



# Aging and Disability Partnership

for Managed Long-Term Services and Supports

## Proposed Medicaid Managed Care Regulations: Guide to Implications for the Aging and Disability Network

### Introduction:

For the first time in over a decade, the Centers for Medicare and Medicaid Services (CMS) is proposing to update the regulations for Medicaid services delivered by managed care organizations (MCOs).<sup>1</sup> The long-term services and supports (LTSS) landscape continues to change, as more states are utilizing managed care for LTSS than ever before. The proposed regulations could introduce sweeping changes to the managed care delivery system and significantly impact community-based programs that provide LTSS services.

While there is extensive coverage of the proposed regulations in the general health policy world, a focus on the particular impact to community-based organizations is missing. This guide attempts to fill that gap, zeroing in on the potential changes to community-based programs under the proposed rule.

The guide focuses on eight key areas of importance to community-based organizations (CBOs) in the Aging and Disability Network:

- 1) Medical Loss Ratio and LTSS
- 2) Beneficiary Support System
- 3) Stakeholder Engagement
- 4) Enrollment and Disenrollment
- 5) Coverage and Continuation of Benefits Pending a Fair Hearing
- 6) Grievances and Appeal
- 7) Network Adequacy
- 8) Disability Accessibility

In addition to an explanation of the relevant sections above, the guide details questions and issues CBOs should consider when reflecting on the rule. The guide is intended to be a useful document for the Aging and Disability Network (the Network), and readers are encouraged to use and distribute any sections of the document.

The proposed rule is currently a CMS proposal and the agency is receiving comments through July 27, 2015. While the final regulation may differ from the language in the proposal, the current document offers a helpful framework for understanding the future relationship between managed care and community based organizations.

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

## Medical Loss Ratio and LTSS

### ***From the Rule:***<sup>2</sup>

The proposal to implement a minimum medical loss ratio (MLR) is arguably one of the most significant changes in the rule. While the overall shift to an MLR is a significant change, the Network may be impacted by the proposal to include long-term services and supports (LTSS) activities as health care service activity in the MLR numerator.

At its most basic level, the MLR measures the share of health care premium dollars spent on medical benefits (the numerator) compared to company expenses, such as overhead and profit.<sup>3</sup> The rule notes that as of this year, Medicaid is the only health program that does not utilize a minimum MLR for managed care plans. The rule proposes an MLR of at least 85% to ensure Medicaid is aligned toward other health care programs. Consumer advocates have long advocated for minimum MLRs in health programs to ensure premiums are paying for consumer needs.

### ***Important Considerations for the Aging and Disability Network:***

The health policy community—state Medicaid agencies, insurance plans, providers, and consumer advocates—will likely weigh in on various elements of the MLR requirement. The Network should consider the requirement’s impact on long-term services and supports.

CMS is proposing to include long-term services and supports activities in the numerator. CMS states the existing definition of health quality activities is broad enough to encompass MCO activities related to service coordination, case management, and activities that support community integration. The existing health care quality activity definition includes activities that are designed to improve health quality, and increase the likelihood of desired health outcomes, and are grounded in evidence based practice.<sup>4</sup>

The Network should consider the following questions:

- 1) Does the existing health care quality definition adequately encompass long-term services and supports?
- 2) What types of activities do MCOs contract with community-based organizations (CBOs) to provide under existing MLTSS arrangements?
- 3) Would the network categorize these activities as service coordination, case management, or community integration support?
- 4) How do these different LTSS activities improve health quality, increase likelihood of desired outcomes, and how are they grounded in evidence-based practice? If these activities are not grounded in evidence-based practices, how do they improve care and services?
- 5) Do current MCO-state-CBO contracts address LTSS activities as part of the numerator for existing MLR requirements?

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<sup>2</sup> Proposed 42 C.F.R. 438.8.

<sup>3</sup> Congressional Research Service, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, available at: <https://fas.org/sgp/crs/misc/R42735.pdf>

<sup>4</sup> 45 C.F.R. 158.150(b).

## Beneficiary Support System

### ***From the Rule:***<sup>5</sup>

The Network will want to pay particular attention to the requirement that states develop a Beneficiary Support System (the System). The System will be responsible for providing consumer counseling, options management, and enrollment assistance. Many of the functions proposed are similar to the existing services and responsibilities aging and disability community-based organizations currently provide. In particular, the Network should pay attention to the choice counseling and conflict of interest requirements.

The System's core purpose is helping beneficiaries understand managed care. As CMS explains, the concept is similar to the State Health Insurance Programs (SHIPs). CMS proposes to redefine choice counseling<sup>6</sup> as providing information and services to help beneficiaries make enrollment decisions.

At a minimum, the System must provide four core functions: 1) choice counseling to all beneficiaries, 2) training for the MCOs on the type and availability of community based services and supports, 3) assistance to all beneficiaries understanding managed care, and 4) additional assistance for individuals receiving LTSS. All services in the System must be available through multiple mediums, including phone, internet, in-person and auxiliary aids and services.

