Medicaid Managed Care Final Regulations: Beneficiary Support Systems[1]

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This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* implementing the requirements for beneficiary support systems.[2] We also include recommendations to help state advocates ensure robust implementation of these systems in their states. These recommendations are highlighted throughout and also listed at the end of this brief.

Beneficiary Support Systems (§ 438.71)

As states begin to implement the updated Medicaid Managed Care rule ("the rule"), there are many opportunities for advocates to push states to improve Medicaid beneficiaries' experiences in managed care. One of the most significant opportunities is the newly required beneficiary support system (BSS).[3] The BSS reflects previous guidance from CMS regarding long term services and supports (LTSS) and recommendations from advocates.[4] The BSS is intended to be a helpful resource for beneficiaries in understanding their options in managed care, accessing resources, and navigating issues in the managed care system. However, many states

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[2] *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. [hereinafter Managed Care Rule]

[3] 42 C.F.R. § 438.71.

[4] CMS, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (May 20, 2013), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf; *see* Managed Care Rule, *supra* note 1, at 7651-54 (explaining how this guidance has been incorporated in the Managed Care Rule); *see also* National Council on Disability, *Medicaid Managed Care for People with Disabilities: Policy and Implementation Considerations for State and Federal Policymakers* (Mar. 18, 2013), http://www.ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726.pdf.

may try to comply with the BSS requirements merely by citing existing customer support systems and community organizations, without providing additional resources or structure. Strong advocacy during the state's planning process for the BSS could instead create a quality resource for beneficiaries that also increases oversight of managed care plans and services issues.

The Beneficiary Support System: Different Functions for Different Beneficiaries

The BSS is supposed to be an access point for information about managed care for all beneficiaries, with a subset of services specific to LTSS. Generally, the BSS provides the basic BSS functions to all beneficiaries prior to and after enrollment in a managed care entity.[5] To receive the additional BSS services, the beneficiary either must use or have expressed an interest in long-term services and supports.

The BSS for All Beneficiaries:

At a minimum, all enrollees and potential managed care enrollees of a managed care entity must have access to a BSS that provides:

- Choice counseling;
- Assistance for enrollees in understanding managed care;
- Assistance for enrollees who use, or express a desire to receive, LTSS; and
- Outreach to beneficiaries and/or authorized representatives.

The BSS must also be accessible in multiple ways including phone, internet, in-person, and via auxiliary aids and services when requested. In addition, the preamble to the rule encourages states, when designing and implementing the BSS, to consider cultural and linguistic competence and outreach for those with limited English proficiency and/or cognitive disabilities.[6]

Although choice counseling is more well-defined, as explained below, the other minimum services are described very broadly, which leaves room for advocacy. For example, helping beneficiaries "understand managed care" could mean anything from providing a short explanation of managed care or a handout to in-depth, time intensive education on the managed care system, the rule, and how to navigate that system. Similarly, outreach could be broad and through various mechanisms, or it could be very minimal. The rule provides some direction as to the vision for these minimum services, but there is still a lot of room for advocacy to push for making these functions as robust and useful as possible.

[5] The phrase "managed care entity" in this document refers to MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities as covered by the rule. A state must have a BSS to provide support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM, or PCCM entity. § 42 C.F.R. § 438.71(a).
[6] Managed Care Rule, *supra* note 1, at 27626.

State Advocacy Tip

The BSS should have a simple system in place for beneficiaries to give permission to others, such as non-legal guardian relatives, to communicate with the BSS on their behalf. If a person is seeking support from the BSS, they may want someone else to help them understand the information. This should be made possible without complicated, time consuming paperwork.

