July 13, 2015

To: n4a Members  
From: Sandy Markwood, CEO  
Re: Discussion Guide and Survey on CMS Proposed Regulations for Medicaid Managed Care

n4a is seeking feedback from our members on how pending regulations may affect Area Agencies on Aging ability to support older adults and people with disabilities receiving Medicaid services. This discussion guide outlines the areas that we have identified as of top importance to our members, although we welcome your thoughts on other sections of the proposed rule, as well. At the end of this guide, please find a link to our online survey, so that we can best collect and digest your feedback and questions.

About the Proposed Regulations

For the first time in over a decade, the Centers for Medicare and Medicaid Services (CMS) is proposing to update regulations covering Medicaid services delivered by Managed Care Organizations (MCOs). The proposed rules would make significant changes to the way the federal government, states and MCOs work together to deliver Managed Care, including Managed Long-Term Services and Supports (MLTSS).

The long-term services and supports (LTSS) landscape continues to change, with more states utilizing managed care for LTSS than ever before. As states have been adopting MLTSS to serve older adults and people with disabilities, Area Agencies on Aging (AAAs) have been playing a key role in those developments by contracting with MCOs for vended services, serving as care coordinators and case managers, or providing options counseling for the managed care and dually eligible population.

The proposed regulations could introduce sweeping changes to the managed care delivery system and significantly impact AAAs and other community-based programs that provide these services. That is why n4a intends to submit comments to the proposed regulations later this month, and that is why we are soliciting your feedback before we craft our final comments.

In drafting the proposed rules, CMS has requested input on a number of key provisions and changes, and specifically seeks examples reflecting how these changes would affect service delivery and stakeholders on all levels. If your agency is participating in—or
planning to participate in—MLTSS in any capacity, it is essential that you provide n4a with feedback and insight about what these changes might mean for your ability to deliver services.

**How to Use this Discussion Guide**

This guide has been developed by n4a but is also informed by an early analysis of the proposed rules by the Aging and Disability Partnership¹, of which n4a is the leading organization.

To ensure that the AAA perspective informs CMS’s final determinations, we have identified five areas that we believe would most affect AAAs engaged in MLTSS:

1) **Beneficiary Support System, including Conflict of Interest Provisions**
2) **Stakeholder Engagement**
3) **Medical Loss Ratio and LTSS**
4) **Network Adequacy**
5) **General MLTSS Provisions**

In addition to an explanation of the relevant sections above, the document details questions and issues AAAs and CBOs should consider when reflecting on the rule. The rule is currently an agency proposal and CMS 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.

1) **Beneficiary Support System and Conflict of Interest Provisions**

*From the Rule:*

The Aging Network will want to pay particular attention to the requirement that states develop a Beneficiary Support System (the System).² 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 AAAs currently provide. In particular, the AAAs 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

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¹ The Aging and Disability Partnership was established by the National Association of Area Agencies on Aging (n4a) as part of Administration for Community Living (ACL) grant “Building the Business Capacity of Aging and Disability Community-Based Networks for Managed Long-Term Services and Supports.” It is a partnership between n4a and the National Disability Rights Network (NDRN), the Disability Rights and Education Defense Fund (DREDF), Justice in Aging, and Health Management Associates (HMA).

proposes to redefine choice counseling\(^3\) 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 in 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. 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.\(^4\)

**Important Considerations for AAAs:**

CMS requests comments 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 in both staff responsibilities and billing practices.

CMS is also seeking input on a requirement to provide training for MCOs on community-based services. The proposal include 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.”\(^5\) The cost estimate section is equally uninformative. CMS estimates the main activity under this function is creating and updating provider training materials. The agency estimates it

\(^3\) Choice counseling definition will be moved to §438.2  
\(^4\) 80 Fed. Reg. at 31182.  
\(^5\) 80 Fed. Reg. at 31272.
will take a business operations specialist three hours to develop the training and one hour to update the materials.6

n4a requests your input on the following questions:

Conflict of Interest
1) How might the prohibition on contracted community-based organizations serving as a choice counselor impact AAAs? What would this mean for your organization?
2) What firewall standard between the choice counseling and other federally funded advocacy functions will preserve the independence of the choice counseling? Is such a firewall standard necessary or will this limit services?
3) How do your current firewalls function effectively without limiting service provision?

