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July 27, 2015

Attention: CMS–2390–P

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
P.O. Box 8016
Baltimore, MD 21244–8016

Re: CMS–2390–P
Comments on Proposed Rules – Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Mr. Slavitt:

Thank you for the opportunity to comment on the proposed amendments to the federal Medicaid managed care and Children's Health Insurance Program regulations.

Empire Justice Center is a statewide, multi-issue, multi-strategy public interest law firm focused on changing the "systems" within which poor and low income families live. Our work covers a full spectrum of poverty law, including Medicaid and health care access, public assistance, child care, food stamps, domestic violence, disability benefits, civil rights and consumer law. The health law practice at Empire Justice Center is focused on providing representation to low-income New Yorkers on health care access issues and supporting other health advocates across the state. Our health practice provides technical assistance and training, takes referrals of complex cases, engages in administrative and legislative policy advocacy, and, when necessary, files class action lawsuits to tackle systemic barriers to accessing health care.

As a statewide organization that has long engaged in Medicaid advocacy, we have experience with both voluntary and mandatory Medicaid managed care. Empire Justice has been appointed to several New York State Department of Health workgroups focused on the state's transition to mandatory managed care for all, including the Nursing Home Workgroup and the Managed Long Term Care Quality Incentive Payment Workgroup. We also meet regularly with and engage in advocacy related to Medicaid managed care with the state through our active involvement with Medicaid Matters New York and the Coalition to Protect New York's Dual Eligibles.

All of our extensive Medicaid-related direct service, technical assistance, policy and litigation work, combine to inform our comments and recommendations on the proposed regulations.

We support HHS's move to modernize and clarify the regulations governing Medicaid managed care programs. Nevertheless, in light of the growing number of individuals who receive their Medicaid through managed care and the move, like New York's, towards mandatory Medicaid managed care for all, we believe the regulations can be further strengthened in a number of ways as set forth below and in the comments of the National Health Law Program (NHeLP).

Empire Justice Center endorses the comments and recommendations of the National Health Law Program (NHeLP) with whom we regularly partner. The remainder of Empire Justice's comments are aimed at emphasizing three areas of the regulations that are of particular concern in New York. Where we make specific recommendations, additions are underlined in **green** and deletions are crossed out in **red**.

I. Statement in Support of and Adopting NHeLP's Comments

As an initial matter, **we adopt as our own and endorse NHeLP's comments on the proposed managed care regulations.** Empire Justice Center has had a long-standing partnership with NHeLP and we frequently consult and collaborate with NHeLP staff to address Medicaid-related issues at the New York state and federal levels. Our adoption of an endorsement of NHeLP's comments comes after thoroughly reviewing and contributing to their comments and confirming that they address Empire Justice's views on the proposed regulations and those areas of the regulations that we believe can be improved.

II. Due Process: Service Authorizations, Continuation of Benefits and Exhaustion of Internal Appeals

We have several concerns about the proposed regulations related to service authorizations, continuation of benefits pending appeals and the proposal to require exhaustion of internal plan appeals. While we understand HHS's desire to align the Medicaid managed care regulations more closely with Qualified Health Plans and Medicare Advantage, Medicaid enrollees are entitled to greater protections to avoid the harm that can result from loss of access to their benefits. Our recommendations for the service authorization, continuation of benefits and in opposition to internal plan exhaustion would strengthen and clarify the proposed regulations to ensure that enrollees' due process rights, as interpreted by the Supreme Court in Goldberg v. Kelly, 397 U.S. 254 (1970), are adequately safeguarded.

a. Service Authorizations (§ 438.210(b))

To ensure continuity of care and access to due process, we join NHeLP in urging HHS to strengthen language pertaining to service authorizations in § 483.210(b). We are concerned

that the timing of reauthorization requests and approvals be set to ensure continuity of care, particularly for LTSS and other services for chronic conditions. Procedures must ensure that services not lapse merely because an authorization period has ended. We recommend protections in this section to ensure that reauthorization requests, where required, are timely filed and processed, and that enrollees are notified if their provider has not submitted a reauthorization request. Additionally, if the managed care entity terminates or reduces the service or course of treatment, the enrollee and provider will receive notice of the termination or reduction in a timely manner so as to allow them to continue benefits pending appeal. Our suggestions for amending § 438.210(b) should be read in tandem with our suggestions for amending § 438 420, Continuation of benefits while the internal managed care appeal and the State fair hearing are pending.

