NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS' (NASOP) COMMENTS ON THE MEDICAID MANAGED CARE PROPOSED RULE

Comment: §431.506 Applicability to Medicaid managed care programs.

NASOP supports this proposed federal rule and its application to managed care programs, as defined in 438.2, to include the full range of applicable waivers. Applying the rule in this way will help ensure that providers deliver quality care no matter the setting and no matter what contractual arrangements are in a state's service delivery system.

Comment: §438.71 Beneficiary support system.

NASOP supports proposed language regarding a beneficiary support system (BSS). Specifically, NASOP supports the stated purpose of a BSS is to support individuals who need long-term services and supports because a subset of this group will need additional help to navigate the complex managed care delivery system. We believe requirements for choice counseling will align with Older Americans Act services such as benefits counseling and aging and disability resource center options counseling services. Including these functions, which are typically in area agencies on aging, recognizes the role of these agencies in the LTSS system. The requirement to train providers on beneficiary needs is also necessary, and NASOP supports the proposed requirements to educate enrollees about managed care and LTSS. NASOP strongly agrees with the proposed rule language that supports various options for beneficiaries to interact with a BSS. Some LTSS recipients will need to speak with a person face-to-face. This requirement is necessary in the federal rule to ensure states do not cut expenses, for example, by offering a telephone and Internet BSS only. A BSS that does not include an option for home and office visits as needed would directly hurt beneficiaries and may result in some not accessing needed services.

Comment: §438.71 (e) Functions specific to LTSS activities.

NASOP has questions about limits placed on the role of a BSS with respect to appeals. Specifically, (e)(3) states, "The system may not provide representation to the enrollee at a State fair hearing but may refer enrollees to sources of legal representation." This goes on to specify that using non-Medicaid funds, entities can provide these services to beneficiaries, as well as choice counseling, subject to CMS-approved firewalls.

This prohibition regarding representation of the enrollee means that state long-term care ombudsman programs cannot serve as members of the BSS without additional burden placed on program operations. A primary function of a state long-term care ombudsman program is to advocate on behalf of residents, including representing their interests and pursuing administrative, legal, or other remedies to protect their health, safety, welfare, and rights (45 CFR §1327.13(a)(5)). Prohibiting a long-term care ombudsman from representing a resident in a Medicaid state fair hearing runs directly counter to this requirement.

NASOP seeks clarification from CMS on why choice counseling and our program's federally-funded advocacy functions cannot exist together. Resident-directed advocacy is a primary operating principle

for a long-term care ombudsman, and is enumerated in federal rule (45 CFR §1327.13 and §1327.19(b)). This principle restricts a long-term care ombudsman from attempting to sway a resident's decision about which managed care organization to choose or whether to file a complaint. Additionally, state long-term care ombudsman programs have federal requirements to operate independently of state Medicaid agencies and be free of conflicts of interest (45 CFR §1327.21). Therefore, it would seem that state long-term care ombudsman programs, by virtue of operating principles and independence requirements, could be a member of the BSS and their role in representing residents in a state fair hearing should not be limited by §438.71(e)(3). As written in this proposed rule, a state long-term care ombudsman program would appear to be required to establish firewalls to provide information and assistance that meets the definition of choice counseling in §483.2. Requiring a state long-term care ombudsman program, which is already required to be independent of the state Medicaid agency, to create additional firewalls to perform a function we already perform in accordance with existing federal law, is burdensome and unnecessary.

§438.71(e)(3) also states that the system may refer enrollees to sources of legal representation. Long-term care ombudsmen are skilled at representing long-term care residents - and in some states, recipients of home care services – in managed care appeals, other disputes, and state fair hearings. Legal aid and other legal services are valuable partners in this effort; however, many legal aid organizations already face overwhelming caseloads. Meeting the demand for our help in grievance functions is a challenge, but representing residents in state fair hearings is an important function we serve. Individuals needing help with a state fair hearing have very few resources to support them. So, it is crucial that these rules avoid placing further burden on the consumer or create new barriers to consumers exercising their right to a state fair hearing.

Comment: §438.100 Enrollee rights.

There is no mention of an enrollee's right to appeal and to voice grievances. NASOP believes it is important to enumerate this as an enrollee's right, and to specify to whom and where they can make complaints.

