

July \_\_, 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:

[Brief introduction of person/organization submitting comments, with explanation of interest in Medicaid managed care]

As CMS has noted, Medicaid managed care has expanded dramatically in recent years, and the existing federal regulations fail to address many important issues. We appreciate CMS's hard work in developing this comprehensive package of proposed regulations, and also appreciate the opportunity to submit our comments for your consideration as you move the regulations to a final form.

We believe that the following issues deserve particular consideration. In some instances we have recommended revisions to the proposed regulations; in others, we indicate our support of the approach taken in the proposed regulations.

For brevity, our comments generally refer to an "MCO" rather than listing all three types of entities: an MCO (managed care organization, a PIHP (Pre-paid Inpatient Health Plan), and a PAHP (Pre-paid Ambulatory Health Plan).

Broadening and Strengthening Definition of Long-Term Services and Supports (42 C.F.R. § 438.2)

We thank CMS for its efforts 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.

To improve the quality of MLTSS, we recommend that the definition of long-term services and supports (LTSS) be revised to more comprehensively address the benefits and purposes 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." Also, we note 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.

#### Tightening Network Adequacy Standards (42 C.F.R. §§ 438.68, 438.206, 438.207)

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.

We offer three suggestions for improving network adequacy standards. First, 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.

Second, we 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.

Third, we recommend that “mechanisms to ensure compliance by network providers” (see proposed section 438.206(c)(1)(iv)) explicitly include enrollee surveys and secret shopper efforts. 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 identify access problems in provider networks.

#### Strengthening Enrollees’ Ability to Make Choices During Enrollment Process (42 C.F.R. § 438.54)

##### *Lengthening Minimum Decision-Making Period from 14 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.<sup>1</sup> Indeed, for that reason, the proposed regulations call for a robust beneficiary support system.

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<sup>1</sup> America’s Health Literacy, Why We Need Accessible Health Information, available at <http://www.health.gov/communication/literacy/issuebrief/#adults>.

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.

#### *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.

#### Allowing Enrollees to Change Their MCO During First 90 Days (42 C.F.R. § 438.56)

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, he 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.

#### Ensuring Informational Notices are Accessible to Limited English Proficient (LEP) Beneficiaries (42 C.F.R. § 438.10)

We appreciate that CMS has addressed language access in the proposed regulations. In order to decrease health disparities for LEP beneficiaries, it is critical that they receive information in a language they can understand. The proposed regulations, however, lack specificity and provide states with too much discretion in creating standards for interpretation and translation. One important deficiency is the regulations' failure to set a firm standard for what constitutes a "prevalent" non-English language. We recommend that the regulations adopt the "safe harbor" provisions outlined in the LEP Policy Guidance for HHS Recipients (Aug. 8, 2003). Under these provisions, prevalence of language is established when 1,000 persons or 5% of the service plan population (whichever is smaller) speak a particular language. Adopting this standard ensures that prevalence will not be based solely on a percentage, and facilitates the ability of LEP beneficiaries to communicate and make decisions.

We also recommend adding a requirement for multi-language inserts in 15 languages to alert beneficiaries of their right to interpreter services. This type of insert is included with all vital documents,

and is used in some states and in the Medicare Advantage and Medicare Part D programs. Using such alerts is an efficient way of improving communications with LEP beneficiaries, whether or not the beneficiary speaks a prevalent language.

Finally, we recommend that the list of documents made available in prevalent non-English languages (see 42 C.F.R. § 438.10(d)(3)) be modified to explicitly include notices of denial and termination of services.

#### Continuing Services to Enrollees During Transitions (42 C.F.R. § 438.62)

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.

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.

#### Coordinating Care (42 C.F.R. § 438.208)

In a provision that offers insufficient protection to enrollees, CMS's proposed language 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 a service plan for providing adequate services and accommodating a beneficiary's needs and preferences.

Regarding the planning process, we recommend that family caregivers, paid or unpaid, be allowed to participate in LTSS service planning, if desired by the enrollee. Otherwise, family members might be barred from participating by the person-centered planning regulations, which on conflict-of-interest grounds generally bar HCBS providers from participating in service planning.