The BSS for LTSS Beneficiaries:

If an enrollee uses or expresses a desire to receive LTSS, then the BSS must perform additional functions. At a minimum, these must include providing:

- An access point for complaints and concerns about managed care enrollment, access to covered services, and other related matters;
- Education on enrollees' grievance and appeal rights within managed care; the state fair hearing process; enrollee rights and responsibilities; and additional resources outside the managed care entities;
- Assistance, upon request, in navigating the grievance and appeal process within the managed care entity, as well as appealing adverse benefit determinations by the managed care entity to a fair hearing. The BSS may not provide representation to the enrollee at the hearing but may refer them to sources of legal representation.
- Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identifying, remediating and resolving systemic issues.[7]

The BSS should help the state with oversight, however, it does not provide any direct oversight of the MLTSS program.[8] The state retains ultimate responsibility for this.[9]

Eligibility for LTSS-Specific Functions of the BSS:

The LTSS-specific functions of the BSS are available not only to those who use LTSS, but also to those who have "expressed a desire" to receive LTSS. This term is not defined, but should include beneficiaries on waiver waitlists and those trying to figure out how to access LTSS. However, LTSS is broader than just waiver services. LTSS is defined as:

[7] 42 C.F.R. § 438.71. CMS plans to provide technical assistance in the identification and review of systemic issues identified through the BSS and believes this will occur as a regular part of its review and oversight of the program.
[8] *Id.*
[9] Managed Care Rule, *supra* note 1, at 27626.

> Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.[10]

Managed care enrollees who have a functional limitation or chronic illness and receive any service that falls within the LTSS definition are supposed to have access to the LTSS-specific BSS functions.[11] Importantly, the LTSS definition is not tied to institutional level of care criteria. CMS declined to change the definition of LTSS to relate to levels of care, such as that for nursing facilities, because most states have LTSS programs that have different criteria for level of care and more expansive scope of services. Similarly, the regulations do not specify the duration of need for an individual to qualify for LTSS, rather, this qualification is determined by the state.[12] Accordingly, advocates should work to broadly and clearly define "those who have expressed a desire for LTSS" as well as ensure the state is properly including all of the people who should be included in the interpretation of LTSS, such as those receiving mental health services that would fit the LTSS definition.

Although the LTSS-specific functions of the BSS are only required for LTSS beneficiaries, states may provide these additional features for all populations.[13] Many advocates submitted comments asking CMS to require these additional functions more broadly, but CMS declined, citing the complexity of services and needs of LTSS beneficiaries.[14] However, advocates know that there are many beneficiaries who do not use LTSS who would benefit greatly from the LTSS-specific BSS functions. If expanding these functions to all beneficiaries seems unlikely in a state, advocates may still try to expand the service to specific populations. These populations could include: children; people with mental health conditions who do not receive LTSS; or individuals who have used the other functions of the BSS who, upon the recommendation of the BSS, have been referred to the LTSS functions for additional support.

State Advocacy Tip

Encourage states to extend the required functions of the BSS. This could include not only providing the LTSS-specific functions for all, but also other services to assist beneficiaries in navigating the managed care system.

[10] 42 C.F.R. § 438.2.
[11] Managed Care Rule, *supra* note 1, at 27650. Although the definition of LTSS is broader for managed care purposes, the actual services and supports available to the beneficiary are still defined by the state in applications to CMS and the contracts with managed care plans.
[12] *Id.* at 27651.
[13] *Id.* at 27629.
[14] *Id.*

Choice Counseling

Choice counseling is a very important function of the BSS because it helps beneficiaries make enrollment decisions, including answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Beneficiaries are to receive personalized assistance, regardless of communication method, to help them understand the materials provided, answer questions about options available, and facilitate enrollment with a particular managed care plan or provider.[15] However, this service does not include making recommendations for or against enrollment into a specific managed care plan or program.

State Advocacy Tip

Encourage states to provide the quality data regarding managed care plans to the choice counselors so as to provide additional information about plan performance to beneficiaries as they are selecting their plan.