The System will provide additional support to beneficiaries utilizing long-term services and supports (LTSS). CMS explains the additional level of support is appropriate because of the increased complexity of care and services the beneficiaries need. For LTSS beneficiaries, the System will provide: 1) an access point for complaints and concerns about enrollment; 2) education on enrollees' grievance and appeal rights; 3) assistance navigating the grievance and appeal process; and 4) review and oversight of LTSS program data to help resolve systemic issues.

To fund the new System, CMS indicates states would be permitted to draw upon and expand, if necessary, existing resources to meet the System standards. CMS indicates the System goals will "most likely be accomplished via a call center," and estimates the cost burden on the state will be minimal.<sup>7</sup>

### ***Important Considerations for the Aging and Disability Network:***

The Network should pay close attention to the second requirement: training for MCOs on community-based services. The proposal includes very few details on this expectation, stating merely that the System must provide training to MCOs and network providers on community based resources and supports "that can be linked with covered benefits."<sup>8</sup> The cost estimate section provides general information. CMS estimates the main activity under this function is creating and updating provider

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<sup>5</sup> Proposed 42 C.F.R. §§438.71, 438.10.

<sup>6</sup> Choice counseling definition will be moved to §438.2.

<sup>7</sup> 80 Fed. Reg. at 31182.

<sup>8</sup> 80 Fed. Reg. at 31272.

training materials. The agency estimates it will take a business operations specialists three hours to develop the training, and one hour to update the materials.<sup>9</sup>

There are two other key areas related to payment and reimbursement for services. First, CMS clarifies that any individual who provides choice counseling services is considered an enrollment broker, must meet conflict of interest standards and cannot have a financial relationship with any MCO. Next, CMS is looking for comments on whether entities that provide non-Medicaid federally financed protections to beneficiaries that include representation at hearings should be allowed to also contract with the Medicaid agency to provide choice counseling as long as appropriate firewalls are in place. CMS anticipates these requirements would include firewalls to separate staff responsibilities and billing practices.

The Network should consider the following questions:

#### Conflict of interest

- 1) What firewall standard between the choice counseling and other federally funded advocacy functions will preserve the independence of the choice counseling?
- 2) How do firewalls and conflict of interest safeguards currently work in community-based organizations? How do organizations design effective firewalls?
- 3) How will federally funded navigators, SHIP programs, dual eligible demonstration ombudsman, Centers for Independent Living, and other consumer assistance network programs work in the System?

#### Training

- 4) How should the System train MCOs on the Network of community-based services?
- 5) How would service coordination change if MCOs and providers received training on community-based services?

#### Outreach

- 6) What does it mean to provide outreach to beneficiaries? What are some of the current best practices for outreach to people with disabilities and people with limited English proficiency?
- 7) What SHIP counselor and long-term care ombudsman best practices that should be employed throughout the System?
- 8) What should notices and websites about the System include to ensure the materials are meaningful and readable?

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<sup>9</sup> 80 Fed. Reg. at 31182.

## Stakeholder Engagement

### ***From the Rule:***<sup>10</sup>

CMS emphasizes the importance of stakeholder engagement throughout the rule, particularly in the section codifying MLTSS guidance.

The rule proposes adding a new section<sup>11</sup> requiring states to create and maintain a state-level stakeholder group involved in the design, implementation, and oversight of the MLTSS program.<sup>12</sup> The proposal is intentionally vague as CMS wants states to have flexibility in determining the composition and frequency of stakeholder engagement meetings. CMS requests comment on: the general approach to the state-level stakeholder group, stakeholder group responsibilities, and meeting frequency.

CMS will also require all MCOs providing LTSS to establish and maintain a member advisory committee. The committee must include a representative sample of the populations the MCO serves.<sup>13</sup>

### ***Important Considerations for the Aging and Disability Network:***

The information in the proposed regulation is more general than the guidance CMS shared with states implementing managed care in 2013.<sup>14</sup> There is little requiring the MCOs to empower members of the stakeholder community to participate in the process. The proposal leaves significant deference to the states and MCOs to determine the composition of state-level stakeholder engagement and MCO member advisory committees. Similarly, the proposal is nonprescriptive in the methods to support consumers and stakeholders.

In the 2013 MLTSS guidance, CMS advised states that the state-level advisory committee should include representatives of the LTSS stakeholder community, including families, caregivers, providers and community-based organizations.

The Network should consider the following questions:

- 1) What kind of supports do consumers, family members, caregivers, community-based organizations, and others need to participate in the stakeholder process?
- 2) How can states and MCOs better engage community-based organizations in the design, implementation and oversight of an MLTSS system?
- 3) What information, such as publication of agendas, locations of upcoming meetings, release of minute, and updates on data, should MCOs and states share with stakeholders?

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<sup>10</sup> Proposed 42 C.F.R. §438.70

<sup>11</sup> Proposed 42 C.F.R. §438.70.

<sup>12</sup> 80 Fed. Reg. at 31144.

<sup>13</sup> Proposed 42 C.F.R. §438.110, 80 Fed. Reg. at 31274.

