

## Medicaid Managed Care Proposed Rule: Key Considerations For Aging Advocates

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### Introduction

Low-income older adults have an important stake in the proposed rule, recently released by the Centers for Medicare and Medicaid Services (CMS), which updates and expands Medicaid regulation of managed care.<sup>1</sup> Because states are increasingly moving older beneficiaries into managed care for their long term care needs, the provisions in the proposed rule affecting delivery of those services are of critical interest to aging advocates.

This paper analyzes the proposed rule, looking particularly at those provisions of most concern to aging advocates. This is not an exhaustive guide, but rather is preliminary overview of information and provides questions to consider when framing comments.

Overall, the proposed rule contains good language and significant improvements to current regulations. In the rule, CMS acknowledges the shift in managed care to incorporate long-term services and supports

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(LTSS) and seeks to include strong beneficiary protections.

The focus of our analysis, however, is on areas where CMS should strengthen and spell out protections and where advocacy input would be most important. Of particular concern are those places in the proposal where there is a lack of detail, where there may be overbroad deference to states, and where information on enforcement is lacking. Also of concern is the extent to which CMS will actively monitor states and plans on the rule's requirements.

The deadline for comments on the proposed rule is July 27 at 5:00 p.m. ET.

<sup>1</sup> [80 Fed. Reg. 31,098 \(June 1, 2015\)](#).

# Defining and Codifying MLTSS

What CMS Proposes (proposed 42 C.F.R. §§ 438.2, 438.3, 438.214 and 438.816; 80 Fed. Reg. at 31141- 31144)

CMS intends to incorporate its previous guidance on managed long-term services and supports (MLTSS) into the regulations.<sup>2</sup> LTSS is defined broadly. CMS considered listing specific services, but determined that such a definition would be too limited.

Each state must inform individual managed care organizations (MCOs) about beneficiaries who need LTSS. The identification of these persons may utilize state staff, the state's enrollment broker, or MCOs. For each identified beneficiary, the MCO must perform a comprehensive assessment. If the state requires MCOs to develop a service plan for such beneficiaries, the service plan must be developed by the beneficiary's provider or a person meeting service coordination requirements, "with beneficiary participation." Another requirement is that the service plan be developed by a person trained in person-centered planning, in compliance with the process described in CMS's person-centered planning regulations.<sup>3</sup>

All Home and Community-Based Services (HCBS) provided through Medicaid managed care must comply with the recent federal regulations for determining when settings qualify as "community-based."<sup>4</sup>

States and MCOs must develop policies and processes for credentialing providers. MCO policies must not discriminate against providers that serve high-risk populations or specialize in high-cost treatments.

## Advocacy Considerations

In several aspects of LTSS, the proposed regulations leave a considerable amount of discretion to the states and to MCOs. Advocates should consider the potential benefit of more detailed requirements.

- *Specifying Services and Supports:* There may be a benefit in providing more detail about what services and supports can be included in LTSS, as long as the listing clearly establishes a floor rather than a ceiling.
- *Service Plans:* Notably the proposed regulations do not require a service plan for a person needing LTSS. Instead, the proposed regulations set standards for planning if the state requires service plans for such beneficiaries.
- *Conflict of Interest in Service Planning:* More detail is needed on how to limit conflicts of interest in the service planning process, given the various financial interests of MCOs and providers.
- *Consumer Rights in Service Planning:* The regulations should be stronger regarding a consumer's rights within the service planning process, to be consistent with the person-centered planning regulations.
- *Provider Credentialing:* The regulations might be revised to set some standards on when a provider might be eligible for credentialing, given the importance of provider quality.

Many issues relevant to LTSS are discussed in the other sections of this guide.

2 See CMS, Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (May 20, 2013).

3 See 42 C.F.R. § 441.301(c)(1).

4 See 42 C.F.R. § 441.301(c)(4), (5).

## Enrollment and Disenrollment

What CMS proposes (proposed 42 C.F.R. § 438.54, 80 Fed. Reg. at 31267-31268)

The rule proposes that, for states using voluntary enrollment as well as those with mandatory enrollment into managed care, enrollment systems must include certain notices and protections. Under both, the rule requires that states provide beneficiaries with 14 days to make a managed care enrollment decision. Beneficiaries must receive informational notices explaining the consequences of enrolling in managed care and their disenrollment rights. If a state uses passive enrollment, i.e., default enrollment unless the person makes an affirmative choice, the state must send beneficiaries confirmation of enrollment in an MCO within five days of enrollment. Both passive enrollment and enrollment by other default processes must seek to assign beneficiaries to plans that preserve existing provider-beneficiary relationships.