The BSS is to provide choice counseling for any potential enrollee prior to first enrollment in managed care and to enrollees when they have the opportunity to change their plans or disenroll.[16] Although not all beneficiaries may choose to seek out choice counseling, the BSS is supposed to make an effort to reach and support all beneficiaries. As a practical matter, this means that the BSS needs to be funded sufficiently to perform the choice counseling and the necessary outreach.[17] In terms of information, at a minimum , the contact information for the BSS must be included in the informational notices provided to each potential enrollee at the time of the individual first become eligible to enroll in a managed care program.[18] This information must be provided within a timeframe that enables the potential enrollee to use the information and services of the BSS in choosing among the available options.[19]

Choice counseling has important conflict of interest and independence provisions. Although choice counseling provides similar services to Marketplace Navigators in that they are assisting people in choosing plans for healthcare coverage, the conflict of interest standards for choice counseling are different and in some ways more stringent.[20] Entities or individuals that provide choice counseling must meet enrollment broker

[15] *Id.* at 27623, 27627.
[16] Enrollees have the opportunity to change enrollment as described in § 438.56(b) and (c).
[17] CMS "expect[s] states to implement their [BSSs] so that they are easily accessible, well publicized, and that they fully educate potential enrollees and enrollees on their enrollment and disenrollment opportunities and limitations." Managed Care Rule, *supra* note 1, at 27617.
[18] 42 C.F.R. § 438.10(c)(2).
[19] 42 C.F.R. § 438.54(c)(3).
[20] Managed Care Rule, *supra* note 1, at 27628.

requirements.[21] An organization also may not provide choice counseling if it has a financial relationship, including as a network provider, with any managed care plan that operates in that state.[22] A financial relationship or interest with a managed care plan may present the appearance of bias, even with safeguards. A managed care plan also may not provide any of the other BSS functions as the expectation is that the BSS is in addition to the current resources within managed care plans for beneficiaries to get information and resolve issues.[23] If a government entity operates a managed care plan, that governmental entity is not allowed to provide choice counseling.

CMS intends that the line for whether an entity is independent of any managed care plan or provider be clear and not up for interpretation.[24] Some commenters had advocated for states to have discretion to determine whether a conflict of interest was a problem, but CMS did not allow for such discretion. States cannot revise the conflict of interest standards to include only the financial interests of direct or indirect ownership of managed care plan or allow other flexibilities that would allow the state to determine whether there is inherent bias when selecting entities for the BSS.[25]

Some entities that receive federal funding, such as FQHCs and Ryan White providers, may perform similar activities to choice counseling but these entities do not have to adhere to the conflict of interest standards as long as they do not have a contract or agreement to provide choice counseling on the state's behalf. However, these activities will not fulfill the state's obligations under the BSS. Other programs that receive non-Medicaid federal funds that provide protections to beneficiaries, such as P&As, that includes representations at hearings may provide choice counseling as long as appropriate firewalls are in place.[26]

State Advocacy Tip

Encourage the use of evaluation tools and assessments to ensure that enrollment brokers are not engaging in inappropriate referrals to other activities. Although having an interest in a managed care plan would violate the conflict of interest requirements, monitoring is likely still necessary to ensure compliance.

[21] 42 C.F.R. § 438.10.
[22] *Id.*
[23] After citing reasons why a managed care plan may not provide the LTSS-specific features of the BSS, CMS concludes that "it is not appropriate for any managed care plan to provide any of the beneficiary support system activities as specified at § 438.71." *Id.* at 27628.
[24] *Id.*
[25] *Id.* at 27630.
[26] Although P&As are not specifically listed as one of the entities that receives federal funding, the preamble is clear that the listed entities is not an exhaustive list of federal grantees that could do choice counseling with appropriate firewalls. Managed Care Rule, *supra* note 1, at 27630.

Timing of BSS Implementation

The requirements for the BSS apply to any rating period for contracts starting on or after July 1, 2018. The term "rating period" is defined in the rule as "a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS . . . ."[27] While many states have multi-year contracts with managed care entities, contracts are often updated. Importantly for purposes of when provisions of the rule have to be implemented, there is usually an annual twelve-month update of the rates for a given contract.[28] For many states, this is on a calendar basis, so the rating period would begin in January of that contract year. For many states this will be in 2018.[29]

Is the BSS a New Program or Entity?

