an MCO, PIHP or PAHP overall, and also to any limited network established within an MCO, PIHP or PAHP by restricting enrollees to specific providers within the overall network.](#)

Strengthening the Process for Granting Exceptions to Network Adequacy Standards

We also recommend strengthening the proposed language relating to network adequacy exceptions: the proposed language does not set any particular standard for when an exception can be granted, aside from saying that an exception must be "based on" the number of providers. To prevent overuse of exceptions, we recommend that an exception be allowed only when the MCO cannot practically meet the network adequacy standards. Also, a state should

be required to explain the reasons why an exception is necessary, and to do so on an ongoing basis to the extent that the state requests that the exception continue.

Recommendation

§ 438.68(d) *Exceptions process.* (1) ~~To the extent the State permits an exception to any of~~ If the MCO, PIHP or PAHP cannot practically meet the provider-specific network standards developed under this section, ~~the standard~~ given the number of providers in that specialty or field who offer services in the MCO, PIHP, or PAHP service area, the State may permit an exception to those standards. If an exception is to be granted, the standard by which the exception will be evaluated and approved must be:

(i) Specified in the MCO, PIHP or PAHP contract, along with the justification for the exception.

(ii) Based, at a minimum, on the number of providers in the relevant ~~health care professionals in that specialty or~~ field who offer services practicing in the MCO, PIHP, or PAHP service area.

(2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis, at least quarterly, and include the findings to CMS in the managed care program assessment report required under § 438.66. These findings in the report must be accompanied by an explanation of why the exception is or is not necessary for the following year.

42 C.F.R. § 438.70 Stakeholder Engagement When LTSS Is Delivered Through a Managed Care Program

We appreciate CMS’s emphasis on stakeholder engagement throughout the proposed regulations and agree with the general intent of the stakeholder engagement requirements. As currently written, however, section 438.70 does not provide adequate detail on the format and frequency of stakeholder input.

Furthermore, CMS’s financial estimates suggest a relatively trivial effort to communicate with stakeholders. The relevant IRC statement claims that existing MLTSS programs already meet the stakeholder engagement requirements, and that only 14 new programs will be subject to the requirements. For each of these states, the IRC estimates an annual “burden” of only four hours per state for soliciting and addressing public input for oversight purposes (see 80 Fed. Reg. at 31182).

We respectfully disagree with CMS’s assessment of the situation. Stakeholder engagement should be an active process in all MLTSS states, involving far more state activity than four hours annually. Accordingly, we recommend revisions that address stakeholder support, as well as the frequency, transparency and accessibility of meetings.

Recommendation:

§ 438.70 The State must ensure the views of beneficiaries, caregivers, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of a State’s managed LTSS program. ~~The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement.~~ The composition, frequency and support of the stakeholder group must include the following:

- a) Participation assistance through transportation assistance, interpreters, personal care assistance, and other reasonable accommodations;
- b) Public meetings held at least quarterly in a venue fully accessible to all stakeholders and telecast or teleconferenced for the public;
- c) Access to information and data from the State on the content of the meetings;
- d) Timely information sharing, including agendas prior to meetings and public minutes following each meeting.

42 C.F.R. § 438.71 Beneficiary Support System (including related reference to section 438.66)

Making Support Services Broadly Available

We strongly support the requirement that states develop a Beneficiary Support System (BSS), but are concerned that the BSS, as described in the proposed regulations, will not be able to fully meet enrollees’ needs. Many of the BSS’s services — accepting complaints and concerns, and educating on and assisting with grievance and appeal rights — are limited by the proposed regulations to enrollees who use, or desire to use, long-term services and supports. We believe that this distinction is inappropriate, as many non-LTSS enrollees are at risk from improper MCO actions, and would greatly benefit from having access to complete BSS services. All BSS services should be available to all enrollees.