<sup>14</sup> Centers for Medicare and Medicaid Services, Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

## **Enrollment, Disenrollment and LTSS:**

### ***From the Rule:***<sup>15</sup>

Individuals with disabilities and seniors often have unique considerations when selecting a managed care plan. The enrollment and disenrollment provisions of the proposed rule address many of these concerns and are of particular importance to the Network. The proposed rule adds a new requirement (Section 438.54) that states develop an enrollment system with a consistent standard for both voluntary and mandatory managed care plans. It also sets broad parameters for the enrollment process, among them that states:

- 1) Provide at least 14 days for beneficiaries to make an enrollment decision;
- 2) Provide 14 days of fee for service coverage while a new managed care plan is being selected; and
- 3) Offer choice counseling services for any new enrollee or for enrollees when they have the opportunity to change enrollment. Choice counseling is the provision of unbiased information on managed care plan or provider options and answers to related questions for Medicaid beneficiaries.

The rule also sets standards for states that use passive enrollment (when the state selects the plan for the potential enrollee and then provides a specific period of time for the potential enrollee to decline the selection before they are enrolled) or automatic plan assignment (when an enrollee is given a specific period of time to affirmatively select a plan, after which if a selection is not made, a plan is automatically assigned). These states would need to:

- 1) Ensure that adequate and appropriate information is provided to beneficiaries explaining the implications of not making a plan selection;
- 2) Ensure that enrollees receive a confirmation of enrollment within 5 days of enrollment; and
- 3) Seek to assign beneficiaries to plans that preserve existing provider beneficiary relationships.

The disenrollment provisions are also revised. One change is an addition to the list of reasons why an enrollee can disenroll from a plan “for cause.” The proposed rule allows enrollees that use managed long-term services and supports to disenroll “for cause” if the enrollee would have to change plans because the long term service and support provider is no longer in the network. The rule would also revise the rule to limit enrollees to only one 90-day without cause disenrollment per enrollment period.

### ***Important Consideration for the Aging and Disability Network:***

The Network should consider whether a minimum of 14 days is a sufficient period of time for a potential enrollee to make a plan decision or whether a longer minimum period, such as 30 or 45 days should be adopted. This question is of particular relevance to people with disabilities and older adults in light of the fact that we are more likely to need services from medical specialists, and non-traditional plan providers such as transportation companies and personal assistants. It can often take more effort and time to gather information about these providers, since the standard brochures and website

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<sup>15</sup> Proposed 42 C.F.R. §438.54 and §438.56.

information about MCOs focuses on access to acute and primary care providers. More time may also be necessary when a person's disability makes it more difficult to access, review, or understand information about a MCO.

The proposed standards for passive enrollments, and auto-assignment are another area of importance. In particular, the rule requires that when states select MCOs they seek to support the preservation of the provider beneficiary relationship. It is not very clear however what this support might entail. The Network may want to consider some factors that would be especially important in a relationship between people with disabilities and providers, which the state should strive to preserve.

The Network should consider the following questions:

- 1) Is 14 days sufficient time for enrollees to make an appropriate plan selection; if not, would 30 or 45 days be more adequate?
- 2) Are there "for cause" reasons for disenrollment, not currently allowed, which should be added to ensure that beneficiaries with disabilities and seniors can disenroll when necessary?
- 3) Are there factors states should be required to consider when selecting a managed care plan for individuals with disabilities and seniors, other than the ones listed, which include: geographic location of the beneficiary, enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, and preservation of the provider beneficiary relationship?
- 4) What are some factors states might consider for passive and default enrollment that would support the preservation of the provider beneficiary relationship?
- 5) What are some delivery methods, and examples of language and phrasing that would satisfy the requirement for states to comply with §438.54(c)(3)(i), (d)(3)(i) requiring adequate and appropriate information to be provided to potential enrollees explaining the implications of not making a plan selection?

### **Coverage and Continuation of Benefits While an Appeal and Fair Hearing are Pending**

#### ***From the Rule:*<sup>16</sup>**

This section discusses both standards for the authorization periods set by MCOs and standards for the continuation of benefits pending the resolution of an appeal. The rule is updated to reflect the reality that managed care entities are serving an increasing number of enrollees with long term service and support needs, and more protections need to be in place to avoid disruptions in care.

The rule also makes some changes to the definition of medically necessary services to be more comprehensive, promote compliance with the Medicaid program for children and youth, and to require that the definition addresses the opportunity for an enrollee to have access to the benefits of community living.

Changes are also made to the appeal process, among them states would be required to respond to requests for expedited authorization determinations and expedited appeals of a termination,

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<sup>16</sup> Proposed 42 C.F.R. §438.210.

suspension, or reduction of a previously authorized course of treatment within 72 hours. This is a change from the current requirement of 3 business days. There is a process for extension of this timeframe up to 14 days, but only if the plan can prove to the state that the extension is in the enrollees interest.