RECOMMENDATION: Amend § 438.210(b) as follows:

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures. **The MCO, PIHP, or PAHP shall disclose to the state and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including LTSS. The MCO, PIHP, or PAHP shall also disclose those processes to the public upon request.**

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS **and other services for chronic conditions** based on an enrollee's current needs assessment and consistent with the person-centered service plan **and not arbitrarily reduce, modify, or deny previously authorized services when the enrollee's needs have not changed**.

(iv) Ensure that initial and reauthorizations of services clearly inform the enrollee and provider of the period of authorization, including the date on which the period of authorization ends and the deadline for requesting reauthorization of services such that services will continue without interruption;

(iv) Shall not require prior authorization for family planning services and supplies consistent with paragraph (a)(4)(ii)(C) of this section.

(v) Shall provide non-emergency transportation services whenever an enrollee needs transportation to receive covered, medically necessary services.

(3) Reauthorization requests. Where required, all requests for reauthorization or continuation of a service must be submitted by the prescribing providers at least 10 calendar days prior to the end of the current authorization period for services to continue without interruption pending the decision on reauthorization.

(i) If the prescribing provider submits the request at least 10 calendar days prior to the end of the current authorization period and the request is approved, there must be no break in service and the service must be authorized beginning on the first day after the end of the authorization period.

(ii) If the request is submitted at least 10 calendar days prior to the end of the current authorization period but the MCO, PIHP, or PAHP does not make a decision approving reauthorization prior to the end of the current authorization period, then the service authorization must continue without interruption until 10 days after a notice of change in services is sent by the MCO, PIHP, or PAHP. r.

(iii) If the prescribing provider submitted the request at least 10 calendar days prior to the end of the current authorization period and requested services are terminated or authorized in an amount, duration, or scope less than that requested

(a) the effective date of the change in services shall be no sooner than 10 days after the date the notice is mailed;

(b) the enrollee will be provided notice of the adverse coverage determination as provided under 42 C.F.R.§ 438.408; and

(c) the MCO, PIHP, or PAHP must ensure the continuation of benefits as required under 42 C.F.R. § 438.420.

[OPTION A:]

(iv) For LTSS and other services for chronic conditions, if the request for reauthorization is not submitted at least 10 calendar days prior to the end of the current authorization period, the plan shall, 10 calendar days prior to the end of the current authorization period, send written notice to the enrollee stating that the authorization period will be extended for 10 calendar days after the end of the current authorization period, and that services will terminate if no reauthorization request is received by the last day of said extension period. The notice shall specify the address and fax number to submit a reauthorization request.

[OPTION B:]

(iv) For LTSS and other services for chronic conditions, when an enrollee has been prescribed a covered service that is subject to prior authorization and that is:

(A) for a chronic condition;

(B) is prescribed on an ongoing basis or with no specific ending date; or

(C) can cause serious harm to the enrollee if interrupted,

the MCO, PIHP or PAHP must provide notice to the enrollee before the expiration of prior authorization for the service. The notice must be provided no more than 40 days, or less than 30 days, prior to the expiration of prior authorization for the service. In the event that the period of authorization is less than 30 days, the notice shall be issued upon authorization.

(v) The notice must:

(A) identify the service,

(B) list the contact information for the provider who previously prescribed it,

(C) inform the enrollee when authorization is ending, and

(D) explain that the service must be prescribed again by an authorized provider at least 10 days prior to expiration in order to prevent possible disruption.