Recommendation

§ 438.71(d) Assistance with complaints, concerns, grievances and appeals. ~~Functions specific to LTSS activities.~~ At a minimum, the beneficiary support system must provide the following support to enrollees ~~who use, or express a desire to receive, LTSS:~~

Training the MCO and Network Providers on Community Services

We often observe current MLTSS systems break down due to the lack of knowledge by the MCO or network provider of the existing network of aging and disability services. We support the proposed section 438.71(b)(1)(ii) requirement on training MCOs and providers, and recommend specifying certain staff to receive the training. For care coordination to truly be

effective, at a minimum, the care coordinators, case managers and MCO staff leading the interdisciplinary team need a clear understanding of the community based supports network.

Recommendation

§ 438.71(d) *Training*. The beneficiary support system must provide training to MCOs, PIHPs, PAHPs, PCCMs, PCCM entities and network providers on community-based resources and supports and coordinating services across the network. that can be linked with covered benefits. At a minimum, all MCO, PHIP, PAHP, PCCM, PCCM entities and network provider care coordinators and interdisciplinary team leaders must participate in the training.

Assisting and Representing Beneficiaries in the Grievance and Appeal Process

The proposed regulations prohibit a BSS from providing representation at a state fair hearing, but state that the BSS “may refer enrollees to sources of legal representation.” This prohibition severely limits the effectiveness of a BSS, as a hearing is precisely where an enrollee needs assistance in order to obtain necessary services. Ideally, the regulations would require that a BSS be able to represent enrollees at hearings; at a minimum, the regulations should require that a BSS establish systems and networks to ensure that representation with fair hearings is available. Our proposed language recommends the former.

We agree with CMS that an entity that provides representation at hearings should not be disqualified from providing choice counseling, provided that appropriate protections are in place. Regarding independence, we also believe that a BSS likely will be more effective if it is housed in a non-profit organization, rather than within state government.

Recommendation

§ 438.71(e)(3) Assistance, upon request, in navigating the grievance and appeal process within the MCO, PIHP or PAHP, as well as appealing adverse benefit determinations by the MCO, PIHP, or PAHP to a State fair hearing. ~~The system may not provide representation to the enrollee at a State fair hearing but may refer enrollees to sources of legal representation.~~

Providing Adequate Resources to Develop and Maintain the System

We are concerned that the beneficiary support systems will not be funded adequately to be effective. CMS estimates one-time expenditures of 150 hours to create a call center and 3 hours to create provider education materials, plus one hour annually for those same materials (see 80 Fed. Reg. at 31182). The CMS estimates are based on the premise that beneficiary assistance will be performed by a call center and existing ombudsman staff, so relatively little additional expense will be incurred. Based on our experiences, we disagree strongly with these assumptions — states currently are not providing adequate support to beneficiaries,

particularly in challenging MCO actions. An effective beneficiary support network would require time and resources that far exceed the current estimates.

Recommendation

§ 438.66(b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP and PCCM entity (if applicable) in at least the following areas:

...

(12) Quality improvement.

(13) [Beneficiary Support System](#).

~~(13)~~ (14) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through ~~(12)~~3) of this section as applicable to the managed care program. ...

42 C.F.R. § 438.206

Availability of Services

To be effective, network adequacy standards should focus at least in part on the experiences of individual enrollees. Direct measurement is one of the best ways to ensure that network adequacy is real. For that reason, we recommend the addition of language specifying that compliance mechanisms for network adequacy include enrollee surveys and secret shopper efforts.

Recommendation

§ 438.206(c) *Furnishing of services*. The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements.

(1) *Timely access*. Each MCO, PIHP, and PAHP must do the following:

(i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.

(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

(iv) Establish mechanisms to ensure compliance by network providers. [These mechanisms must include, but are not limited to, enrollee surveys and secret shopper efforts.](#)

(v) Monitor network providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply by a network provider.

42 C.F.R. § 438.207 Assurances of Adequate Capacity and Services

As discussed above in our recommendations for section 438.68, evaluations of network adequacy should include not only full provider networks, but also sub-networks of providers affiliated with particular provider groups. Accordingly, we recommend that section 438.207, concerning assurances of adequate capacity, also be revised to refer to both networks and sub-networks.