Training
4) How should the System train MCOs on the network of available community-based services?
5) How would service coordination change if MCOs and providers received training on available community-based services?
6) What other training requirements should be included in the System?

Outreach
7) How can we leverage our expertise and experience to ensure that MCOs conduct effective outreach to older adults and people with disabilities?
8) What are some of the best practices of the SHIP counselors, long-term care ombudsman and other outreach work your agency has done that should be employed throughout the System?

2) Stakeholder Engagement

From the Rule:

CMS emphasizes the importance of stakeholder engagement throughout the rule, particularly in the section on codifying MLTSS guidance.7

The rule proposes adding a new section8 requiring states to create and maintain a stakeholder group involved in design, implementation and oversight of the MLTSS program.9 The proposal is intentionally vague as CMS intends states to have flexibility in determining the composition of and frequency of stakeholder engagement meetings.

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7 80 Fed. Reg. at 31142.
8 Proposed 42 C.F.R. § 438.70.
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.\textsuperscript{10}

**Important Considerations for AAAs:**

The importance of including AAAs in stakeholder engagement activities has been demonstrated clearly, however, there is little guidance to the MCOs on their responsibility to empower members of the stakeholder community to participate in the process and the information in the proposed regulation is more general than the guidance CMS shared with states implementing managed care in 2013.\textsuperscript{11} 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 guidance also had more information on stakeholder support, requiring states to facilitate consumer participation through transportation assistance, interpreters, personal care assistants, and other reasonable accommodations, including compensation.

n4a requests your input on the following questions:

1) How can states and MCOs better engage AAAs in the design, implementation and oversight of an MLTSS system?
2) What value do you think that AAAs uniquely bring to the stakeholder engagement process?
3) What kind of supports, if any, would AAAs need to participate in the stakeholder process?

**3) Medical Loss Ratio and LTSS**

*From the Rule:*

The proposal to implement a minimum medical loss ratio (MLR) is one of the most significant changes in the rule. While the overall shift to an MLR is a sweeping change, Aging Network entities will likely be significantly affected by the proposal to include

\textsuperscript{10} Proposed 42 C.F.R. §438.110, 80 Fed. Reg. at 31274.
long-term services and supports (LTSS) activities as health care service activities 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. 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 percent to ensure Medicaid is aligned with other health care programs.

**Important Consideration for AAAs:**

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

CMS is looking for comment on their approach to include long-term services and supports activities in the MLR 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. Given that AAAs in particular engage heavily in the activities that CMS is now proposing to classify as health care instead of administrative expenses, how might this affect contracted services?

Briefly, the existing health care quality activity definition includes activities that are designed to: improve health quality, increase the likelihood of desired health outcomes, are directed to individual enrollees and are grounded in evidence-based practice.

**n4a requests your input on the following questions:**

1) Does the existing health care quality definition adequately encompass long-term services and supports?
2) How do these different LTSS activities improve health quality and 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?
3) If you have an MLTSS contract with an MCO, how are your LTSS activities currently classified?

**4) Network Accessibility and Adequacy**

_**From the Rule:**_

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State and federal network accessibility requirements are not new, but the current regulatory framework for managed care was developed when LTSS services were extremely limited in number and geographic scope. The proposed rule aims to align Medicaid managed care standards with other public and private health care programs by requiring that states and MCOs provide information and resources to enrollees such as enrollee handbooks, provider directories, appeal and grievance notices and other critical notices in a format that “may be easily understood and readily accessible.” Additionally, the rule requires that alternative formats and auxiliary aids and services requested must be available at no cost upon request.