(~~3~~**4**) That any decision to deny, **terminate or reduce** a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

b. Continuation of Benefits (§ 438.420)

Empire Justice Center thanks HHS for promulgating an amendment to § 438.420 that the preamble confirms is intended to protect the right to continued benefits pending an appeal. But we have concerns that the language as drafted does not fully implement HHS' stated intent to be consistent with the requirements for constitutional due process. As stated above, we understand HHS' desire to align Medicaid managed care with Qualified Health Plans and other plan types. However, the due process right to continuation of benefits pending a hearing is unique to Medicaid, and calls for procedures that diverge from those common in other plan types. The related concept of an "authorization period" in § 438.210 is one that also must be crafted specially to protect the due process rights of Medicaid enrollees (see comments above). As HHS recognizes, Medicaid managed care plans now cover LTSS, behavioral health care, and other ongoing services for long-term chronic conditions. Due process requires that an enrollee be guaranteed continuation of these services regardless of whether an "authorization period" has expired.

Allowing the lapse of an authorization period to deprive an enrollee of continued benefits pending an appeal inflicts two types of harms requiring due process protection. First, under Goldberg v Kelly, enrollees have the poverty-driven, "brutal need" for continued benefits pending appeal that rises to the level of a constitutional protection. Second, if services simply lapse at the end of an authorization period, with no guarantee of continuation if the managed care entity decides to reduce or even terminate services, the enrollee has the perpetual status as an "applicant" for a service, with no entitlement to the service despite the plan's prior determination of eligibility. Yet due process places on the Medicaid program, and therefore the managed care entity, the burden of proving that the enrollee is no longer eligible for a service for which she was previously found eligible. Mayer v. Wing, 922 F. Supp. 902 (SDNY 1996). People with chronic conditions and life-long disabilities cannot be in the perpetual position of having to re-apply for the same services they depend on to meet their daily needs, simply because an arbitrarily defined authorization period has lapsed.

We make the following recommendations for § 438.420. Our suggestions for amending § 438.420 should be read in tandem with our suggestions above for amending § 438.210(b), (authorization of services). Specific regulatory language is recommended at the end of this section.

1. **Conform § 438.420(b) to amended § 438.420(c) and remove any condition that precludes the continuation of benefits pending a hearing or internal appeal if the previous authorization period has expired.** By its amendment to § 438.420(c), HHS now ensures that an enrollee can maintain the previously authorized level of benefits uninterrupted pending the State fair hearing decision – including during the pendency of the plan level appeal – regardless of whether the authorization period expires. However, **unless § 438.420(b) is similarly amended by deleting subsection (4), an enrollee may not have benefits continue in the first place if, when the appeal is requested, the authorization period has already expired**. As currently written, a plan can time its notice of action to deny continuation of benefits to an enrollee. In New York, the denial of continued benefits because of a lapsed authorization period was such a concern – especially in the context of the MLTSS program – that the state amended its Medicaid law in 2014 to require continued benefits regardless of whether an authorization period ended. N.Y. Social Services Law § 365-a(8). While we are relieved that NYS requires stronger due process protections than existing federal regulations, we urge HHS to carry out its stated intent in the preamble and ensure that the end of an authorization period never results in loss of access to continued benefits.
2. **Remove the requirement that enrollees affirmatively request continuation of benefits pending appeal**. HHS has left unchanged the existing requirement in § 438.420(b)(5) that an enrollee affirmatively request continuation of benefits. This requirement does not exist in regulations governing all other Medicaid hearings. See 42 CFR § 431.230. Requiring an affirmative request for continuation of benefits imposes a burden on enrollees of which they are

generally unaware, and to which they are not accustomed in other Medicaid hearings. In our experience in New York, enrollees calling a plan or state call center to request an internal appeal or a hearing are not asked whether they are requesting continuation of benefits. New York recently revised its managed care hearing request form to give the enrollee the option of opting out of continuation of benefits. States should have the option of using this procedure. As long as a request is timely filed, benefits should continue pending the appeal, with the option of the enrollee to decline such benefits. We agree that the enrollee should be informed of potential liability to repay the cost should the appeal be decided adversely.