The rule proposes that in states that limit disenrollment, beneficiaries must have the right to disenroll from a plan without cause within the first 90 days of initial enrollment in the plan. The proposed rule expands “with cause” disenrollment to allow a beneficiary utilizing long-term services and supports to disenroll from an MCO if the beneficiary’s residential, institutional, or employment supports provider moves out of network.

### Advocacy Considerations

CMS explicitly recognizes that beneficiaries are best served when they make an active enrollment decision. To this end, CMS proposes consistent standards for enrollment into plans. Stakeholders should consider whether these standards are adequate to ensure that beneficiaries can exercise informed choice.

- *14-Day Enrollment Period:* In light of the needs of the population served by Medicaid, including the level of health literacy, language proficiency, reliance on family members for assistance, and other factors, stakeholders should consider whether a 14-day enrollment period is sufficient or whether a longer amount of time is needed when making an enrollment decision. It would also be helpful to share experience with the challenges this population has faced in receiving enrollment counseling in the past.
- *Informational Notices:* The proposed rule does not address the adequacy of the informational notices that must be sent to beneficiaries regarding enrollment. Stakeholders should consider whether the standards outlined in the rule should also include requirements for beneficiary testing, plain language standards, and requirements for alternative formats and translation of notices for limited English proficient populations.

## Appeals and Grievances

What CMS proposes (proposed 42 C.F.R. §§ 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.424, 431.200, 431.220, 431.244; 438.420; 80 Fed. Reg. at 31102, 31139)

The rule proposes to align the appeals and grievance procedures more closely to processes in place for Medicare Advantage plans and private health plans. Accordingly, the rule proposes to adopt consistent terminology, timelines, and notice requirements as follows:

- Replace the term “action” with “adverse benefit determination.”
- Limit the internal plan appeal process to only one level of appeal.
- Permit beneficiaries to request a state fair hearing only after exhausting the plan’s single level of appeal; beneficiaries will have 120 days after a plan’s final resolution to request a state fair hearing rather than the 20-90 day timeframe currently in place;

- Allow:
  - A provider to request an appeal on behalf of a beneficiary without the beneficiary’s written authorization; and
  - Beneficiaries to file a grievance at any time.
- Adopt:
  - A 60-day timeline to file an internal plan appeal after the beneficiary receives an adverse benefit decision rather than leaving it to the state to choose an appeal timeline between 20 and 90 days.
- Require:
  - A notice of adverse benefit determination to include the beneficiary’s right to access to all records and incorporate consistent language regarding the plan’s right of recoupment if a beneficiary does not prevail in the appeal;
  - MCOs to send a beneficiary an acknowledgment receipt for each appeal or grievance filed;
  - MCOs to accept and consider all evidence submitted regardless of whether the documentation was considered in the initial review;
  - Notices to ensure meaningful access for people with disabilities and limited English proficiency; and
  - MCOs to continue to provide benefits through the state fair hearing upon a beneficiary’s request even if the authorization has expired.
- Shorten:
  - The period of time MCOs have to make a standard appeal decision from 45 days to 30 days; and
  - The period of time MCOs have to make an expedited appeal from 3 working days to 72 hours.

## Advocacy Considerations

CMS strives to reduce the confusion experienced by beneficiaries who transition among different insurance coverage types. While advocates share this goal, alignment should not come at the expense of robust consumer protections. Stakeholders should consider whether the proposed solutions for alignment afford beneficiaries adequate protections through the appeal process.

- *Right to a State Fair Hearing:* Many states currently allow beneficiaries access to a state fair hearing upon an initial adverse benefit decision. This protection affords beneficiaries with immediate independent review of an adverse decision. Denying immediate access to this route of appeal — by requiring an internal plan appeal first — could negatively impact beneficiaries. CMS requests specific comment on this proposal.
- *Recoupment:* It is important that beneficiaries receive adequate notice that they may be financially liable in the event of an adverse final resolution. However, further clarity and specificity regarding how this recoupment is presented in notices is required to ensure that its inclusion does not deter beneficiaries from seeking an appeal.

