

Comments from MAXIMUS on
**FCC SECOND FURTHER NOTICE
OF PROPOSED RULEMAKING**
order on reconsideration, second report and order,
and memorandum opinion and order

MAXIMUS submits these comments in response to order
(Second FNPRM and Report and Order): WC Docket Nos. 11-42, 09-197, and 10-90 .

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Since 1975 MAXIMUS has worked with both the Federal and every State government to achieve effective and consumer-focused administrative services that achieve their health and human services policy objectives. In particular, as the largest provider of Medicaid and Children's Health Insurance Program (CHIP) managed care enrollment services in the United States, MAXIMUS provides choice counseling, outreach, education and enrollment services to more than half of the Americans who receive their Medicaid benefits through the managed care model. Today we provide these services in 20-states, including five of the seven states with the largest number of Medicaid managed care beneficiaries: California, Michigan, New York, Pennsylvania and Texas. In addition to our work with the States, we provide the Federal government with Medicare appeals, consumer support to Healthcare.gov — including eligibility appeals determinations — and manage the Ticket to Work program, among many other relationships.

Through the years we have processed more than 53 million Medicaid and CHIP enrollments, learning first-hand the help and facilitation that is needed for potential enrollees and managed care beneficiaries in Medicaid; working across the states on innovative, efficient and secure use of state, Federal and 3rd party data and information to provide transparent processes to achieve the highest levels of program integrity while delivering simplified administrative procedures that improve the ability to engage, identify prospectively-eligible citizens and connect them with the government benefits for which they are eligible. It is from this long, deep and wide perspective that we are pleased to provide the following comments to the Second FNPRM and Report and Order.

Our commentary focuses on how Medicaid — the single largest population among the handful of presumptive-eligibility programs for Lifeline — has developed, maintained and recently amplified in their own proposed rulemaking the importance of conflict-free, independent eligibility determination and enrollment services as the foundation to ensure transparent and administratively-simplified citizen services across the country. The implications to the Second FNPRM and Report and Order are primarily in Section B; Third-Party Eligibility Determination, but reflective in Section C, Increasing Competition, with regard to streamlining Eligible Telecommunications Carrier (ETC) designation and in Section D, Enhanced Consumer Protections (de-enrollment) and Section E, Efficient Administration (use of subscriber data, provider transfers).

Independence and Freedom from Conflict of Interest

The omnibus Balanced Budget Act of 1997 (BBA '97) passed by Congress and signed into law in August of that year, among many other things, enabled and encouraged states to move to Managed Care as a seminal restructuring from the historical fee-for-services Medicaid delivery system. Section 4707, Protections Against Fraud and Abuse, introduced the concept of a Federally-funded, state-administered enrollment broker in "marketing Medicaid managed care organizations and other managed care entities to eligible individuals", stating the enrollment broker "to be necessary for the proper and efficient administration of the State [Medicaid] Plan". The Act outlined two conditions be met:

- **"(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities."**
- **"(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act."**

This statute was placed into regulation (updated in June and October, 2014) by the Department of Health and Human Services (HHS) under 42 CFR 438.810, with the scope, role and requirements described as follows:

(a) Terminology. As used in this section —

- Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO [Medicaid Care Organization], PIHP [Prepaid Inpatient Health Plan], PAHP [Prepaid Ambulatory Health Plan], or PCCM [Primary Care Case Management] delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;
- Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;
- Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both, and;
- Enrollment services means choice counseling, or enrollment activities, or both.

(b) Conditions that enrollment brokers must meet...:

- (1) Independence. The broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it—
 - (i) Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;
 - (ii) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or
 - (iii) Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in the State.
- (2) Freedom from conflict of interest. The broker and its subcontractor are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them —

- (i) Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;
 - (ii) Has been excluded from participation under title XVIII or XIX of the Act;
 - (iii) Has been debarred by any Federal agency; or
 - (iv) Has been, or is now, subject to civil money penalties under the Act.
- (3) Approval. The initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS.

Passage of the BBA '97 statutes and publication of the independent, conflict-free enrollment regulations was based on nearly 30-years of evidence on how to optimize Medicaid beneficiaries' access and effective use of managed care; a near perfect analog to that described in this Second FNPRM. At this time Medicaid managed care had hit an enrollment peak and many states were seeing shrinking participation of health plans, narrowing networks of providers, and increasing challenges to the cost/quality of the program; in particular the degree of fraud, waste and abuse of the then provider-led enrollment processes. The BBA '97 addressed these challenges through actions to broaden program access, redefine the benefits offered, restructure provider and distribution rules, and realign the relationships and responsibilities of beneficiary use to the Medicaid program. Over the 12 years between 1997 and 2009, enrollment in Medicaid managed care increased from 8 million to 49 million, with 23 million in comprehensive risk-based plans.

Through the independent and conflict-free enrollment function, beneficiaries' hesitancy to accept managed care over the traditional fee-for-service Medicaid relationship with providers was overcome because they had access to clear, unbiased counseling of their health plan choices; free from the potential of "sales" pressures inherent in the pre-1997 Medicaid managed care delivery system. Moreover, Medicaid managed care providers were given a structured, fair and equitable ability to supply health insurance products to satisfy this demand. With passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the health insurance exchanges, Federal and State, in conjunction with those states choosing to expand Medicaid followed the independent, conflict-free enrollment processes originally outlined in the BBA '97 because of the successful track record established in the decades following its passage.

