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December 20, 2012

Jill Brown
Office of Legal Services
275 East Main Street 5 W-B
Frankfort, KY 40601

Re: Comments on Medicaid Managed Care Regulation 907 KAR 17:005

Dear Ms. Brown:

We write on behalf of the Kentucky Equal Justice Center, a civil legal services program that works closely with legal aid organizations and community partners across Kentucky. Our advocates assist consumers who receive medical coverage under Medicaid. We appreciate this opportunity to provide feedback on the critically important Medicaid managed care regulations. We already have received many questions about enrollment, coverage, and continuity of care, and we believe that we can provide useful information and suggestions to enhance these regulations.

Overall, we appreciate the thoughtfulness put into this regulation. It is clear that your office put substantial work into them and has produced an excellent product. The following are our suggestions to improve the regulations based on our experience working with Medicaid beneficiaries and the responses we have received so far.

Although we have provided comments on several sections of the regulation, we want to draw attention to some important themes in our suggested changes:

- Improved language access is necessary to make the MCOs usable for the entire beneficiary population

- Enhanced access to due process rights would better ensure enrollee service and MCO compliance

The discussion below is organized by sections of the regulation. For each section addressed, we indicate the subject matter addressed, provide comments and, where possible, make suggestions for the language of the regulation.

Section 1. Definitions

Section 1 provides useful definitions for understanding the regulation and its interactions with Kentucky and federal law. It covers a wide array of terms from "adverse action" to "risk adjustment."

Comment: We appreciate the definition in Subsection (50), which defines medical necessity in accordance with 907 KAR 3:130. Additionally, we want to comment on definitions that may be unclear, as follows:

- Subsection (6) describes "behavioral health services," including those in both inpatient and outpatient settings. We want to emphasize that many behavioral health services occur outside of traditional clinical settings. In particular, individuals can receive services in the home.

- Subsection (33), which defines "foster care," is confusing. To meet the definition a child must both be "placed in the custody of the Commonwealth of Kentucky" and "waiting for a permanent home." However, some children in foster care may already be in what will be their permanent home, whether this is with their biological family or a potential adoptive family. For that reason, we suggest that the requirement be that *either* condition is met.

- Subsection (66) defines a "qualified alien." The current definition includes several scenarios that would qualify an individual for permanent residence. However, 907 KAR 1:011(5)(12) includes other options to qualify. We can see no reason for the discrepancy and recommend that Subsection (66) be changed to coincide with Section 1:011.

  Suggested language:

  (6): "Behavioral health service" means a clinical, rehabilitative, or support service, in an inpatient or outpatient setting, or in the home, to treat a mental illness, emotional disability, or substance abuse disorder.

  (33): "Foster care" means the DCBS program which provides temporary care for a child:
  (a) Placed in the custody of the Commonwealth of Kentucky; ~~and~~ or
  (b) Who is waiting for a permanent home.

  (66): "Qualified alien" means an individual as defined in 907 KAR 1:011(5)(12)~~who is lawfully admitted into the United States of America for permanent residence under Title 8 of the United States Code (The Immigrant and Nationality Act)~~ including, but not limited to:
  (a) An asylee;
  (b) A refugee;
  (c) An individual who:
  1. Has been paroled into the United States of America for a period of one (1) year;
  2. Has had his or her deportation withheld;
  3. Has been granted conditional entry into the United States of America; or
  4. Is a Cuban or Haitian entrant who was receiving Medicaid benefits on August 22, 1996; or
  (d) A battered immigrant.

Section 2. Enrollment of Medicaid or KCHIP Recipients into Managed Care

Section 2 provides an overview of the mandated enrollment process for eligible Medicaid beneficiaries and sets out how and when enrollees may transfer between plans. It also details

which beneficiaries may not be required to enroll in a MCO. This section provides important information for beneficiaries and advocates to better understand this necessary process.

Comment: We are concerned that this section does not clearly state the requirement that MCOs must accept transferring enrollees. Nothing in the regulation prohibits a MCO from preventing a Medicaid beneficiary who wishes to switch plans during open enrollment periods from doing so. The intent of the program is to allow freedom of choice for the beneficiaries, but without a specific prohibition against denial of transfers this goal could be unmet. We proposed adding this language to Subsection (13).