# Beneficiary Support System

What CMS Proposes (proposed 42 C.F.R. § § 438.71, 438.10, 80 Fed. Reg. at 31136-31137, 31160, 31241)

CMS proposes creating a new section requiring that states develop a Beneficiary Support System (System). The System will provide all managed care beneficiaries with enrollment support. For LTSS participants, the System also will provide assistance in navigating the managed care grievance and appeals process.

Regarding enrollment, the System must conduct outreach to Medicaid beneficiaries, choice counseling, and training for the MCO network providers on community-based resources and supports. For “beneficiaries who use, or express a desire to receive, LTSS,” the System must provide additional assistance services that include four core components: 1) an access point for complaints about the MCO, 2) education on grievance and appeal rights, including the state fair hearing process, 3) assistance in navigating the appeals process, and 4) review and oversight of LTSS program data to help the Medicaid agency resolve systemic issues. Under Function 3, assistance with appeals, the rule expressly prohibits the System from providing representation to the beneficiary at the state fair hearing. CMS proposes an exception to this prohibition if the System uses non-Medicaid funding and has established firewalls to provide choice counseling as an independent function.

## Advocacy Considerations

While CMS is proposing a new regulatory section for the System, it notes that it does not expect states to develop an entirely new consumer network. CMS anticipates states will draw upon and expend existing resources to develop the System. A key question is how will the existing network of consumer assistance services be incorporated into the System, and whether this will appropriately meet consumer’s needs for support.

- *Choice Counseling:* States have flexibility to determine the entity that will provide choice counseling. This entity is considered an enrollment broker and must be independent of the MCO. Advocates should weigh in on the relationship between the existing State Health Insurance Programs (SHIPs) and private Medicaid enrollment contractors, and how each might function under the System’s choice counseling provision.
- *County MCOs:* In states where a county operates a managed care plan, the conflict of interest standards prohibit the county from serving as a choice counselor. Advocates should consider how this prohibition could impact existing SHIP programs or other counseling services administered by Area Agencies on Aging or Councils on Government.
- *Training on community services:* The proposal requires the System to train MCOs on community based organizations (CBOs), but does not detail the training’s purpose. There is value to improved coordination between the MCO and CBOs. Advocates should consider how this training function would improve coordination and what requirements for training should be included. More broadly, advocates may also want to think about other training requirements that could be included in the rulemaking.
- *Firewalls and Medicaid-financed programs:* The rule prohibits Medicaid funded entities from assisting beneficiaries at a state fair hearing. However, CMS is requesting comment on whether entities that provide non-Medicaid funded hearing assistance should be allowed to contract with the state to provide choice counseling.

# Network Adequacy

What CMS Proposes (proposed 42 C.F.R. §§ 438.358(b)(4), 438.68, 438.206, 438.207 and 440.262; 80 Fed. Reg. at 31144- 31148, 31156)

Adequacy standards for specified providers must include time-and-distance standards, which in turn must consider factors including:

- utilization of services;
- location of providers and beneficiaries;
- providers' ability to communicate with limited-English-proficient beneficiaries; and
- physical access.

For LTSS, adequacy standards also must consider elements that would support a beneficiary's choice of provider and community integration. A separate standard must be developed for LTSS where the provider travels to the beneficiary. Standards may vary depending on the geographic area (e.g., urban v. rural).

For enforcement of the standards, CMS is "considering requiring a mix of approaches, such as conducting beneficiary surveys, reviewing encounter data, calculating and reporting of HEDIS<sup>5</sup> measures related to access, implementing secret shopper efforts, and a systematic evaluation of consumer service calls," and requests input on this issue.

A state can grant exceptions to network standards if the conditions for exceptions are set out in the state-MCO contract and the MCO monitors access to that provider type on an ongoing basis.

A state must publish its adequacy standards on the state's website and make them available upon request in alternate formats. An MCO's External Quality Review must include a validation of network adequacy; CMS suggests that such validation might include activities such as direct testing or telephone calls. The information developed from an External Quality Review must include an MCO-specific assessment of access to services.

## Advocacy Considerations

The factors specified by CMS are all relevant. The question is whether the regulations as proposed are specific enough to ensure network adequacy, and practical enough to be used in an effective way.