Additionally, as long as a beneficiary has filed a timely appeal during the time in which a service was authorized, the state has an obligation to continue to provide benefits to enrollees without interruption until the conclusion of an appeal or fair hearing about an adverse benefit determination.

***Important Considerations for the Aging and Disability Network:***

The Network should pay attention to the proposed standards for prior authorization periods. People with disabilities and older adults can be especially disadvantaged by prior authorization limitations, since they are primarily designed to control costs by eliminating unnecessary coverage of acute care services. For individuals with chronic conditions, the requirement to repeatedly visit a doctor to obtain approval for treatment causes unnecessary doctor visits and enhances the risk of a gap in services. The new rule attempts to mitigate the potential harm of prior authorization periods for people with LTSS needs by requiring that States ensure “authorization periods support individuals with ongoing or chronic conditions or who require long-term services and supports.”

Another focus is the change to ensure that the definition of “medically necessary supports” addresses the opportunity for an enrollee to access the benefits of community living. The Network may want to consider if the rule needs more detail on the types of services and supports that may be necessary to facilitate community integration for people with disabilities.

The Network should consider the following questions:

1. Since standards for prior authorization periods can be useful for individuals with LTSS needs, and yet on its face appear to be more costly for states. The Network may want to consider supporting these standards, and sharing examples of how the standards will may result in cost efficiencies.
2. Is the phrasing of §438.210(a)(4)(ii)(B) that a state must ensure that “service authorization standards are appropriate for and do not disadvantage individuals that have ongoing chronic care conditions or need LTSS” strong enough to provide the protections necessary to avoid disruptions in care; if not, what is alternative language?
3. Is more detail needed to help states identify the types of medically necessary services and supports that would typically facilitate the opportunity for individuals with disabilities to access the benefits of community living? If so, what is some proposed language?
4. Is the definition of “adverse benefit determination” sufficient to address the barriers people with disabilities face accessing benefits pending resolution of appeals, if not what should be added to the definition?

## Grievances and Appeals and LTSS

### ***From the Rule:***

Changes to the appeal and grievance provisions of the rule are intended to further align Medicaid requirements with Medicare Advantage and private plans. Toward this end the rule proposes to:<sup>17</sup>

- Change some definitions, among them:
  - Replace the term “action” with “adverse benefit determination.” This will expand opportunities for beneficiaries to appeal adverse determinations, and clarify that could include determinations based on medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit.
  - Create a definition of “grievance system” to clarify that plan must have a formal structure of policies and procedures to appropriately address both appeals and grievances.
- Change the appeal process
  - Plans may require only one level of internal appeal before a beneficiary is permitted to request a state fair hearing.
  - Enrollees are required to seek this one level internal appeal before they can pursue a state level hearing
- Revise and establish timeframes
  - Sets a uniform minimum standard of 60 calendar days from receipt of an adverse benefit determination for a beneficiary to request an appeal.
  - Revises the requirement for plans to issue a decision on appeals from 45 days to 30 days; and for expedited appeals from 3 calendar days to 72 hours.
  - Lengthens the timeframe for enrollees to file state fair hearing requests to 120 calendar days from a decision on internal appeal.
- Add a requirement that grievance and appeal notices ensure meaningful access for people with disabilities and individuals with limited English proficiency; and clarifies that plans must give enrollees reasonable assistance, including auxiliary aids and services upon request, in completing forms and taking other procedural steps.
- Give enrollees a right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's claim for benefits. This would include information regarding medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits; and
- Allow plans to recoup from enrollees the cost of defending an appeal, in the event that the enrollee receives a final adverse decision.

### ***Important Considerations for the Aging and Disability Network:***

Individuals with disabilities and seniors often have barriers as a result of disability that can make it more difficult to meet short deadlines for requesting appeals or responding to information related to appeals

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<sup>17</sup> Proposed 42 C.F.R. §§ 434.400 438.402 438.408, 438.406 and 438.408.

and grievances. The Network will want to carefully review proposed timeframes to ensure they account for the extra time individuals with disabilities may require.

The proposed rules permit plans to recoup the cost of defending an appeal of an adverse benefit determination if the final ruling is against the beneficiary. CMS recognizes that such notice may deter an enrollee from exercising the right to appeal. The agency plans to issue future guidance on the model language and content of such notice to avoid dissuading enrollees from pursuing appeals. Our network may want to consider proposing some model language for these notices.

The proposal to require beneficiaries to exhaust the internal appeals process before they can pursue a state level hearing will impair a beneficiary's access to a timely state hearing is another important area of focus. The Network should consider the following questions:

- 1) Is 60 calendar days from receipt of an adverse benefit determination sufficient time for a beneficiary to request an appeal?
- 2) What model language should be required on notices indicating that in the event an enrollee receives an adverse decision on appeal the plan may seek to recoup the cost of defending the appeal?
- 3) How might the requirement to exhaust the internal appeal process prior to pursuing a state fair hearing be an unnecessary burden on individuals with disabilities and seniors? Provide examples if available.