Recommendation

§ 438.207(a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart.

(b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) *Timing of documentation.* Each MCO, PIHP, and PAHP must [develop and](#) submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) On an annual basis.

(3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including [but not limited to](#)--

(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider [network or to any sub-network of providers or provider groups](#); or

(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

42 C.F.R. § 438.208 Coordination and Continuity of Care

Requiring Service Plans for LTSS, Improving Service Plans, and Strengthening Appeal Rights

Several of our recommendations for section 438.208 are aimed at clearing up some confusion in the current draft, which generally has a combined discussion of treatment plans for enrollees with special health care needs, and service plans for enrollees receiving LTSS. Our recommended language improves clarity by separating treatment plans from service plans and also, within LTSS, separating home and community-based services from nursing facility services.

In a provision that offers insufficient protection to enrollees, CMS's proposed subsection (c)(3) gives states the option of whether to require treatment plans for persons with special health care needs, and service plans for persons receiving LTSS. We see no reason not to make these plans mandatory for the relevant populations. We are particularly familiar with LTSS, and understand the importance of service plans for providing adequate services and accommodating individual beneficiaries' needs and preferences.

CMS's proposed subsection (c)(3)(iii) calls for a treatment plan or service plan to be approved timely by a MCO, PIHP, or PAHP, if approval is required. We recommend that this provision be revised to specify that evaluations for approval be done by persons with appropriate expertise in the enrollee's needs. Such a requirement would improve the accuracy of the approval process, and protect enrollees from unjustified denials. Our recommended language is drawn from a similar provision at CMS's proposed section 438.210(b)(3).

We also recommend in a new subsection (c)(3)(ii)(A) that family caregivers, paid or unpaid, be allowed to participate in the LTSS service planning process, if desired by the enrollee. Otherwise, family members might be barred from participating by the person-centered planning regulations at section 441.301(c)(1)(vi).

Also in the new subsection (c)(3)(ii)(A), we recommend that enrollees have the right to appeal a service plan as an adverse benefit determination. In the HCBS system, the service plan is a vital document, and the consequences of an inadequate or inappropriate service plan can be dire. A clear appeal right is vital for the service planning process to reach its potential as a planning mechanism that truly is person-centered.

Finally, in CMS's proposed subsection (c)(3)(v), we recommend deleting a reference to section 441.301(c)(3). The citation is applicable only to home and community-based services, but the text of proposed subsection (c)(3)(v) refers both to treatment plans (which relate to special health care needs) and LTSS service plans (which relate both to home and community-based services, and nursing facilities). Since the text of proposed subsection (c)(3)(v) explicitly describes when plans must be reviewed, the specific reference to section 441.301(c)(3) (which contains a very similar description) is unnecessary and should be deleted.

Recommendation

(c) *Additional services for enrollees with special health care needs or who need LTSS. (1) Identification.* The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms--

(i) Must be specified in the State's comprehensive quality strategy in § 438.340.

(ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.

(2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate.

(3) *Treatment/service plans.* ~~If the State requires MCOs, PIHPs, or PAHPs to produce a treatment or service plan for an enrollee who requires LTSS or has with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the enrollee must have a the treatment or service plan. must be~~

(i) For an enrollee with special health care needs, a treatment plan must be developed by the enrollee's provider ~~or individual meeting LTSS service coordination requirements~~ with enrollee participation, ~~and~~ in consultation with any other health care professionals caring for the enrollee.

(ii) For an enrollee who requires LTSS, including but not limited to home and community-based services, and nursing facility services, the service plan must be developed in compliance with relevant federal standards.

(A) For home and community-based services, the service plan must be developed by a person trained in person centered planning using a person-centered process and plan as defined in § 441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans. A family caregiver, paid or unpaid, may participate in the planning process. The written service plan must comply with the notice requirements of section 438.404, giving notice to the enrollee that he or she has the opportunity to appeal the service plan as an adverse benefit determination.

(B) For nursing facility services, the service plan (also called a care plan) is developed in compliance with the standards in section 483.20 of this chapter.