3. **Provide additional protections for people with disabilities and limited English proficiency with respect to recoupment.** While we support the amendments made to clarify requirements for recoupment, we recommend additional protections for people with disabilities and limited English proficiency.

RECOMMENDATION: Amend § 438.420(a), (b) and (d) as follows

(a) *Definitions.* As used in this section—

Timely fil**es**~~ing~~ means filing on or before the later of the following—

(i) ~~**Within 10 calendar days of the MCO, PIHP, or PAHP mailing the notice of adverse benefit determination.**~~ **Before the date the adverse coverage determination is to take effect. (The MCO, PIHP, PAHP must mail an advance notice as required by § 438.404(c)(1)).**

(b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur: …

(1) The enrollee or the provider **timely files** ~~**files the appeal timely**~~;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment **or services**;

(3) The **course of treatment** or services were ordered by an authorized provider; **and**

~~**(4) The original period covered by the original authorization has not expired; and**~~

(**4**~~**5**~~) The enrollee **or provider** request**s or, at state option, the enrollee has not affirmatively declined continuation of benefits under § 438.210(b)(3)**.

* * *

(d) *Enrollee responsibility for services furnished while the appeal is pending.* … Such practices must be consistently applied within the State under managed care and FFS delivery systems. **To recover costs from an enrollee who has LEP or has a disability that requires information provided in alternate formats, the MCO, PIHP, or PAHP may only recover the cost of the services furnished to the enrollee**

while the MCO, PIHP or PAHP appeal and State fair hearing are pending if the MCO, PIHP, or PAHP can document that it provided the enrollee with information about recovery in the enrollee's language or in an alternate format to meet the needs of an individual with a disability.

c. Do not Require Exhaustion of Internal Appeals (§ 438.402 and related § 438.408)

HHS requested comment on its proposal to require enrollees to exhaust the plan level appeal procedures before gaining access to a State fair hearing. We join NHeLP in opposing this proposal. We strongly believe that it would be a mistake to eliminate states' flexibility to decide whether to require their residents to exhaust the plan-level grievance and appeal system before requesting a State fair hearing. Without doubt, there are instances where enrollees convince health plans to reverse initial decisions; however, the plan-level review is not an impartial review under the law.

For 20 years, New York has opted not to require exhaustion of internal appeals for enrollees in standard Medicaid MCOs and, effective July 1, 2015, eliminated the exhaustion requirement for enrollees in partially capitated MLTSS plans. HHS' proposed exhaustion requirement would entail a drastic change for 4.5 million Medicaid recipients in New York State alone and cause untold confusion and harm. It is imperative that states continue to have the option of whether to require exhaustion, based on myriad local considerations and historic practices.

As stated above New York stopped requiring exhaustion of internal plan appeals in its three year old mandatory MLTSS program on July 1, 2015. During the three years exhaustion was required in MLTSS, the requirement triggered notice and procedural problems that interfered with enrollees' ability to access the fair hearing process and their right to continued benefits pending the outcome of the hearing. Plans frequently failed to give notice following an internal appeal of the "right to request to receive benefits while the hearing is pending, and how to make the request," § 483.408(3)(1)(iii), leaving enrollees without critical continuation of benefits. Moreover, a review of New York's public fair hearing decision archive reveals that many enrollees simply failed to understand the exhaustion requirement and had their fair hearings dismissed without ever receiving an opportunity to be heard.