### **Network Adequacy**

#### ***From the Rule:*<sup>18</sup>**

There are other aspects of the proposed rule's network adequacy section that will interest the Network in addition to the accessibility provisions. The rule establishes that any state that contracts with an MCO for the delivery of Medicaid services "must develop and enforce network adequacy standards consistent with this section."<sup>19</sup> CMS then follows a two-fold approach to what must be in the standards: "at a minimum" time and distance access requirements for seven categories of providers,<sup>20</sup> and then elements that the states "must consider" when developing time and distance network adequacy standards.<sup>21</sup> There are at least three important things to note about this approach:

- The rule does not give actual travel times or distances, or even ranges of those, to indicate when enrollees are too far away from a provider for the network to be adequate, but simply requires states to develop these kinds of standards.
- CMS is less prescriptive when it establishes eight elements that states must consider in their network adequacy standards, stopping short of suggesting *how* time and distance standards could adequately incorporate such elements as anticipated Medicaid enrollment and numbers and types of health care professionals; the rule does not outright require states to incorporate the eight elements.

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<sup>18</sup> Proposed 42 C.F.R. §§ 438.68, 438.206, 438.207.

<sup>19</sup> Proposed 42 C.F.R. § 438.68 (a); 80 Fed. Reg. at 31271.

<sup>20</sup> Proposed 42 C.F.R. § 438.68 (b)(1); 80 Fed. Reg. at 31271. Currently this list only includes medical and behavioral health providers, as opposed to LTSS providers.

<sup>21</sup> Proposed 42 C.F.R. § 438.68 (c); 80 Fed. Reg. at 31271.

- This somewhat bifurcated approach to the development of standards is further complicated for LTSS providers, who are divided into two kinds of categories: provider types “in which an enrollee must travel to the provider to receive services” and who will be subject to time and distance standards, and provider types “that travel to the enrollee to deliver services” that will be subject to “network adequacy standards other than time and distance standards.”<sup>22</sup>

In the proposed rule, CMS gives states considerable flexibility to establish MCO network adequacy standards and account for provider availability, which can vary widely depending on such factors as rural vs urban characterization, type of provider, the history of managed care within the state, and the rarity of a particular specialty (or needed treatment). As well, CMS seems to be very aware that that managed LTSS is still a relatively new thing and gives states a great deal of discretion to develop potentially totally novel network adequacy standards, especially for LTSS provider types that travel to an enrollee’s home.

CMS gives states two additional tools to maximize flexibility in provider networks. The rule explicitly allows states to develop varying standards for the same provider type on the basis of geographic area.<sup>23</sup> The rule also contemplates states having an “exception” process for its provider-specific network standards.<sup>24</sup> While there are some consumer safeguards for the exception process that mainly focus on ensuring on ensuring some transparency and monitoring in the development and use of the exception process, the rule clearly seems to contemplate, for example, the state releasing an MCO from meeting time and distance access requirements if the MCO has an insufficient number of specialists in its service area.

Finally, the proposed rule does lay responsibility for the availability of MCO services squarely on the state with the state, which “must ensure” that MCO provider networks for contractually covered services “meet the standards developed by the State.”<sup>25</sup> However, when the proposed rule drills down into actual provider compliance with timely access standards, it refers to states contractually ensuring that MCOs establish monitoring and enforcement mechanisms.<sup>26</sup>

The proposed rule currently contemplates document review as the primary means for state and CMS enforcement of network adequacy. Each MCO is to submit documents that demonstrate “an appropriate range of preventive, primary care, specialty services, and LTSS,” and maintenance of a provider network that “is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.”<sup>27</sup> MCOs must submit documentation at least when a contract with the state is entered, annually thereafter, and any time “there has been a significant change in the MCO’s operations. Note that the state can specify both the format of MCO documentation, as well as what constitutes a “significant change.” The state, in turn, is required to submit an assurance of compliance to CMS that includes “an analysis that supports the assurance of the adequacy of the network,” and make any collected MCO documentation available to CMS upon request.

***Important Considerations for the Aging and Disability Network:***

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<sup>22</sup> Proposed 42 C.F.R. § 438.68 (b)(2); 80 Fed. Reg. at 31271.

<sup>23</sup> Proposed 42 C.F.R. § 438.68 (b)(3); 80 Fed. Reg. at 31271.

<sup>24</sup> Proposed 42 C.F.R. § 438.68 (d); 80 Fed. Reg. at 31271.

<sup>25</sup> Proposed 42 C.F.R. § 438.206(a); 80 Fed. Reg. at 31275.

<sup>26</sup> Proposed 42 C.F.R. § 438.206(c); 80 Fed. Reg. at 31275.

<sup>27</sup> Proposed 42 C.F.R. § 438.207(b); 80 Fed. Reg. at 31275.

The approach to network adequacy outlined in the rule lacks specifics on a number of points that may be particularly relevant to aging and disability networks.