(iii) The treatment or service plan is approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP. Evaluations for approval shall be conducted by representatives of the MCO, PIHP, or PAHP with appropriate expertise in addressing the enrollee’s medical, behavioral health, or long-term services and supports needs.

(iv) The treatment or service plan is developed and implemented in accord with any applicable State quality assurance and utilization review standards.

(v) The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee ~~per section § 441.301(c)(3) of this chapter.~~

42 C.F.R. § 438.210 Coverage and Authorization of Services

Establishing the Ability to Live in Community as a Component of Determining Medically Necessary Services

Our recommendation here stems from our concern that the proposed regulations do not provide sufficient guidance to states as to what constitutes “medically necessary services” in the case of LTSS. Currently, MCOs rely on state medically necessary definitions to authorize services. Existing definitions, however, generally are limited to enrollee’s medical needs and are a poor fit with LTSS.⁵ Accordingly, we recommend that the mention of community living in section 438.210(a)(5)(iii)(D) be modified to explicitly reference independence and the ability to live in the setting most integrated with the community.

Recommendation

§ 438.210 *Coverage and authorization of services.* (a) Coverage. Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(5) Specify what constitutes “medically necessary services” in a manner that—

(iii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that ~~address:~~

(A) ~~The prevention, diagnosis, and treatment of~~ Prevent, diagnose and treat an enrollee’s disease, condition, and/or disorder that results in health impairments and/or disability.

⁵ Kaiser Family Foundation, *Rebalancing in Capitated Medicaid Managed Long-Term Services and Supports*, available at <http://kff.org/report-section/rebalancing-in-capitated-medicare-managed-long-term-services-and-supports-programs-issue-brief>.

- (B) ~~The ability for an~~ [Assist an](#) enrollee to achieve age-appropriate growth and development.
- (C) ~~The ability for an~~ [Assist an](#) enrollee to attain, maintain, or regain functional capacity.
- (D) ~~The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living.~~ [Ensure the enrollee receives necessary long-term services and supports to remain independent and in the most integrated setting.](#)

42 C.F.R. § 438.330 Quality Assessment and Performance Improvement Program

Allowing for Use of Unvalidated Performance Measures As Necessary

Most LTSS performance measures are not yet validated, as the validation process can be expensive and lengthy. We recommend that, while validation processes are ongoing, states and MCOs should be allowed to use unvalidated LTSS measures as necessary. Use of these measures will help support the quality and availability of LTSS, pending the formal validation of additional LTSS measures.

Recommendation

§ 438.330(c)(4) *LTSS performance measurement*. The State must require, through its contracts, each MCO, PIHP, and PAHP that provides LTSS services to include, as a part of its performance measurement activities under this paragraph and in addition to other measures required of all MCOs, PIHPs, and PAHPs, measures that assess the quality of life of beneficiaries and the outcomes of the MCO, PIHP, or PAHP's rebalancing and community integration activities for beneficiaries receiving LTSS. [These measures may, as necessary, include measures that are not yet formally validated, if an inadequate number of validated measures are available, and the measures chosen have reasonable indications of usefulness and trustworthiness.](#)

42 C.F.R. § 438.334 Medicaid Managed Care Quality Rating System

Evaluating Access to Services, and Tightening Process for Evaluating Requests to Use Different Rating System

We recommend that “access to services” be added as a core component of the quality rating system. A rating system would be woefully inadequate if it did not address access and related issues.

We also recommend that CMS’s proposed language be modified to establish more clarity around a state’s request to use a rating system different from that developed by CMS. At a minimum, a state should be required to explain its justification for using a different rating

system, and the general public should be given an opportunity to respond to the state's request.

Recommendation

§ 438.334(a)(1) Each State contracting with an MCO, PIHP, or PAHP must establish a quality rating system for Medicaid managed care plans that meets the requirements of this section.

(2) The quality rating system must be based on the following ~~four~~ three components:

(i) Clinical quality management.

(ii) Member experience.

(iii) Plan efficiency, affordability, and management.

(iv) Access to services.