Suggested language:

(13) An enrollee may change an MCO for any reason, and the transfer must be accepted by both MCOs, regardless of whether the MCO was selected by the enrollee or assigned by the department

Section 3. Disenrollment

Section 3 states that only the department can disenroll a member from a MCO plan. It then outlines the process by which a MCO may request the disenrollment a member and the procedure for that process.

Comment: Generally, we appreciate the restrictions against disenrollment. We are concerned, however, by the deemed approval protocol in Subsection (6)(b). The protocol states that if the Cabinet fails to make determination in a timely manner, then the disenrollment takes effect. We understand that this language is from 42 CFR 438.56(e)(2) and Cabinet must follow federal law. We also understand that with increased caseloads, timely determinations may not always be possible. We only ask that there be a requirement to practice due diligence and that all enrollees receive proper notice of the disenrollment.

Suggested language:

(6)(c): The department shall practice due diligence to ensure a determination within the timeframe specified in (6)(a). The department shall also ensure that the disenrolled member receives written notice of the disenrollment.

Section 4. Enrollee Rights and Responsibilities

Section 4 outlines the policies that must be developed to protect enrollees and their rights under managed care. Additionally, this section delineates what responsibilities enrollees have to ensure that their care is appropriate.

Comment: We appreciate the care the department has taken with this section. Because we work with many individuals with disabilities, we feel that it is necessary to clarify that some enrollees may need reasonable accommodations to be able to meet these requirements. The Americans

with Disabilities Act requires that entities not discriminate against individuals with disabilities and provide accommodations to standard practices when reasonable.

Suggested language:

(1)(c): If an enrollee is unable to fulfill the responsibilities set forth in (1)(b) due to a disability, the department and the MCO will provide a reasonable accommodation as required by the Americans with Disabilities Act (42 U.S.C. 12101 et seq.).

Section 5. Enrollee Grievance System

This section outlines an enrollee's right to contest MCO actions with which they disagree. It defines the process by which an enrollee can file an internal grievance with the MCO if s/he receives an adverse action, as well as how to appeal an adverse decision on a grievance.

Comment: We appreciate the consumer protections outlined in Section 5. We particularly appreciate Subsection (2), which allows an enrollee to pursue a state fair hearing under KRS 13 B without exhausting their MCO's internal grievance system.

As noted in our comments regarding Section 4, we want to emphasize the importance of accommodating individuals with disabilities. We suggest that this section also include language referring to the Americans with Disabilities Act and include a "good clause" provision to allow enrollees to file a grievance more than 30 days following an incident, when there is sufficient reason.

Additionally, we believe that consumer rights can be enhanced by modifying Subsection (16). The current language requires that, when a provider files an appeal, the provider is the only person to whom the MCO must send notice. Several Medicaid programs can only be applied for by a provider, but the consumer still has great interest in whether s/he receives the service. In these cases, it is proper to provide notice to both the provider and the consumer, especially because the consumer may not learn of the adverse action from the provider.

Lastly, we have concerns about Subsection (17). Specifically, we believe that it is inconsistent with Subsections (5) an (8). Subsection (17) states that MCO must provide continuing benefits to the enrollee for up to 14 days after a resolution letter, unless the enrollee files for an appeal. Since an enrollee has 30 days to file a grievance or appeal, the MCO should continue to provide benefits during that time. Otherwise, an enrollee could chose to appeal an inappropriate adverse action in a timely manner, but lose benefits.

Subsection (17) also should make clear that the expedited review process applies to both initial grievances and to appeals.

Suggested Language:

(5): An enrollee shall have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with the MCO, unless there is good

cause to extend this deadline or the enrollee requests a reasonable accommodation as required by the Americans with Disabilities Act (42 U.S.C. 12101 et seq.).

(8) An enrollee shall have thirty (30) calendar days from the date of receiving a notice of adverse action from an MCO to file an appeal either orally or in writing with the MCO, unless there is good cause to extend this deadline or the enrollee requests a reasonable accommodation as required by the Americans with Disabilities Act (42 U.S.C. 12101 et seq.).