Once a plan is developed, CMS's proposed language calls for a treatment plan or service plan to be approved timely by an MCO, if approval is required. We recommend that the regulation specify that evaluations for approval be done by persons with relevant expertise in the enrollee's type of condition and service needs. Such a requirement would improve the accuracy of the approval process, and protect enrollees from unjustified denials.

Because some service plans are inadequate, 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.

#### Establishing a Robust Appeals and Grievances Process (42 C.F.R. § 438.408)

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 his access to an independent decision maker.

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.

#### Continuing Benefits While Appeals Are Pending (42 C.F.R. § 438.420)

We thank CMS for specifying that benefits continue during appeal of a reduction or termination of services, consistent with the policies followed in fee-for-service Medicaid. This is an especially important protection for beneficiaries receiving home and community-based services; they should not be deprived of these vital services without an opportunity first to have a ruling on their appeal.

#### Enabling the Beneficiary Support System to Provide Meaningful Assistance (42 C.F.R. § 438.71)

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 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.

We note that 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.

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.

Finally, we express our concern 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.

Establishing the Ability to Live in Community as Component of Determining Medically Necessary Services (42 C.F.R. § 438.210)

We thank CMS for recognizing the importance of community living in determining when LTSS and other services are medically necessary. Our suggestion here is a small one: 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.

Including Expenses of Service Coordination and Community Integration in Determining Whether MCO Allocates Adequate Percentage of Revenue to Services (42 C.F.R. §§ 438.4, 438.8)

We commend CMS for establishing an 85% medical loss ratio, and also agree with CMS that the following three services should be considered as activities that improve health care quality for the purposes of calculating the ratio: 1) service coordination, 2) case management and 3) activities supporting state goals for community integration.

CMS proposes to include those three activities as activities that improve health care quality by discussing them in the preamble to the proposed regulations (see 80 Fed. Reg. at 31110). We recommend that CMS instead add an explicit reference to these activities in section 438.8(e)(3)(i), to ensure that states and MCOs recognize that these activities are included.

Establishing Effective Quality Assessment Systems (42 C.F.R. § 438.330)

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 be allowed to use unvalidated LTSS measures as necessary. Use of these measures will help support the quality and availability of LTSS, pending formal validation of additional LTSS measures. CMS could make this accommodation in the preamble to the final regulations and/or in written guidance.

Also, we are opposed to the loose process proposed to allow a state to be exempted from collecting and reporting on performance measures or on performance improvement projects. The regulation lists no particular standard for granting an exemption; in the preamble, CMS suggests three possible justifications for an exemption. We approve the first two proposed justifications: 1) the measure does not apply to the enrollee population, or 2) the number of enrollees for a particular measure is too small for reasonable analysis. We disagree strongly, however, with the third proposed justification: the MCO's performance has exceeded the 90<sup>th</sup> percentile for at least three consecutive years (see 80 Fed. Reg. at 31150). The 90<sup>th</sup> percentile (or any other percentile) may not indicate adequate performance; in any

case, good performance should not justify a complete, ongoing exemption. Even for a high-performing MCO, measurement is vital in monitoring ongoing compliance.

We recommend that the regulations be revised to allow exemptions only when collection and reporting would be futile or irrelevant. The proposed regulations, by setting no standard for granting exemptions, unnecessarily weaken quality of care protections.

Establishing Effective Quality Ratings Systems (42 C.F.R. § 438.334)

The proposed regulations require a quality rating system to consider specified components. We recommend that “access to services” be added as a required component. A rating system would be woefully inadequate if it did not address access and related issues. Also, we recommend that “affordability” be deleted as one of these components. The cost to Medicaid beneficiaries should not vary from MCO to MCO, since cost-sharing is set by federal and state governments, not by individual MCOs. Furthermore, if “affordability” refers to the cost to the MCO or the state, it may be in an enrollee’s best interests to be in a less “affordable” system.

We also recommend that the proposed regulations be revised 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.

Again, thank for your hard work in this area, and for your consideration of our comments.

Sincerely,