...

(c) *Alternative quality rating system.* Upon CMS approval, a State may opt to use an alternative quality rating system that utilizes different components than those described in paragraph (a)(2) of this section, incorporates the use of different performance measures than those described in paragraph (a)(3) of this section, or applies a different methodology from that described in paragraph (b) of this section. A State must submit a written request to CMS, following a public notice and comment period of at least 30 days. The request must explain the purported advantages of the alternative quality rating system, compared to the system otherwise required by this section.

42 C.F.R. §§ 438.402, 438.408

General Requirements, and Resolution and Notification: Grievances and Appeals

Availability of State Fair Hearing

We agree that aligning appeals and grievances procedures across insurance products will help to reduce confusion and administrative inefficiencies. Alignment, however, is not advisable to the extent that it erodes existing consumer protections. Specifically, the proposed regulations do not allow an enrollee to request a state fair hearing without first completing an appeal within the MCO. Requiring this extra step can be harmful to an enrollee by delaying her access to an independent decision maker, particularly when the enrollee faces the risk of recoupment if she ultimately is unsuccessful.

We recommend that the regulations ensure an enrollee's option of requesting a state fair hearing directly after receiving initial notice of an adverse benefit decision. In the alternative, we request that the regulations maintain the status quo, under which the states, with input

from stakeholders, decide whether the state's Medicaid managed care program should require an MCO appeal as a precondition to a state fair hearing.

Recommendation

§ 438.402(c)(1)(i) An enrollee may file a grievance and an appeal with the MCO, PIHP, or PAHP. ~~An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.~~

...

§ 438.408(f) Requirements for State fair hearings. (1) Availability. An enrollee may request a State fair hearing ~~only after receiving notice that the MCO, PIHP or PAHP is upholding the adverse benefit determination~~ at any time after receiving an initial notice of an adverse benefit decision from the MCO, PIHP or PAHP.

42 C.F.R. § 438.420 Continuation of Benefits While Appeal or State Hearing Is Pending

We are appreciative that CMS has taken steps to allow for continued benefits while an appeal or state hearing is pending, without regard to whether a service authorization has expired. This right to continued benefits is particularly important for enrollees reliant upon HCBS. When these enrollees' HCBS is improperly terminated or reduced, they deserve to have their current level of services continue until their side of the matter can be heard by a hearing officer.

This protection is absent in current managed care regulations, which allow continuation of services only through the duration of a service authorization. In our work, we frequently see the negative consequences of this policy, as enrollees lose needed services before they can be heard in the appellate process

CMS's proposed revisions would establish an important consumer protection in managed care. Notably, CMS's proposed revisions would put managed care procedures in line with the procedures routinely applicable in fee-for-service procedures, which do not require an ongoing authorization to continue services prior to a fair hearing (see 42 C.F.R. § 431.230).

Further regulatory revision is necessary, however, because CMS's proposed revisions have not completely addressed the situation. While subsection (c) properly provides for continued benefits, subsection (b)(4) makes continuation contingent on an ongoing service authorization. Accordingly, we recommend that subsection (b)(4) be removed.

Recommendation

(b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:

- (1) The enrollee or the provider files the appeal timely.
- (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- (3) The services were ordered by an authorized provider.
- ~~(4) The original period covered by the original authorization has not expired.~~
- ~~(5) The enrollee requests extension of benefits.~~

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- (1) The enrollee withdraws the appeal.
- (2) Ten days pass after the MCO, PIHP, or PAHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
- (3) A State fair hearing office issues a hearing decision adverse to the enrollee.

(d) *Enrollee responsibility for services furnished while the appeal and state fair hearing is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may recover the cost of the services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter. The ability of the MCO, PIHP or PAHP to recoup the costs of services from the enrollee must be specified in the contract. Such practices must be consistently applied within the State under managed care and FFS delivery systems.

Conclusion

Again, thank for your hard work in this area, and for your consideration of these recommendations. Please feel free to contact us at any time with questions or suggestions.

Sincerely,

Kevin Prindiville
Executive Director