(16) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee ~~or~~ and a provider, if the provider filed the appeal.

(17) An MCO shall:

(a) Continue to provide benefits to an enrollee until one of the following occurs:

1. The enrollee withdraws the appeal;
2. ~~Fourteen (14)~~ Thirty (30) days have passed since the date of the resolution letter, provided the resolution of the grievance or appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or
3. A state fair hearing decision adverse to the enrollee has been issued;

(b) Have an expedited review process for grievances and appeals when the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee's life or health or ability to attain, maintain, or regain maximum function;

(c) Resolve an expedited grievance or appeal within three (3) working days of receipt of the request; and

(d) Extend the timeframe for an expedited grievance or appeal in paragraph (b) of this subsection by up to fourteen (14) calendar days if the enrollee requests the extension or the MCO demonstrates to the department that there is need for additional information and the extension is in the enrollee's interest.

Section 6. Member Services

Section 6 sets out requirements for MCO Member Services programs. These requirements include when the programs must be open, what services they must provide, and instructions for assisting vulnerable populations.

Comment: As consumer advocates, we are particularly interested in services available to enrollees of the MCOs. We applaud the level of care and detail the department has devoted to this section. In particular, we appreciate the sections that require MCOs to provide interpreter services to members with limited English proficiency. We believe that these requirements should be clarified to ensure their reliable use. The regulations do not specify how or when these services should be offered. In other words, the regulation should define both the protocol and timeliness of the program.

Suggested Language:

(3) An MCO shall:

(a) 1. Provide foreign language interpreter services for an enrollee and advertise the availability of the services and process for obtaining them.

2. Interpreter services shall be available free of charge.

3. Interpreter services shall be available promptly, consistent with standards of timely care,

Section 7. Enrollee Selection of Primary Care Provider

Section 7 describes which MCO enrollees must chose a primary care provider and which cannot be forced to do so. It also outlines the process for a MCO to assign an enrollee a primary care provider.

Comment: We are confused by Subsection (7)(g), which states that an enrollee shall have the right to change primary care providers "at any time with cause which shall include and enrollee." This sentence is nonsensical. Additionally, the sub-numbering appears out of order. We have attempted to alter the language in a way that makes sense, but request that the department reviews this section.

Suggested Language:

(7) Upon enrollment in an MCO, an enrollee shall have the right to change primary care providers:

(a) Within the first ninety (90) days of assignment;
(b) Once a year regardless of reason;
(c) At any time for a reason approved by the MCO;
(d) If during a temporary loss of eligibility, an enrollee loses the opportunity in paragraph (b) of this subsection;
(e) If Medicare or Medicaid imposes a sanction on the PCP;
(f) If the PCP is no longer in the MCO provider network; or
(g) At any time with cause, which shall include ~~and~~ the enrollee:

1. Receiving poor quality of care; or

~~3~~2. Lacking access to providers qualified to treat the enrollee's medical condition.

Section 9. Member Handbook

Section 9 details the requirements of member handbooks that MCOs must provide for enrollees. These handbooks will assist members and their advocates in better understanding the programs. The handbooks will provide important information that will not only help the members navigate the program, but also will help them achieve the best health outcomes by providing higher quality service.

Comment: We greatly appreciate the requirement that the handbooks be provided in Spanish and any language spoken by at least 5% of the potential enrollee or enrollee population. We think, however, that the Standard Metropolitan Statistical Area (SMSA) or the enrollee's county

might be more appropriate units of area for measurement than the entire enrollee population. There is great diversity across the Commonwealth of Kentucky and applying the 5% threshold by area would reflect that.

Additionally, our work with behavioral health providers and consumers teaches us that knowledge of specialty services is low in many communities. Medicaid beneficiaries may be eligible for such programs as Impact Plus, targeted case management, multiple waiver programs, and the full range of extended services under EPSDT. We feel that specifically including information on these services will increase their usage and improve treatment of this community.