There is no specific mention of an enrollee's right to self-determination only the right to "participate in decisions regarding his or her health care, including the right to refuse treatment." NASOP recommends adding the enrollee's and member's right to self-determination among those listed in subsection §438.100 (b)(2).

Comment: §438.110 Member advisory committee.

This section requires the MCO, PIHP, PAHP that covers LTSS to establish and maintain an advisory committee. There is one sentence about the committee composition; however, there is nothing to describe the role of the advisory committee. NASOP recommends clarification about the scope/role of the advisory committee is needed ensure that the committee is not just for appearances, but actual depth. We suggest that CMS develop a more detailed description about the make-up, mission and role of the Member Advisory Committee in the spirit of the Federal Advisory Committee Act (FACA) http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/index.html.

Comment: <u>Subpart F in general</u>

NASOP suggests replacing "dispose" (&"disposition") as used in this specific section, and throughout Subpart F, with resolve/respond (resolution/response). "Dispose" implies a more negative treatment than "resolve" or "respond".

Comment: §438.402(b) <u>Level of Appeals</u>.

NASOP suggests replacing the word "may" in the proposed regulation with "shall." The revised requirement would read "Each MCO, PIHP and PAHP *shall* have only one level of appeal for enrollees." Using the word "may" implies permission to have only 1 level of appeal. After reading this entire Subpart, it appears that the intent is actually to require only one level.

Comment: §438.402 (c)(1) <u>Filing requirements</u>. <u>Authority to file</u>.

(i) NASOP suggests adding "appropriate legal representative" in addition to enrollees themselves as parties who are authorized to file grievances and/or appeals. Not all enrollees may have the capacity to take these actions independently.

(ii) NASOP suggest that CMS clarify whether or not enrollee, or appropriate legal representative, authorization/permission is necessary whenever a provider exercises the right to request an appeal on an enrollee's behalf. To be consistent with person-centered planning, no action should be taken in behalf of an enrollee without the enrollee's involvement.

Comment: §404(b)(2) <u>Content of Notice.</u>

NASOP suggests adding "policies and procedures" to the list of information that an enrollee is entitled to if s/he has questions about an adverse benefit determination. While the list in the proposed rule seems extensive, adding the terms "policies, procedures and similar guidance" broadens the list to clearly allow access, free of charge, to the information that is used to reach substantive coverage decisions and clarifies that the policies/procedures/guidance that support adverse determinations are not to be regarded as "internal use only."

Comment: §406 <u>Handling of Grievances and Appeals. (b) Special Requirements.</u>

(5) NASOP suggests rewording this rule to improve clarity. The proposed language is dense and ambiguous. Suggest reordering the information to read "*Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).*"

Comment: §438.410 <u>Expedited Resolution of Appeals. (b) Punitive Action.</u>

NASOP suggests moving this requirement out of this section and creating a separate heading "Punitive Action Prohibited" since the prohibition applies to other scenarios not just the "expedited appeals" covered by this heading. We also suggest providing some examples as to what CMS might consider punitive actions to be.

Comment: §438.414 <u>Information about the grievance system to providers and subcontractors.</u>

NASOP suggests expanding this section to include a requirement to provide information about the grievance/appeal system to all enrollees upon their enrollment. The more often enrollees are educated about the grievance appeal system the more likely they will be able to understand and use it. Enrollment is a prime opportunity for education that should not be missed.

Comment: §438.416 <u>Recordkeeping requirements</u>.
(b) NASOP suggests adding a new item (7) --- "Name(s) of individual(s) deciding the grievance/appeal" --- to the items that each MCOs, PIHPs, and PAHPs must maintain in each grievance/appeal record. The actual names of staff may be useful in identifying and/or addressing patterns and trends in the grievance appeal resolution process.

Comment: §438.420 <u>Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending. (d) Enrollee responsibility for services furnished while the appeal and state fair hearing is pending.</u>

As currently written, the rule will require the enrollee to repay all benefits provided throughout both the initial appeal level and the fair hearing process. This could be a barrier to legitimate appeals if enrollees have to bear the entire cost of services provided throughout the process. NASOP suggests different responsibilities of cost for different levels of appeal. Require that the MCO, PIHP, Or PAHP include the cost of services provided during the first level of appeal as a "covered service" but require enrollee repayment for services provided during the fair hearing stage. Requiring that providers bear some responsibility can promote more accurate initial determinations, more timely first level determinations, and encourage enrollees to exercise their due process rights.