- Does the rule contemplate time and distance access standards that are the same or completely different for medical and LTSS provider types?
- Where do skilled nursing homes and other LTSS residential facilities fit in to the rule’s categorization of LTSS providers? Enrollees initially have “to travel” to such facilities, but thereafter take up residence within the facility where it could be argued that LTSS providers “travel to the enrollee to deliver services.” On the other hand, shouldn’t MCOs be encouraged to network with a geographically diverse range of nursing and institutional LTSS facilities since enrollees may well desire to remain as close as possible to their prior communities and the communities where friends and family may still reside?
- In addition to the 8 elements that must be considered by states when developing time distance standards for an enumerated list of providers (note that CMS reserves the right to add to this list), there are additional elements that states are required to consider for their LTSS networks. These include elements that support an enrollee’s choice of provider and strategies to support an enrollee’s community integration. Given the increased emphasis on the delivery of integrated care and care coordination, it is unclear whether these additional elements can or should also be considered in the establishment of network adequacy standards for the delivery of non-emergency medical care, for example.
- It is unclear how CMS will monitor and enforce a state’s appropriate “consideration” of the elements contained in the rule?

In the rule, CMS states that it chose time and distance standards because they are commonly used in the commercial and state Medicaid managed care programs and because the agency believes they are an accurate measure of enrollee’s timely access to care. At the same time, CMS specifically requests comment on whether there are other types of measures, such as provider-to-enrollee ratios that should be proposed, and on whether states should be given full flexibility to select and define the type of measure that each state wishes to use for determining the network adequacy of specified provider types. In the case of time and distance standards, CMS requests comment on whether the rule should actually set a time and distance or other standard per provider type, county, or other geographic basis.<sup>28</sup> The aging and disability network should provide CMS with its views on the need for clarity and direction in the rule, as well as the network’s experience of the kinds of standards and measures needed to ensure that MCOs build adequate LTSS provider networks.

With regard to state enforcement of provider network adequacy, CMS writes that “for access standards to be effective, states will need to have mechanisms in place for ensuring that those standards are being met” by MCO networks.<sup>29</sup> Comment is requested on the both the kinds of mechanisms that states could use to monitor for timely access (e.g., conducting enrollee surveys, reviewing encounter data, calculating and reporting relevant HEDIS measures, implementing secret shopper programs, and so forth), and on whether the rule should explicitly require states to have some or all of these mechanisms in place. The network in each state will have valuable insight on both of these points, in light of their historical experience with managed care network adequacy and state regulation of managed care. The

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<sup>28</sup> 80 Fed. Reg. at 31145.

<sup>29</sup> 80 Fed. Reg. at 31147.

aging and disability network's ongoing experience with the dynamic nature of provider networks over time also equips it to meet CMS' request for comment on how frequently MCOs should submit network certification materials, and how often the state should review such materials.

Overall, CMS appears to be very open to receiving stakeholder comment about many aspects of its approach to managed care network adequacy: the types of measures that states must include, the elements that states must consider, state flexibility in standard setting, monitoring and enforcement mechanisms, and especially how all of these aspects relate to the full range of managed LTSS providers. This is a key area of the rule that could benefit greatly with informed comments from the aging and disability network, including the network's thoughts on how LTSS providers, advocates and other stakeholders can and should be involved in the establishment of LTSS provider network adequacy standards.

The Network should consider the following questions:

- 1) How has your state monitored and enforced MCO network adequacy in the past? What kind of monitoring mechanisms help ensure MCOs meet the needs of Medicaid eligible seniors and people with disabilities?
- 2) Are there other providers, including LTSS providers, that should be explicitly included among the list of providers for which the state must develop time and distance standards if their services are covered under the contract (e.g., skilled nursing facilities)?
- 3) What are other ways that LTSS network adequacy can be measured if providers go to an enrollee's home? When enrollees typically travel to LTSS provider locations, what will be the possible impact of impact of time & distance standards on provider availability? Does this division between LTSS providers make sense?
- 4) Are there any "significant changes" in the composition of an MCO's LTSS network that should trigger submission of additional MCO documentation to the state (the examples given in CMS's commentary to the rule are only medical)?
- 5) Is CMS involvement in network capacity sufficient to support changes under the proposed rule?
- 6) Do you have suggestions for how the proposed rule could encourage states to solicit and incorporate input from key stakeholders such as Medicaid beneficiaries and LTSS providers as well as MCOs when developing LTSS network adequacy standards?
- 7) Is the exceptions process too wide, or does it need additional safeguards, such as some documented evidence of an MCO's efforts to obtain contracts with sufficient specialists, or input from affected Medicaid beneficiaries/enrollees before an exception standard can be approved?

## **Disability Accessibility**

### ***From the Rule***<sup>30</sup>

People with a wide range of functional limitations receive unequal and ineffective health care when services are delivered in an inaccessible physical environment or when providers and plans fail to provide accommodations and policy modifications mandated under federal law.<sup>31</sup> Advocates have

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<sup>30</sup> Proposed 42 C.F.R. §§ 438.10, 438.68, 438.206.