Suggested Language:

(2) A member handbook shall:
(a) Be available:
1. In English, Spanish, and any other language spoken by at least five (5) percent of the ~~potential enrollee or~~ enrollee population or enrollee county's population or standard metropolitan statistical area (SMSA);
2. In hardcopy; and
3. On the MCO's website with web links in Spanish and any other language spoken by at least five (5) percent of the SMSA;
(b) Be written at no higher than a sixth grade reading comprehensive level; and
(c) Include at a minimum the following information:
1. The MCO's network of primary care providers, including the names, telephone numbers, and service site addresses of available primary care providers;
2. The procedures for:
a. Selecting a PCP and scheduling an initial health appointment;
b. Obtaining:
(i) Emergency or non-emergency care after hours;
(ii) Transportation for emergency or non-emergency care;
(iii) An EPSDT service, including extended services;
(iv) A covered service from an out-of-network provider; or
(v) A long term care service;
(vi) A specialty behavioral health service, such as Impact Plus and targeted case management;

Section 12. Provision of Information Requirements

This section outlines the requirements for MCOs when providing information to their members and ensures that the information be understandable by a wide range of people, including people with disabilities and those with low reading comprehension.

Comment: We especially appreciate the emphasis in Section 12 that the Cabinet has given to making information accessible to enrollees. We feel that this section could be strengthened by adding requirements for language translation, as required by 42 U.S.C §§ 2000d. Providing written materials in the enrollee's native language is particularly important when the information

is essential to medical care, such as informed consent materials before a surgery. We suggest that this be required in at least the top five languages in Kentucky.

Suggested Language:

(2) Written material provided by an MCO to an enrollee or potential enrollee shall:
(a) Be written at a sixth grade reading comprehension level;
(b) Be published in at least a twelve (12) point font;
(c) Comply with the requirements established in 42 USC Chapter 126 and 47 USC Chapter 5 (the Americans with Disabilities Act);
(d) Be updated as necessary to maintain accuracy; and
(e) Be available in Braille or in an audio format for an individual who is partially blind or blind.
(f): Be available in a language other English when either (i) that language is spoken by at least 5% of the enrollees in an SMSA or the enrollee's county; or (ii) the information is essential to the health of the beneficiary.

Section 13. Provider Services

Section 13 outlines the services MCOs must make available to providers in their network. These services must include the full range of information that providers need to practice effectively within the Medicaid system, such as which services are covered and Medicaid procedures.

Comment: As we noted in our comments regarding Section 9, knowledge of specialty behavioral health services is limited for providers and consumers alike. We encourage the Cabinet to require trainings on these services for providers to increase access for beneficiaries.

Suggested Language:

(f) Provider orientation and training, including:
1. Medicaid covered services;
2. EPSDT coverage, including extended services;
3. Medicaid policies and procedures;
4. MCO policies and procedures; and
5. Fraud, waste, and abuse;
6. Specialty behavioral health service, such as Impact Plus and targeted case management;

Section 14. Provider Network

To provide adequate services to all enrollees each MCO must have a sufficiently robust provider network. Federal Medicaid law requires this.[1] This requirement is especially important in a rural state like Kentucky where some areas have very few doctors, hospitals, and pharmacies. Section 14 outlines the requirements for MCO network adequacy and delineates when a MCO must report its inadequacy to the department.

[1] 42 U.S.C. § 1396a(a)(30)(A).

Comment: We are worried that this section allows for too much discretion by the MCOs. We hope, of course, that all MCOs will report any inadequacies to the department. However, the department has a duty to ensure that Medicaid funds are applied appropriately and in accordance with state and federal law. For this reason, we suggest that a subsection be added requiring continued oversight by the department.

Suggested Language:

At least twice a year, the department will review the network of each MCO and determine if it meets adequacy standards. If it does not, the department shall require an immediate corrective action plan.

Section 15. Provider Access Requirements

Section 15 expands on the requirements from Section 14 by setting standards for access beneficiaries must have to providers in their area. It requires availability of a primary care provider within thirty minutes or thirty miles in urban areas and forty-five minutes or forty-five miles for urban areas. Additionally, it outlines the maximum time an enrollee must wait to receive an appointment.