In June of this year, HHS published in the Federal Register a notice of proposed rulemaking (NPRM CMS-2390-P) to modernize Medicaid managed care regulations to reflect changes in the current usage of managed care delivery systems. Within these proposed modernized rules, HHS proposes language to strengthen its commitment to shielding Medicaid beneficiaries from enrollment support and facilitation that may be tainted — in perception and actuality — by an enrollment broker steering potential enrollees to a managed care entity with which it has a business relationship both pre-enrollment as well as post-enrollment. Extension of the independence and conflict of interest language to post-enrollment activities reflects HHS interests to ensure that Medicaid enrollees have the unbiased information about the benefits for which they have been enrolled to achieve optimal outcomes from their use over the lifecycle of their Medicaid relationship.

The independent and conflict-free enrollment business model -- implemented, tested and proven over decades of use within Medicaid -- provides the FCC, facing an analogous opportunity with Lifeline, to leverage the effectiveness of an existing Federal program and expand outreach efforts. We believe that the benefits of incorporating this framework as a foundational element to the final rulemaking the FCC considers related to modernizing the Lifeline program will help achieve rapid adoption and be fundamental to achieving the outcomes defined for the new rules.

Realizing the benefits of Lifeline

In paragraph 27 of the Second FNPRM, the Commission seeks comment on potential impacts of additional broadband expansion of Lifeline. Within the text a number of examples are provided — telehealth consultations, remote monitoring, improved access to those individuals receiving long-term services and supports among them. **The practical and empirical evidence is clear, the more informed a beneficiary is of their health benefits the more likely they are to make better choices regarding health decisions.** In our experience working with the Medicaid populations, moving beyond awareness to understanding both the health and the financial implications of these choices through access to unbiased counseling — pre- and post-enrollment — is critical. **Equipping low-income households with the necessary tools and support system to realize the benefits of broadband during the Lifeline relationship is the means through which they ultimately will realize those benefits well beyond their time on the Lifeline program.**

MAXIMUS experience in pre-enrollment choice counseling in Medicaid — understanding the health needs, assessing the existing health risks, informing prospective beneficiaries of plan and provider options to address the needs and risks, and facilitating enrollment in these plans — is a proven example that could help the Commission achieve this stated objective in the Second FNPRM. As an independent and conflict-free counselor, the Medicaid enrollment broker provides beneficiaries with unbiased information they can trust to make the best decisions for themselves and their families in context to their current health status and towards a desired future health status.

Introducing this independent third-party role into the Lifeline process, as outlined in paragraph 63 of the Second FNPRM, both relieves the telecommunications carriers of this cost and complexity while enabling low-income households' use of the Lifeline benefit. Under today's structure, the policy intentions of the Lifeline program — providing subsidized access to low-income telecommunications solutions as a "hand-up" out of poverty — are generally delinked from the broader informed use of other the means-tested benefits such as Medicaid and Supplemental Nutritional Assistance Programs (including the National School Lunch programs) that are the pre-qualifying eligibility determinants of Lifeline. The current retail channels used by beneficiaries to procure Lifeline are ill-equipped to provide this support, and burdening them with this responsibility is unnecessary especially when both state and Federal governments have in-place the capabilities through which such a linkage is achievable.

Since Medicaid is the single-largest pre-qualified population for Lifeline, using the existing enrollment broker function for Lifeline would achieve the following benefits for the Commission:

1. Administrative simplification for prospective beneficiaries and the telecommunications providers. Educational and culturally-sensitive counseling of the scope and responsibilities of using Lifeline can be extended to include Lifeline. This counseling would include how to best access benefits applications and use information through the Lifeline tools. For eligible telecommunications companies, they receive pre-qualified and eligible enrollees through whom they can assist in managing the households' broader telecommunications needs.
2. Improved control over fraud, waste and abuse. The current Medicaid processes already achieve a 3% or lower eligibility determination error rate, and enhanced access to multi-source validating and verifying data from across state agencies and 3rd party data providers eliminates a duplicated expense by the Commission to achieve improvement and elimination of program fraud, waste and abuse.
3. Accelerate achieving the mandate of Lifeline. The Lifeline program was enshrined into the Telecommunications Act of 1996 because access to the rapid exchange of information through universally-available telecommunications services was crucial to full participation in society and

the economy. Using the proven-effective, independent and conflict-free Medicaid enrollment model, the Commission establishes a direct link of the enabling telecommunications tools to a cost-effective support-system through which eligible beneficiaries can take advantage of the information they need to improve their well-being and improve their contributions to society.

MAXIMUS applauds the Commission on the intentions outlined in these new rules. The concepts outlined towards providing enhanced, equitable access to the benefits of Lifeline through integration with existing means-tested programs and processes is a pragmatic, efficient and achievable objective. A fundamental precept used to transform and propel access to Medicaid managed care was the introduction of independent choice counseling, free from conflicts of interest, to prospective beneficiaries. This model has been refined, improved and perfected over the years and is now a bulwark upon which Medicaid intends to support post-enrollment activities in the years to come. We believe the Commission, faced with an analogous opportunity for improving access, efficiency and effectiveness of the Lifeline program, will benefit by including this approach within the final rulemaking.



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