- *Specific Standards:* Advocates should consider whether the regulations should establish any standards or guidelines for particular time and distance standards.
- *Weighing Factors:* States may be able to "consider" various factors in developing standards, but it may be unclear how all those factors are incorporated into a standard. It seems unlikely that there exists an algorithm that utilizes all the CMS-specified factors to create a standard.
- *Monitoring:* Another consideration is how usable these network adequacy standards are in real life, for state agencies, MCOs, and consumers. Consider the accessibility of the relevant information and the ease (or difficulty) of making the required determinations. A recent report by the HHS Office of Inspector General (cited by CMS in the proposed regulations) found that most states did not find *any* violation of access standards over a five-year period, and most findings of violations were based on a state's direct testing of MCO compliance.<sup>6</sup>

5 HEDIS refers to a quality measurement system called the Healthcare Effectiveness Data and Information Set.

6 HHS OIG, State Standards for Access to Care in Medicaid Managed Care, OEI-02-11-00320, at 15-16 (Sept. 2014).

- *Exceptions Process:* The exceptions process likely should be tightened or limited. It would be too easy for a contract to exempt a particular MCO, based on the proposed regulations' current language.

## Service Authorization and Care Continuity

What CMS Proposes (Proposed 42 C.F.R. §§ 438.210, 438.4, 438, 80 Fed. Reg. at 31120, 31126-31127)

With the aim of ensuring that MCOs appropriately provide long-term care services, the rule proposes changes that include LTSS in the definition of medical necessity, that set out utilization management guidance, and that require rate setting that treats LTSS costs as a health expense. Under the rule, state-MCO contracts must define medically necessary services. Part of the definition must include the MCO's responsibility for covering services that address the "opportunity" for the individual receiving LTSS to have "access to the benefits of community living." The MCO can set utilization management standards as long as LTSS services are authorized in a way that "reflects" the beneficiary's need for LTSS services. Finally, the rule requires MCOs to authorize LTSS based on the individual's needs assessment, and requires consistency between service authorization and the person-centered plan.

Further, to ensure care continuity, the capitation rate must be adequate to meet the requirement that MCOs ensure the availability of coordination and continuity of care.

### Advocacy Considerations

CMS proposes important consumer protections that could increase access and availability of LTSS services. However, the language is currently vague, raising concerns whether states and MCOs will interpret the proposal in a consumer-centric way. Advocates should consider the following:

- *Authority To Set Service Definitions:* CMS leaves responsibility to the state and MCOs to define and specify the amount, duration, and scope of the MCO services in the state-MCO contract. The state and MCO also have the authority to set the definition for medically necessary service in the contract.
- *HCBS Medically Necessary Service:* The contract only has to explain the MCO's responsibility to cover services that address the "opportunity" to have access to the benefits of community living. Consider whether addressing the opportunity for community living is a sufficiently clear directive to authorize home and community based services as a medically necessary service and what other formulations might be more effective.
- *Utilization Management:* The proposal requires that utilization management "reflect" the beneficiary's LTSS needs. Advocates should consider how their state would interpret the utilization management authority and share examples of past state practice. Consider other formulations that may include assisting with meeting the need, documenting the need, or providing services to meet the need.
- *Service Authorization Consistent With Person-Centered Plan:* Similar to the above question, the requirement that MCOs authorize a service "consistent" with the person-centered service plan creates questions. "Consistent" with the plan could mean authorizing the services requested in the person-centered plan, or it could mean authorizing services that are similar to the general goals of the person-centered plan. Advocates should share examples of how their state may interpret this directive.
- *Care Continuity:* The care continuity requirement is unquestionably vague. Advocates in MLTSS and dual eligible states should share examples of their state's existing care continuity requirements, and discuss how the requirement could be improved by this rule.

# Quality Measurement and Improvement

What CMS Proposes (proposed 42 C.F.R. §§ 438.310- 438.370, 431.500-506; 80 Fed. Reg. at 31148-58)

CMS describes its strategy as focusing on three principles: transparency, alignment with other systems of care, and consumer and stakeholder engagement.

Currently, CMS requires states to develop a quality strategy for services provided through managed care. The proposed regulations extend that requirement to all Medicaid-funded programs. As part of that strategy, states annually publish quality metrics and performance standards on the Internet.