Comment: We are concerned by the difference in wait times between behavioral health and other specialists. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Section 512[2] requires parity between physical and mental health in Medicaid when services are performed through a managed care organization. The regulation as written does not comply with this law. Enrollees should not have to wait times for behavioral health services up to twice as long as for services in Subsection (4). We suggest that appointment wait time for all specialist services be 30 days.

Suggested Language:

(4) (a) An appointment wait time for a specialist, except for a specialist providing a behavioral health service, shall not exceed thirty (30) days from the referral for routine care or forty-eight (48) hours from the referral for urgent care.

(b) 1. A behavioral health service requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.

2. Behavioral health urgent care shall be provided within forty-eight (48) hours of the referral.

3. A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge.

4. A behavioral health service appointment not included in subparagraph 1, 2, or 3 of this paragraph shall occur within ~~sixty (60) days~~ thirty (30) days of the referral.

[2] 29 U.S.C. § 1185a.

Section 29. Covered Services

Section 29 details which services the MCOs must provide and those for which they are not responsible. It also outlines which specialty services must be available without a referral, such as primary dental care and HIV testing.

Comment: We appreciate the detail in this section because of its importance to our clients. In particular, we greatly appreciate Subsection (5) and its requirement that beneficiaries be able to use out-of-network providers for family planning services.

Section 31. Second Opinion

Section 31 requires that enrollees have the option of a second opinion should they disagree with the decision of a provider.

Comment: We are confused by this section and request clarification. As written, enrollees only have this right concerning a complex or chronic condition. The phrase "complex" condition is undefined and vague. Additionally, we know of no language in federal Medicaid law that allows for this distinction. We suggest that this clause of the section be removed to allow for second opinions in all cases. Alternatively, the section at least should define precisely which conditions give rise to the right.

Suggested Language:

An enrollee shall have the right to a second opinion within the MCO's provider network for a surgical procedure or diagnosis and treatment ~~of a complex or chronic condition~~.

Section 41. Coordination Between a Behavioral Health Provider and a Primary Care Provider

Section 41 provides important protocols for coordination between behavioral health and primary care providers. It specifically deals with the screening practices expected of primary care providers.

Comment: We appreciate the requirements outlined in this section. One of the advantages of managed care is the ability to better coordinate these services. We would like to note that the program "Teen Screen" is an effective mechanism for screening adolescent patients.
The only suggestion that we would make would be to add language about specialty behavioral services, such as Impact Plus and targeted case management, which many providers do not know about.

Suggested Language:

(1) An MCO shall:

(a) Require a PCP to have a screening and evaluation procedure for the detection and treatment of, or referral for, a known or suspected behavioral health problem

or disorder.
(b) Provide training to a PCP in its network on:
1. Screening and evaluate a behavioral health disorder;
2. The MCO's referral process for a behavioral health service, including specialty services;
3. Coordination requirements for a behavioral health service; and
4. Quality of care standards;

Section 42. Court-Ordered Psychiatric Services

Section 42 outlines the requirements for MCOs to provide psychiatric services to enrollees when ordered by the court system. MCOs also are required to coordinate inpatient services with those provided their behavioral health services on an outpatient basis.

Comment: We are concerned by the distance consumers may have to travel to receive these services. The farther away the enrollee is placed to receive these services, the less likely they will receive visits from friends and family, which can be very helpful for their treatment and recovery. While we do not have the expertise to determine what distance would be a reasonable outer limit, we suggest that the Cabinet consider this issue and set time and mileage limits.

Suggested Language:

(1) An MCO shall:
(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapter 202A and 645;
(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);
(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and
(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee's region in accordance with 908 KAR 3:040 and in accordance with the *Olmstead* decision
(e) Ensure that all enrollee's receive services within their own communities, so that no enrollee or enrollee's family has to travel an unreasonable distance to receive inpatient services.

Section 43. Legal Guardian

Section 43 outlines the rules regarding legal guardians who represent an enrollee's interests under certain circumstances.