<sup>31</sup> 29 U.S.C. §§ 701 *et seq.*, 42 U.S.C. §§ 12101 *et seq.*

worked for several years to elevate this issue with CMS and states, and the proposed rule appears to respond to these concerns in a number of new ways. First, the proposed rule adopts requirements on *how* states and MCO's disseminate information, second the proposed rule newly articulates *what* must be included in that information, and third the proposed rule gives new MCO provider network adequacy requirements

To begin with, information requirements now explicitly obligate states and MCOs to provide information such as enrollee handbooks, provider directories, appeal and grievance notices, and other critical notices to enrollees and potential enrollees in a manner and format that "may be easily understood and readily accessible."<sup>32</sup> Readily accessible is further defined as "electronic information and services which comply with modern accessibility standards such as Section 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities."<sup>33</sup>

Even though the definition appears to be limited to electronic information, the accessibility obligation extends to written materials in accord with existing federal laws. Under the rule, written materials must be made available in alternative formats, and auxiliary aids and services for effective communication must be provided upon the request of a potential enrollee or enrollee and at no extra cost. Moreover, written materials for potential enrollees must include taglines in each prevalent non-English language as well as in 18 pt. font. The state's website and MCO websites must also be readily accessible and include the types of information listed above,<sup>34</sup> with the further obligation to provide information in an electronic form that can be electronically retained and printed.

Second, the information requirements section obligates MCOs to not only make a provider handbook available in electronic or paper form, but the handbook must include information about "whether the provider's office/facility is accessible for people with physical disabilities, including offices, exam room(s) and equipment."<sup>35</sup> This is a new obligation that the rule recognizes as necessary because MCOs are increasingly providing services to persons with disabilities, who cannot meaningfully access "the full scope of services at a provider's office" without accommodations.

Third, the proposed rule's network adequacy requirements explicitly direct states to develop and enforce standards that consider, among other things, the "ability of healthcare professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities."<sup>36</sup> Moreover, the proposed rule holds states accountable for ensuring that, in their contracts with MCOs, each MCO "must ensure that network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities."<sup>37</sup>

Taken together, the above provisions provide a picture of what the longstanding requirement that MCO contractors must agree to comply with applicable Federal and state civil rights laws and regulations,

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<sup>32</sup> 42 C.F.R. § 438.10 (c); 80 Fed. Reg. at 31263.

<sup>33</sup> 42 C.F.R. § 438.10 (a); 80 Fed. Reg. at 31263.

<sup>34</sup> In the rule CMS recommends that states and MCOs consult the latest Section 508 guidelines issued by the U.S. Access Board or W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA for online accessibility. 80 Fed. Reg. at 31159.

<sup>35</sup> 42 C.F.R. § 438.10 (h)(1)(viii); 80 Fed. Reg. at 31265.

<sup>36</sup> 42 C.F.R. § 438.68 (c)(viii); 80 Fed. Reg. at 31271.

<sup>37</sup> 42 C.F.R. § 438.206 (c)(3); 80 Fed. Reg. at 31275.

including the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973,<sup>38</sup> actually looks like in application. As well, the rule establishes a specific section on enrollee rights that places states under an obligation to ensure both that MCOs comply with federal and state laws including the Rehabilitation Act of 1973 and Titles II and III of the ADA, and provide enrollees with written notice of their enrollee rights, which includes MCO compliance with federal and state laws.<sup>39</sup> With proper enforcement, such notices could greatly assist seniors who have newly acquired functional impairments as well as people with long-held disabilities who acquire additional conditions as they age and struggle even to obtain accurate information about a healthcare professional's capacity to provide accessibility and accommodations.

***Important Considerations for the Aging and Disability Network:***

While healthcare professionals and MCOs have been subject to federal and state disability laws for decades, the detailed disability accessibility requirements proposed in the rule may still take some health policy stakeholders such as state Medicaid agencies, insurance plans and providers by surprise. Organizations and individuals in the Network should share their experience and views on the difference that healthcare accessibility will make in the lives of seniors and people with disabilities of all ages. Enrollees with disabilities, family members and friends have spent countless hours on trying to overcome a disability-related barrier or finding/paying for personal assistance on tasks that could have been performed independently with provider accommodations. This is energy that could be better spent on preserving health, maintaining relationships, and engaging in enjoyable activities.

The new information, provider directory, and network capacity requirements will apply to physicians, hospitals, pharmacies, behavioral health *and* LTSS providers. This fact raises a number of potential issues. With regard to the kind of information that must be provided to potential enrollees, the rule indicates that the state must provide sufficient information for beneficiaries to know and understand what it means to them to participate in a managed care program, regardless of whether the Medicaid managed care program is mandatory or not. If the beneficiary has an option to choose among MCO options, then she must have information about each choice available.

CMS requests feedback on an approach that emphasizes state flexibility by only listing a minimum set of information elements such as disenrollment rights, service area, covered benefits, and cost sharing that must be provided, and giving states the option of providing this information in paper **or** electronic formats. The aging and disability network should provide CMS with examples on how fully and inclusively your own state has embraced the role of educating Medicaid beneficiaries about managed care and their choices.