CMS proposes to have authority to specify performance measures, methodologies for calculating quality ratings, and performance improvement projects. Under the proposal, states can request exemptions from CMS-developed performance improvement projects.

Each MCO is required to assess the quality of LTSS, including use of performance measures that assess quality of life, and that evaluate MCOs' rebalancing and community integration activities. CMS encourages use of consumer surveys in LTSS, and solicits comment on how they might be best used.

At least annually, the state must review the effectiveness of each MCO's quality assessment and improvement program. This review must include any MCO activities to support rebalancing.

To better align with non-Medicaid systems, CMS proposes to review participating MCOs with standards at least as stringent as those that are used in Medicare and private health care plans. The state can do the review itself, or rely on private accreditation, or both.

CMS also proposes to require an on-line quality rating system. It will take elements from existing measures, and be developed with notice and comment.

External review quality reports must include performance measure data for any collected performance measures and performance improvement projects. These reports must be available on a state's Medicaid website.

## Advocacy Considerations

Especially regarding public access to information, the proposed regulations are a substantial improvement over the current system. One concern is making sure that all the data will be meaningful for consumers in real life situations.

- *Specificity:* The focus on rebalancing is welcome, but could benefit from more specificity on recommended performance measures.
- *Private Accreditation:* One potential issue is the state's ability to rely on private accreditation. This arguably reduces state accountability. On the other hand, reliance on private accreditation is increasingly common.
- *Quality of Life Measures:* CMS has asked for input on how quality of life should be measured; consumers and consumer organizations should be sure to weigh in on this question.



# Rebalancing

What CMS Proposes (proposed 42 C.F.R. § § 438.4, 438.8, 438.330, 80 Fed. Reg at 31119, 31142, 31150-31151)

The rule encourages states and plans to promote community integration in its sections on medical loss ratio (MLR), performance measurement, and home and community-based services. In the rate setting section preamble, capitation rates should be “sufficient and appropriate” to promote community integration of beneficiaries, where feasible. The rule proposes that activities related to rebalancing effort can be categorized as a health activity, and therefore included in the numerator for purposes of calculating the MLR, which is a percentage of the MCO aggregate income that is spent on beneficiaries’ benefits.

Importantly, the rule would require that a state’s performance improvement program include measures that evaluate MCO performance on three rebalancing performance areas: 1) beneficiary’s quality of life, 2) plan’s rebalancing and community integration outcomes, and 3) for states that offer self-direction, measures specific to self-direction.

## Advocacy Considerations

At a high level, the rule incorporates important rebalancing components. However, the stated goal of MLTSS is to rebalance spending toward community services, yet the rule does not do enough to motivate states and plans to achieve that outcome.

- *Lack of Rate Setting Detail:* Although the rate setting preamble includes a recommendation for sufficient rates to support rebalancing, the regulatory language merely states the rates must be “appropriate for the populations to be covered and the services to be furnished under the contract.”
- *Silence on Rebalancing Incentive Payments:* Beyond payment for services, there is no requirement that states use the rates to incentivize plans to promote HCBS. Further, there is no requirement in the rates that they be sufficient to assist individuals transitioning out of institutional settings and into the community. Advocates should reflect on their current rate setting models, and discuss their ability to pay for community transitions.
- *Numerator Activities:* Advocates should provide details on the kinds of activities that should be included as a community integration activity for purposes of the MLR numerator. The proposed rule does not detail the types of activities that fall under this umbrella.
- *Need For Rebalancing Measures.* CMS’ overall proposal for quality assessment improvement gives great deference to states. While the rule includes three LTSS-specific quality areas, it does not recommend any LTSS-specific quality measures. Advocates may wish to review a joint advocate 2013 memo to CMS regarding specific rebalancing measures.<sup>7</sup>
- *No regulation on Olmstead:* The preamble includes a discussion that all programs be implemented consistent with the ADA and *Olmstead*; however, the actual regulation is silent on integrating and implementing *Olmstead* into managed care contracts and state-federal agreements.

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<sup>7</sup> Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers, available at: [http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo\\_01.13.14.pdf](http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf).

## Conclusion

The final Medicaid managed care regulations that emerge from this rulemaking may well control Medicaid managed care for decades. Comments by advocates working with aging beneficiaries can provide important facts and perspectives to help ensure that CMS produces strong regulations that correct deficiencies in the current regulatory regime and expand consumer protections.

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