Unlike Medicare beneficiaries, Medicaid enrollees are uniformly, by definition, unable to afford to purchase health insurance out of pocket. Enrollees with disabilities can face particular stress and disadvantage if they are required to go through multiple levels of review, particularly when the claim involves an initial denial.

We understand that some insurance conglomerates might favor an exhaustion requirement on the grounds that they rely on the internal appeals process to make them aware of a problem. However, if the health plan is implementing benefit and coverage policies as it should, then appeals should be infrequent, and problems should not come onto the plan's radar only when a formal dispute is filed. Importantly, the managed care entity can always

decide to change its decision, right up to the point where the State fair hearing decision is issued.

The decision whether or not to require exhaustion should remain a matter to be left to the State and stakeholders in the State.

RECOMMENDATIONS: Amend § 438.402(c), 438.408(d)(2) and 438.408(e) as follows (the recommended changes to § 438.408 are in addition to those recommended by NHeLP, which we also support):

Amend § 438.402(c):

(c) *Filing requirements.* (1) *Authority to file.* (i) An enrollee may file a grievance and an appeal with the MCO, PIHP, or PAHP **and may request a State fair hearing**. ~~**An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is uphold.**~~

* * *

(2) *Timing*—

* * *

(iii) In a State that does not require exhaustion of MCO, PIHP and PAHP level appeals, the enrollee may request a State fair hearing.

Add a subsection (iii) to § 438.408(d)(2) (Format of Notice/Appeals):

(iii) Where the issue of the appeal is a reduction, suspension, or termination of a previously authorized service, and the appeal is not resolved wholly in favor of the enrollee, the written notice of disposition must be timely and be mailed in the timeframes as defined in section 438.404(c).

Amend § 438.408(e) (Content of Notice):

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed. **Where the issue of the appeal is a reduction, suspension, or termination of a previously authorized service, the notice shall specify (i) the type and amount of services previously authorized, (ii) the type and amount of services the plan originally proposed to reduce, suspend or terminate, and (iii) the type and amount of services the plan has decided to reduce, suspend or terminate based on the appeal, and the effective date of said action which shall be no less than 10 days after the date of said notice.**

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits **in the type and amount of services authorized prior to the initially proposed reduction, suspension or termination** while the hearing is pending, and how to make the request; and

III. Enrollment in Managed Care (Proposed 42 CFR § 438.54)

Empire Justice supports HHS's efforts to create consistent and clear rules regarding enrollment in managed care in both mandatory and voluntary states. We are especially supportive of the proposal to require FFS Medicaid prior to enrollment or assignment into managed care. However, while the proposed regulations will help smooth the managed care enrollment process and protect beneficiaries, we believe it is necessary to further clarify and strengthen the enrollment process to address barriers to enrollment that regularly leave Medicaid recipients without access to medically necessary care.

In New York, we have encountered substantial delays in getting people enrolled into our mandatory MLTSS Program, which provides LTSS to dual eligibles and other Medicaid recipients These delays are due to numerous and varied obstacles to enrollment that result from the way in which the MLTSS enrollment process is designed.

New York does not provide LTSS services through FFS on a temporary basis while Medicaid beneficiaries seek enrollment in an MLTSS plan. As a result individuals mandated into the MLTSS program are not able to access critical home health and other community based long term care services until they are enrolled in a plan. The period of time individuals must wait for services is lengthy; from the time of a Medicaid eligibility determination, it typically takes at least two months, frequently much longer, for a person to get into an MLTSS plan and begin to receive services from that entity. During those months, individuals in need of services are left without care in their homes, end up hospitalized, or are forced into a nursing home, as have a number of our clients, solely because their enrollment in MLTSS is still pending and they are not permitted to obtain necessary services through FFS Medicaid.