The proposed rule distinguishes between enrollees and potential enrollees for the kind of information that must be provided. For example, potential enrollees must be provided with information about covered benefits, including those benefits that are provided through an MCO and any benefits that are provided directly through a state. Enrollees, on the other hand, are to be provided with information on “the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.”

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<sup>38</sup> 42 C.F.R. § 438.3 (f)(1); 80 Fed. Reg. at 31256.

<sup>39</sup> 42 C.F.R. § 438.100(d) and (a)(1); 80 Fed. Reg. at 31272-73.

For many people and older adults with disabilities and chronic conditions, details of coverage are very important. In theory, different Medicaid MCOs should offer substantially the same benefits, but the details of each plan's formulary, how it authorizes treatments and delivers benefits, its experience with coordinating medical and LTSS services, and how the plan handles grievances and appeals for specific kinds of benefits such as durable medical equipment could be vital considerations that some beneficiaries need to know *before* choosing a plan. The Network's knowledge of the kind and depth of information that beneficiaries need to make informed choices should be shared with CMS, as well as thoughts about *when* such information should ideally be provided since the rule currently does not indicate how quickly MCOs or the state must provide alternate formats once enrollees request such formats; there is also no clear requirement for MCOs and the state to track the request so that an enrollee need not make the request repeatedly as information is issued.

The network also has valuable insight into how MCOs could fairly assess and consistently report over time on the accessibility of their network provider offices and facilities for the MCO's provider directory. Assessment of accessibility could be achieved through MCO-based site reviews, the hiring of 3<sup>rd</sup> parties who could visit offices and/or interview provider staff, provider self-reporting, enrollee reporting, or some combination of these and other approaches. Since accessibility involves some degree of expertise in the ADA's structural requirements, and is not limited only to physical accessibility but includes policy modifications and effective communication procedures as well, whoever is doing the assessment must have some training in the ADA. Enrollees with disabilities and their families will be extremely frustrated if they arrive at a provider's office only to encounter a single entrance stair that had been overlooked, an exam table that does not lower as promised, or the absence of any large font self-care materials. The network may also have ideas about how MCOs could help inform their LTSS providers of their ADA obligations and incentivize individual or organizational compliance.

The proposed rule's direction to states to consider disability accessibility as an element of network adequacy is a positive development. However, it will still be up to states to actually develop network adequacy standards, monitoring tools, and enforcement mechanisms that adequately take accessibility into account. States, MCOs and providers across the country have varied widely historically in the degree to which they have understood and complied with their federal disability rights obligations in Medicaid delivery. The aging and disability network in each state has a lot of experience with how accessibility issues have arisen in the past for enrollees with various functional limitations, and can advise CMS on whether states need greater clarity in the development of accessibility network adequacy standards, monitoring and enforcement in light of how much change is required in the status quo.

The Network should consider the following questions:

- 1) How will the proposed state and MCO communication obligations impact Medicaid beneficiaries with disabilities and functional limitations who need alternative formats and auxiliary aids and services?
- 2) How will community based organizations within MCO networks meet their own information requirement obligations (e.g., notice of accessibility rights, website accessibility, provisions of alternative formats and auxiliary aids and services), and how could MCOs assist with or incentivize compliance?

- 3) How will provider network accessibility be assessed? Examples of different methods include self-reporting, plan site visits, 3<sup>rd</sup> party telephone or in-person interviews, beneficiary reporting, or a combination of these.
- 4) As currently written, the information requirements seem to bypass the need to include information about the kinds of accommodations that people with mental disabilities may need, such as flexibility in appointment times and policies or allowing service animals in the office. How could MCOs collect this information as part of the accessibility assessment of provider offices that is already required?
- 5) How can information about reasonable accommodation and effective communication policies and actual practices among providers be captured accurately and in the detail required by people with disabilities and the aging community?
- 6) How will updated accessibility information be collected for the provider directors, and what is the best way to ensure and maintain accuracy?
- 7) Is there additional information that people with disabilities and seniors need to know in order to make informed enrollment decisions and ensure they know how to use plan benefits?
- 8) How will enrollees and potential enrollees be able to enforce their accessibility and language access rights?
- 9) How will network accessibility standards, and especially those that extend beyond structural accessibility to accommodations, communications and equipment, affect MLTSS providers?
- 10) How can the state best facilitate and ensure that MCOs meet their accessibility and accommodation obligations under this section?
- 11) How can CBOs with existing accessibility knowledge and expertise work with MCOs to achieve greater overall network accessibility?
- 12) What are effective ways for MCOs to build accessible provider networks? What are effective ways for states to monitor and enforce how MCO provider networks meet the state's physical accessibility and accommodation standards?

## **CONCLUSION**

The proposed Medicaid managed care regulation introduces significant changes to the delivery of long-term services and supports. If implemented as drafted, it will impact the way community-based organizations deliver valuable services and interact with states and managed care plans. While the rule proposal is just the start of the process, it offers insight on the changing role of community-based organizations in the ever-evolving managed long-term services and supports delivery landscape.