In many states, the BSS responsibilities likely will be performed by an existing program or entity within the state, or a combination of programs.[30] CMS indicated that some states had existing programs that already did much of the work of the BSS, that many states should be able to adapt existing programs, and that only a few states likely needed to create something they did not already have.[31] In the preamble to the rule, CMS acknowledged that many of the LTSS functions of the BSS likely already exist within the Medicaid program and that there is not intent to require the states to develop a new system of delivering the LTSS BSS functions.[32] CMS expects that many states will select multiple entities to perform the different functions of the BSS and that such a system could result in additional beneficiary protections.

Although different entities may make up the BSS, it must remain "an independent resource to aid potential enrollees in selecting a managed care plan and to assist enrollees in navigating the managed care delivery system."[33] In addition, the parts of the BSS that perform the choice counseling function must meet the standards for independence and conflict of interests. The preamble to the rule also emphasizes that the BSS is not intended at all to replace the existing information requirements and grievance and appeals systems within a managed care plan.

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[27] 42 C.F.R. § 438.2.
[28] 42 C.F.R. § 438.6; *see also* Managed Care Rule, *supra* note 1, at 29525; CMS, 2016 Medicaid Managed Care Rate Development Guide (Sept. 2015), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf. Rate certifications should be done on an annual basis except in certain circumstances.
[29] CMS Webinar, *supra* note 26.
[30] *Id.* at 27624. "[S]tates need not develop a new system if the current system meets the standards specified at § 438.71."
[31] CMS, Webinar: Medicaid and CHIP Managed Care Final Rule: Beneficiary Experience and Provisions Unique to Managed Long Term Services and Supports (MLTSS) (May 12, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/mltss-webinar.pdf; *see also* Managed Care Rule, *supra* note 1, at 27778-79.
[32] Managed Care Rule, *supra* note 1, at 27624.
[33] *Id.*

At a minimum, the BSS is a call center with staff that have email capability who will assist beneficiaries with questions. Many states already have such a function as part of customer service or complaint line, but states may also use a vendor, amend an existing contract which may be for an enrollment broker, or add staff or train existing internal call center, outreach, or ombudsman staff. CMS believes most states will use existing structures. For the choice counseling and LTSS functions, the call center will likely perform most of these responsibilities and existing community-based outreach/education and ombudsman staff will probably fulfill the in-person requests. CMS does not expect that states will incur significantly increased costs if they expand existing systems to fulfill the BSS requirements.[34]

State Advocacy Tip

Include strong coordination during enrollment between the BSS and the managed care plans when an individual is changing plans. Although CMS declined to mandate requirements about these processes, such coordination would be beneficial to individuals to ensure a smooth transition between plans.

The expectation that a state will use existing resources, including community-based organizations (CBOs), to fulfill the BSS responsibilities is both positive and negative. CBOs, such as Areas Agencies on Aging, Aging and Disability Resource Centers, State Health Insurance Programs, P&As, Developmental Disabilities Councils, University Centers for Excellence in Disabilities, Centers for Independent Living, legal services, and other community resources all have expertise and experiences that could benefit individuals access to the BSS. They often have longstanding ties to the community, an understanding of available resources, and experience providing population-specific assistance, education, training, and counseling to people who rely on Medicaid. Incorporating these entities into the BSS structure may help create a "no wrong door" approach to the BSS, provide additional information to help the BSS identify systemic issues for LTSS beneficiaries, and complement monitoring efforts generally. However, as much as these CBOs' involvement in the BSS would be helpful to beneficiaries, there should be a functional system for the organizations to communicate with one another and the state. In addition, there should also be appropriate funding if these entities are performing functions of the BSS. Most of the CBOs are already underfunded and cannot be expected to take on additional functions that are the responsibility of the state without additional funding.