To protect Medicaid enrollees during the period prior to managed care enrollment, we urge HHS to clarify the proposed regulations as follows (specific regulatory language is proposed at the end of this section):

1. The regulations should specify that all state plan services must be made available during the period of FFS coverage, including community-based LTSS, such as personal care services.
2. For mandatory states, the regulations should specify that FFS coverage must continue until an individual enrolls in and is receiving services under a managed care plan. Enrollment would occur following an individual selecting a plan or, if a selection is not made, after auto-assignment.

We also join with NHeLP in recommending that the choice period for enrolling in a managed care plan be extended from 14 to 45 days. Fourteen days is insufficient to ensure that enrollees are able to make informed decisions. Enrollees need sufficient time to research and compare their plan options. For some enrollees, this might also mean enlisting a consumer counselor for help or communicating with doctors and other providers to ensure continuity of care. It is critical that enrollees are able to choose a plan that best meets their health and life needs since they could be locked into that plan for up to one year. We therefore urge HHS to adopt a 45-calendar day election period. The 45-calendar day period should start five, rather than three, days after the notice specified in subsection (c)(3) is sent; three days is likely to be insufficient time for an enrollee to receive and open a mailing.

We appreciate that HHS recognizes the importance of not only providing enrollees with sufficient time, but also appropriate information to make an informed plan selection. We strongly support HHS' proposal to ensure that enrollees have clear and timely information regarding plan enrollment and disenrollment. We recommend that states' informational notices explain not only the implications of not making a plan choice, but also the implications of making a plain choice (e.g., in states that limit disenrollment, that the enrollee can only disenroll without cause in the first 90 days, that after the 90 days they might need cause to disenroll; if the enrollee does not have cause to disenroll, they would be locked into their plan for up to 12 months, etc.). We further urge HHS to require states to include enrollment and disenrollment forms in the informational packets.

> **RECOMMENDATIONS:** Amend § 438.54(c), applicable to voluntary managed care programs, and § 438.54(d), applicable to mandatory managed care programs, as follows:
>
> **§ 438.54(c):**
>
> (2) A State must provide potential enrollees at least ~~14~~ **45** calendar days of FFS coverage **that includes all state plan services, including community-based LTSS,** to provide the potential enrollee the opportunity to actively elect to receive covered services through the managed care or FFS delivery system. If the potential enrollee elects to receive covered services through the managed care delivery system, the potential enrollee must then also select a MCO, PIHP, PAHP, PCCM, or PCCM entity.
> . . .
>
> (3) The State must develop informational notices that clearly explain the implications to the potential enrollee of **making and** not making an active choice between managed care and FFS and declining the MCO, PIHP, PAHP, PCCM, or PCCM entity selected by the State, if relevant to the State's managed care program. These notices must:
>
> (i) Comply with the information requirements in § 438.10.
>
> (ii) Have a postmark or electronic date stamp that is at least ~~3~~ **5** calendar days prior to the first day of the election period identified in paragraph (c)(2) of this section.

(4) Enrollment and disenrollment forms

(i) The State agency shall make an enrollment/disenrollment form available in information notices mailed to beneficiaries, at the enrollment presentations, by posting on a website that is accessible to the public, and at agency approved sites. The State agency or MCO, PIHP, PAHP, or PCCM shall mail the enrollment/disenrollment form to a beneficiary within three working days of receiving a telephone or written request for a form.

(ii) Plans shall make an enrollment/disenrollment form available at member services departments, by posting on a website that is accessible to the public, and shall mail the form to a beneficiary within three working days of receiving a telephone or written request for a form.

§ 438.54(d):

(2) A State must provide potential enrollees at least ~~14~~ **45** calendar days of FFS coverage **that includes all state plan services, including community-based LTSS,** to provide the potential enrollee the opportunity to actively select their MCO, PIHP, PAHP, PCCM, or PCCM entity. **The FFS coverage shall continue until the potential enrollee is enrolled in and receiving services through their MCO, PIHP, PAHP, PCCM, or PCCM entity.**

(3) A State must provide informational notices to each potential enrollee that explain the process for enrolling in a MCO, PIHP, PAHP, PCCM or PCCM entity including the choice of MCOs, PIHPs, PAHPs, PCCMs or PCCM entities available, **the implications to the potential enrollee of making and not making an active choice,** how to make the enrollee's selection of a MCO, PIHP, PAHP or PCCM known to the State, and enrollee's right to disenroll within 90 days from the effective date of the enrollment. These notices must:

(i) Comply with the information requirements in § 438.10.