Comment: We appreciate Subsection (1)(c) in particular, which describes some of the rights that consumers retain regardless of the presence of a guardianship. We feel that the section should make clear, however, that the interests of the consumer control. This is necessary because, in some cases, a guardian may wish to take potentially adverse action to those interests. To preserve this right, we suggest that Subsection (1)(c) clarify that the enrollee can pursue alternative representation without the consent of the guardian.

Suggested Language:

(c) An enrollee shall have the right to the following without the consent of the legal guardian:

1. Represent the enrollee; or
2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 45. Service Authorization and Notice

Section 45 details what information must be given after a MCO makes a decision to approve or deny a service. It outlines when notice is required, to whom, and what that notice must include.

Comment: The requirements for notice in Section 45 are important to us as legal representatives for Medicaid beneficiaries. As a preliminary matter, there is an error in Subsection (3)(a)(1), which says "… or the provider acting on behalf of and with content of an enrollee," but should presumably be "with the consent of an enrollee."

Additionally, we feel that the language in Subsection (4)(2) is too narrow. This portion outlines what must be in the notice regarding certain adverse actions. Currently, it is limited to adverse actions relating to medical necessity and a coverage denial, but we suggest that it go further. Any adverse action gives rise to appeal and grievance rights, and the enrollee has a right to written notice in those cases.

Suggested Language:

(4) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide:

(a) A notice to the:

1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within two (2) business days of receipt of the request for service; and
2. Requesting provider, if applicable;

(b) ~~For an adverse action relating to medical necessity and a coverage denial, a notice to the enrollee, which~~ The notice shall:

1. Meet the language and formatting requirements established in 42 CFR 438:404;
2. Include the:
   a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;

b. Reason for the action;
c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
d. Right of the enrollee to request a state fair hearing;
e. Procedure for filing an appeal and requesting a state fair hearing;
f. Circumstance under which an expedited resolution is available and how to request it; and
g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstance under which the enrollee may be required to pay the costs of these services;

Section 56. Prompt Payment of Claims

Section 56 outlines the reimbursement requirements for providers from the MCOs. It also states when a MCO should alert a provider that the MCO does not intend to reimbursement a service.

Comment: We are concerned that Section 56, as written, does not provide adequate notice to the enrollee. If a MCO denies a service or approves it in an amount, duration or scope that is less than requested, the regulation reasonably requires the MCO to give notice to the provider. However, we suggest that, since the enrollee is the individual unable to benefit from the full service, s/he should receive notice as well. This will allow enrollees to more easily challenge adverse actions.

Suggested Language:

(2) An MCO shall:
(a) Comply with the prompt payment provisions established in:
1. 42 CFR 447.45; and
2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700-730; and
(b) Notify a requesting provider and the enrollee of a decision to:
1. Deny a claim; or
2. Authorize a service in an amount, duration, or scope that is less than requested.

Section 68. Termination of MCO Participation in the Medicaid Program.

Section 68 states that the department shall terminate MCO participation in the Medicaid program according to KRS 45A.

Comment: We are concerned that this section does not detail what would cause the department to take this action. We suggest that non-compliance with the Medicaid Managed Care regulations be cause for termination, at least in egregious cases. These regulations outline many important provisions that protect consumers and providers alike. If they are not strictly enforced, the Medicaid program will not run effectively. We feel that explicit penalties for non-compliance should be written into the statute.

Suggested Language:

The department shall terminate an MCO Participation in accordance with KRS Chapter 45A. If the department finds that a MCO is not in compliance with this regulation, it will attempt remedial action. In extreme cases, non-compliance may result in termination from the program.

As a final note, although it may not be appropriate for these regulations, we hope that the MCOs will be required to consider the recommendations of the Medicaid Advisory Committee (MAC). It is unclear what role the MAC will play in the managed care system. The MAC provides important perspectives from the provider and consumer communities and allows those most affected by MCO policies to have a voice in Frankfort. We strongly encourage the continued consideration of this committee's recommendations.

Thank you for allowing us to comment on this regulation. We request a copy of the statement of consideration from the public hearing to be sent to us. Please feel free to contact us at (859) 233-0323 if you have any questions.

Sincerely,

Anne Hadreas, Health Law Fellow
Rich Seckel, Director
Anne Marie Regan, Senior Staff Attorney