It would likely be most effective for a single state agency to be charged with operating the BSS and for arranging contracts and other agreements with other state agencies and CBOs. The BSS should not be a patchwork arrangement of different CBOs designated by the state, but should be an agency that utilizes CBOs through

[34] Managed Care Rule, *supra* note 1, at 27778.

agreement to fulfill certain functions, presumably in return for funding. For example, a state should not be allowed to determine that its SHIP will operate as the call center, track the calls in a minimal manner for the LTSS requirement regarding systemic issues, and refer callers to other CBOs because they already do the work.

State Advocacy Tip

Include training to network providers as part of the BSS functions. Although the final rule did not require such training, managed care plans are encouraged to include training related to the BSS, including the services for LTSS beneficiaries.

Funding of the BSS

The BSS is like other Medicaid administrative functions for which the state may receive federal matching funds. To be eligible for this funding, the BSS services must not duplicate services paid by other programs, the services must meet the conflict of interest provisions, the costs must be supported by a cost allocation methodology in the state's approved cost allocation plan, and there must be CMS approval.[35] These requirements are based on the conditions that must be met for the state to claim federal matching funds for administrative services and for funding enrollment broker services.[36] Although states may not use federal matching funds for legal representation, such as at fair hearings, there are Medicaid mechanisms to fund direct case advocacy through the LTC Ombudsman Program.[37] While previously the idea of such a beneficiary support program has been referred to as an ombudsman type program, there are differences. In fact, CMS explicitly stated in the preamble

[35] 42 C.F.R. § 438.10; 42 C.F.R. § 438.816; Managed Care Rule, *supra* note 1, at 27625. Cost allocation plans must describe how the state agency will identify, measure, and allocate all state agency costs incurred in support of all programs administered or supervised by the state agency. Managed Care Rule, *supra* note 1, at 27631 (citing 45 C.F.R. § 95.505).

[36] Section 1903(a)(2) of the Act allows for an enhanced match of 75 percent for certain services, but the BSS is not eligible for the enhanced match.

[37] Many commenters wanted the BSS to be able to represent individuals at fair hearing, but legal representation is not among the activities eligible for FFP. Managed Care Rule, *supra* note 1, at 27629. The term "case advocacy" is used in the preamble, but likely refers to the typical work of an ombudsman as opposed to case advocacy by legal services. *See* CMS Informational Bulletin, Medicaid Administrative Funding for Long Term Care Ombudsman Program Expenditures (June 18, 2013), https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-18-2013.pdf; *see also* CMS, Best Practices for Home and Community-Based Ombudsman (Jan. 2013), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/best-practices-for-hcbs-ombudsmen.pdf (discussing states that have LTC Ombudsman programs for HCBS); *see also* NASUA, Charting the Long-Term Care Ombudsman Program's Role in a Modernized Long-Term Care System, http://www.nasuad.org/documentation/ombudsman/ChartingLTCOP_ Role.pdf (discussing the roles and possible conflicts of LTC ombudsman programs).

that likely not all of the ombudsman activities traditionally found in a long-term care ombudsman office are eligible for Medicaid funding as part of the BSS for LTSS.[38]

Commenters to the proposed rule were concerned that there would not be sufficient funding for the BSS and that Medicaid beneficiaries would end up bearing the burden of the costs of these services. However, Medicaid beneficiaries cannot be charged for BSS services and can only be charged for services covered under the state plan or premiums as approved by CMS.[39] CMS encouraged states in the preamble to use existing resources and systems to the extent feasible, including community organizations and resources that otherwise meet the standards of the final rule.[40]

Although it is clear that states get federal matching funds for the BSS, it is not as clear how the states will support the CBOs that it may depend on as part of, or an essential source of referrals for, the BSS. Most CBOs already operate on limited funding and may not be prepared for the additional work sent their way by the BSS. States could use FMAP to provide grant funding to CBOs as long as they met the conflict of interest provisions and other requirements, but the BSS should not rely on CBOs to perform an unfunded services. Advocates should carefully review a state's plan regarding the BSS to ensure that all of the required services are performed by state agencies or funded contracts sufficient to meet the expected demand.