(ii) Have a postmark or electronic date stamp that is at least ~~3~~ **5** calendar days prior to the first day of the election period identified in paragraph (d)(2) of this section.

(4) Enrollment and disenrollment forms

(i) The State agency shall make an enrollment/disenrollment form available in information notices mailed to beneficiaries, at the enrollment presentations, by posting on a website that is accessible to the public, and at agency approved sites. The State agency or MCO, PIHP, PAHP, or PCCM shall mail the enrollment/disenrollment form to a beneficiary within three working days of receiving a telephone or written request for a form.

(ii) Plans shall make an enrollment/disenrollment form available at member services departments, by posting on a website that is accessible to the public, and shall mail the form to a beneficiary within three working days of receiving a telephone or written request for a form.

IV. Transition Rights of Enrollees During Managed Care Entity Contract Termination or Withdrawal from Service Area

We commend HHS for addressing transition protections in the proposed regulations. Too often, enrollees must disrupt long-standing relationships with their existing providers when they newly enroll in managed care or change plans, which can cause serious gaps in care that threaten the enrollee's health and well-being.

We are concerned, however, that the regulations do not adequately lay out procedures and protections for enrollees who must disenroll from a managed care entity because that entity's contract has terminated or because the entity is withdrawing from a service area within the state.

Empire Justice is currently addressing enrollee concerns about an MCO in New York's MLTSS program that is withdrawing from eight counties in upstate New York. In one county, the MCO's roster comprises nearly two-thirds of the total population in the MLTSS program. Yet, no plans to transition enrollees from the departing MCO have been developed. Instead, we have learned that the MCO will "encourage" people to select a different plan by September 1. As this MCO is the lowest rated in the regions from which it is departing, we are concerned that the encouragement to choose a different plan will include poor quality care, and service denials and reductions. We have requested establishment of a transition plan to ensure continuity of care for enrollees and minimize the upheaval the plan withdrawal is causing.

To minimize disruption in care and gaps in services when a managed care entity's contract is terminated or the entity withdraws from a service area within the state, we recommend that HHS add to the regulations the following protections:

1. **A choice period** during which enrollees can evaluate, select and enroll in a new managed care entity. This choice period should be consistent with the enrollment period proposed in § 438.54 (with the modifications proposed previously in this letter). A choice period will give Medicaid enrollees the opportunity to evaluate other plan options in the region.
2. **Default assignment** following the choice period, in a mandatory state. If the Medicaid enrollee has not selected a plan during the choice period, s/he may be auto-assigned to a new plan using the same methods of auto-assigning a person under proposed § 438.54(d) (with the modifications proposed previously in this letter).
3. **FFS coverage** of all state plan services, including LTSS, in mandatory states if the remaining managed care entities in the service area do not have capacity to take on new enrollees. FFS coverage should be provided until such time as the remaining plans have capacity to accept new enrollees.
4. **Transition of care protections** that ensure the Medicaid enrollee has access to services in the same amount they previously had, and is permitted to retain their

current provider for a period of time if that provider is not in the new managed care entity's network. These protections should be consistent with proposed § 438.62, which already provide some protections when a plan's contract is terminated. The transition protections given to enrollees whose plan's contract ends or leave a service area must also include NHeLP's recommendations for § 438.62, including the recommendation that expands the circumstances in which continued services must be provided to enrollees.

Thank you for your consideration of the above comments.

Respectfully Submitted,

/s/
Amy E. Lowenstein
Senior Health Attorney