The rule also addresses network capacity from an accessibility framework. Under the approach proposed by CMS, the state will establish standards for MCO network capacity and ensure that those standards are met. These standards are supposed to consider the accessibility of service providers for people with physical disabilities and functional limitations and mandate that providers make reasonable accommodations. The standards also must include culturally competent communications and accessible equipment. States must also ensure that there are sufficient and adequate health care and LTSS providers within the managed care network for enrollees with disabilities or limited English proficiency. All individuals must have sufficient access to services.

The rule proposes that states set time-distance standards as the fundamental means of establishing network adequacy for medical providers, but the approach to LTSS is different. CMS directs states to look at standards “other than time distance” when LTSS providers are traveling to the enrollee. CMS suggests a number of elements for states to consider in establishing these standards, but ultimately the states will have the responsibility to establish, monitor and enforce network accessibility, capacity and adequacy.

**Important Consideration for AAAs:**

The information format change means that MCOs and the AAAs they contract with will need to meet information requirement obligations and ensure that provider networks are accessible to older adults and people with disabilities. The rule provides little clarity and seeks input on how the provider network will be collected accurately and consistently assessed. For AAAs contracting with MLTSS providers, there will be considerable accessibility requirements for beneficiary information and resources.

Network adequacy and capacity requirements are new for Medicaid Managed Care—particularly MLTSS. AAAs and other CBOs that are well versed in accessibility standards will need to work with MCOs to ensure that their providers and networks meet state accessibility requirements.

AAAs will also need to work with MCOs and states to ensure that network adequacy standards meet the needs of seniors and people with disabilities. AAAs and CBOs providing LTSS may approach network adequacy differently than other providers—the end goal is to provide services to people who need those services—but will MCOs and
other medical providers take the same approach? Or will proposed accessibility and adequacy standards be a disincentive for providers to contract with MCOs?

**n4a requests your input on the following questions:**

1. How would your agency comply with accessibility requirements for beneficiary information?
2. How can information about reasonable accommodations for LTSS providers be collected regularly and accurately?
3. Are there other ways that LTSS network adequacy can be measured other than time distance standards?
4. What are effective ways for states to monitor and enforce how MCO provider networks meet accessibility and adequacy standards?

**5) General Long-Term Services and Supports Provisions**

*From the Rule:*

This section details some of the miscellaneous LTSS provisions throughout the proposed rule:

**Definition:** CMS broadly defines long-term services and supports. CMS considered listing specific services, but determined that such a definition would be too limited.

- Is there a benefit to including greater detail about the services and supports included in the LTSS definition? Or providing consistency between LTSS defined in the rule and in other CMS-issued regulation and guidance?

**LTSS as a medically necessary service:** 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.”

- Is the “opportunity” for community living a sufficiently clear directive to authorize home and community-based services as a medically necessary service?

**Developing a Person-Centered Plan:** A service plan must be developed with enrollee participation, by a person trained in person-centered planning, and in compliance with CMS’s person-centered planning regulations.

- Is the requirement that MCOs authorize a service “consistent” with the person-centered service plan clear enough to ensure the person-centered plan is implemented? How would states, MCOs and CBOs interpret the directive?

As previously mentioned, n4a is interested in our members’ feedback to other provisions in the rule not mentioned in this discussion guide. There is a place on our online survey [14 42 C.F.R. §§ 438.2, 438.3, 438.214 and 438.816; 80 Fed. Reg. at 31141- 31144]
that will allow you to submit additional comment, or you may email n4a’s Director, Public Policy and Advocacy Autumn Campbell with suggestions for further examination.

LINK TO SURVEY (pending)

Thank you for taking time to help n4a develop our response to CMS’s proposed rules. We intend to release our final comment letter before or on the deadline of July 27, which will we share with our members and publicly on our website.