Reporting Requirements for BSS Activities & Performance

The BSS is a required part of monitoring and there are requirements regarding reporting on the activities of the BSS. States are required to submit to CMS a report on each managed care program administered by the State regardless of the authority under which it operates that includes information on the activities and performance of the BSS.[41] Such reports are not due until 180 days after each contract year and the initial report is not due until the contract year following the release of CMS guidance regarding the content and form of the report. This report must be provided to the LTSS stakeholder group and be posted publicly on the state website.[42]

There are broad requirements in the regulations regarding monitoring and performance data that reference the BSS, but there are not specifics about needs to be collect about or by the BSS. The rule requires that the mandated state monitoring plan for the managed care programs address the performance of the BSS, along with other enrollee materials and customer services.[43] Such monitoring and reporting is expected to not simply report on the activities of the BSS, but to also assess the performance of the BSS to drive continual

[38] *Id.* at 27624 (referencing the proposed rule, refers to previous guidance on funding LTC ombudsman expenditures, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-18-2013.pdf). The preamble reiterates that not all ombudsman services may fit under the BSS services such that administrative funding would be available. *Id.* at 27626.
[39] Managed Care Rule, *supra* note 1, at 27625.
[40] *Id.*
[41] 42 C.F.R. § 438.66(e).
[42] Managed Care Rule, *supra* note 1, at 27625 (citing 438.,66(e)(3)(i)-(iii)).
[43] 42 C.F.R. § 438.66(b)(4); § 438.340.

improvements.[44] The data collected from the monitoring activities must be used to improve the performance of the managed care program. This data includes customer service performance data submitted by each managed care entity and the performance data submitted by the BSS.[45] Data from member grievance and appeal logs as well as provider compliant and appeal logs are part of the data gathered in monitoring. If the BSS is set up such that it gathers good data about complaints from beneficiaries, the data may be useful to compare whether managed care entities are accurately recording grievances and provider complaints.

Advocates should work to define what information they want to be included in the monitoring reports about the BSS as the state works to develop monitoring plans and data reports. Data could include more than simply the number and topic of calls, but also how the BSS responded to the call, timeliness in response, time spent with beneficiaries per contact, and other call quality metrics. The rule does not require certain timeliness standards, but states are expected to consider timeliness and availability standards of their programs and populations when developing and implementing their BSSs.[46] How the BSS is responding to calls is important information about the quality of the service being provided by the system. For example:

- Is the BSS spending time understanding the person's issues and questions, providing information in an accessible way, sending information, providing follow-up, etc. This would be useful information to know by issue as well.
- If a person is calling with a complaint about a managed care entity, is the BSS providing thorough information - spending time to explain to the person what a grievance is, what they should expect it to accomplish, and how to file a grievance? Is the BSS providing written materials about the grievance process, contact information for grieving, and self-advocacy materials about filing effective grievances?
- Are referrals provided if there are relevant referrals for the individual's issues and are they provided information about what the agency they are being referred to does so the person understands whom they are calling and what to expect? For example, if the individual is calling about difficulties with a provider, is the BSS referring the person to legal services and the P&A even though the issues with the provider have nothing to do with a denial or reduction in services?
- Is data collected about whether the person is calling about a specific managed care program, service, or provider? Such information is necessary for the BSS to fulfilling the requirement to track systemic LTSS issues. However, if the BSS also collected the information for non-LTSS calls it would gather valuable information about problems with network adequacy, access to care issues, trends regarding individual managed care entities, and other issues. At the very least, if the BSS reflects a lot of complaints about a particular managed care entity but that entity reports data showing little complaints, the BSS information would demonstrate that there is likely something wrong with how the managed care entity is handling customer service and logging complaints.
- Is the information collected in such a way as to be able to track negative actions against enrollees by specific plans? CMS expects that data from the BSS will help the state monitor whether managed care

[44] Managed Care Rule, *supra* note 1, at 27625.
[45] 42 C.F.R. § 438.66(c)(12).
[46] Managed Care Rule, *supra* note 1, at 27627.

plans are taking punitive or negative actions against enrollees and whether they are engaging in excessive or abusive recoupment practices.[47]

In addition to the types of data collected, the responsiveness of the BSS to requests for information or for assistance with complaints is important to the effectiveness of the BSS. If individuals do not feel like the BSS is helpful to them, they will stop asking the BSS for assistance. Not only will this fail the beneficiaries because they are not receiving the intended benefit of the BSS, it will also negatively impact the state's ability to monitor issues with the managed care plans, especially with LTSS. Advocates may want to use the sample policy for § 1557 discrimination complaints as an example of features to incorporate in the BSS's policies regarding replying to beneficiaries.[48] Responsiveness is important not only in terms of timeliness, but also in how the BSS staff interact with beneficiaries. Advocates should work for clear standards about how a request is handled and for required training of BSS staff. This could include requesting that stakeholders be offered the chance to provide input on the BSS operations manual.

Role for Advocates

In structuring their BSSs, states are encouraged to consult with a variety of stakeholders as they develop and implement their programs.[49] Managed care plans may be part of the planning process, just like other stakeholders, but the BSS itself must remain independent from the managed care plans.[50] The structure, function, and resources of the BSS could have a significant impact on the experience of beneficiaries in managed care and it could affect the work of the state's CBOs. Therefore, advocates should actively participate in any planning for the BSS. This may include initiating conversations with the state and presenting what advocates expect the BSS to look like and include before the state creates its own plan. In addition to the issues already identified, the following are possible points of advocacy that were included in the preamble to the rule regarding the BSS:

- Ensure there is a simple system in place for beneficiaries to give permission to others, such as non-legal guardian relatives, to communicate with the BSS on their behalf. This is likely more important for LTSS beneficiaries because of the more in-depth services available. Although it is important that the BSS maintain privacy protections, there also needs to be a way for an individual to easily give permission to a friend or family member who is seeking information and assistance on their behalf. The BSS should not require arduous, time consuming processes that must be completed before the BSS will provide information (non-private) to an individual trying to help a beneficiary. If a person is seeking support from the BSS, they may want someone else to help them understand the information from the BSS and they should be able to confirm personal information and give verbal permission as opposed to complicated, time consuming paperwork.

[47] *Id.* at 27638.
[48] *See* 45 C.F.R. pt. 92, Appendix A.
[49] *Id.* at 27627.
[50] *Id.* at 27625.

- Extend the required functions of the BSS as "States can choose to expand the scope and types of resources available under the [BSS] as appropriate."[51]
- Encourage states to provide the quality data regarding managed care plans to the choice counselors.[52]
- Include strong coordination during enrollment between the BSS and the managed care plans when an individual is changing plans. Although CMS declined to mandate requirements about these processes, such coordination would be beneficial to individuals.
- Include training to network providers. Although the final rule does not require the BSS to train network providers, managed care plans are encouraged to include training related to the BSS, including the services for LTSS beneficiaries. Plans are also encouraged to work with providers regarding the best methods of accessing and coordinating the resources that are available to support beneficiaries.[53] In addition, states may determine that specific training elements are needed based on their delivery systems for healthcare and social services as well as the needs of the covered populations.
- Encourage the use of evaluation tools and assessments to ensure that enrollment brokers are not engaging in inappropriate referrals or other activities. Although having an interest in a managed care plan would violate the conflict of interest requirements, monitoring is likely still necessary to ensure compliance.[54]

NHeLP continues to provide assistance on implementation of the updated Medicaid Managed Care Rule. Please contact us if questions arise in your work.

[51] *Id.* at 27626.
[52] *Id.* at 27626.
[53] *Id.* at 27629.
[54] *Id.* at 27631.