Comments and Responses on ARC 2241C
Medicaid Managed Care Chapter Revision
Received by December 4, 2015

The following person/organization provided written comments, which are included in the summary below:

1. Shelly Chandler, Executive Director, Iowa Association of Community Providers
2. Jason Velinsky, Operations Director, Caretech, Inc.
3. Dan Royer, Vice President, Finance Policy, Iowa Hospital Association
4. Clare Kelly, Executive Vice President & CEO, Iowa Medical Society
5. Kelsey Clark, Executive Director, Iowa Behavioral Health Association
6. Bob Bartles, Executive Director, Hope Haven Area Development Center
7. Bill Nutty, Vice President, Regulatory and Government Affairs, Iowa Healthcare Association
8. Kent Sovern, AARP Iowa State Director
9. Jennifer Donovan, Staff Attorney, Iowa Legal Aid
10. Judith Benson, Attorney At Law
11. Lynn Boes, Iowa Nurses Association
12. Gaye Johnson, ChildServe

Summary:
The Department received multiple comments from 12 respondents. The comments were lengthy and in many instances duplicative and were therefore summarized. An electronic copy of the comments are available upon request by email at: policyanalysis@dhs.state.ia.us.

The Department rules are not intended to reiterate all provisions of the managed care contracts or all applicable federal requirements. The Department's contracts with the MCOs require compliance with all applicable legal requirements.

Based on the public comments received the Department will be amending the proposed rules as follows:

The Department is proposing the following amendments to the noticed rule:

- "Level of Care" means an evaluation to determine and establish an individual's need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future ~~(one month or less~~).

- **73.4 (1) (a)"**During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, **for any reason**, in writing or by a telephone call to the enrollment broker's toll-free member telephone line."

- **73.12(1)(f)** For a resident of a rural area that has only one ~~"contractor"~~ appropriate provider of a needed service, the denial of the enrollee's request to exercise the enrollee's right to obtain services outside of the MCOs network (~~if applicable~~).

- **73.14(1)(b**) b. ~~Ten days have passed from the date the managed care organization mailed the notice of an adverse decision, unless a state fair hearing has resolved the matter; or~~ Ten days pass

after the MCO mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

Public comment and the Department response:

73.1 Definitions
The Department received 6 comments on definitions. 1) Out-Of-Network, Non-Contracted and Non-Participating Provider 2) Level of Care 3) Emergency Services 4) Clean Claim

COMMENT 1: **Out-of-Network, Non-Contracted and Non-Participating Provider** The respondent stated that **t**hese are key terms that should be clearly defined and referenced accordingly as they have a significant impact on how providers are to be reimbursed for providing health care services to Medicaid beneficiaries.

RESPONSE: The Department does not support the recommendation to add new definitions related to these terms. The rules define a participating provider; a provider who does not meet that definition will be considered a non-participating provider. While different terminology is used at times the Department believes that the meaning and intent of the terminology is clear related to managed care networks and provider participation status.

COMMENT 2: Clean Claim Three similar comments suggested that the definition of "clean claim" is too vague and requested different language.

RESPONSE: The Department does not support this recommendation. As drafted, the definition of a "clean claim" encompasses the type of criteria suggested so additional detail is not necessary.

COMMET 3: Level of Care The respondent stated the definition mentions an individual's need for the level of care "within the near future" (one month or less). The CFR has different language with regard to the period of time when there is a reasonable indication that a person might need services in the near future. As the standard is different in federal law, Iowa should adopt different standards for these different populations as well.

RESPONSE: The Department accepts this recommendation and will make the following change:

"Level of Care" means an evaluation to determine and establish an individual's need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future ~~(one month or less~~).

COMMENT 4: **Emergency Services** The respondent was supportive.

RESPONSE: The comment for emergency services was supportive of the definition.

73.3 Enrollment
The Department received four comments relating to enrollment. 1) Member Choice counseling 2) Presumptive and Retroactive Eligibility 3) Adequate decision making time 4) New reimbursement subrule

COMMENT 1: Member Choice Counseling The respondent requested amended language to prohibit any restrictions on physicians' ability to discuss with their patients the different managed care coverage options and how they align with the patient's unique healthcare needs.

RESPONSE: The Department does not support this recommendation. Member choice counseling, as defined, meets federal requirements. Providers may provide objective information and education but cannot direct clients to a specific MCO per federal regulations. The purpose of this federal regulation is to allow members to make an informed and active choice in the selection of their health care coverage.

COMMENT 2: Presumptive and Retroactive Eligibility-The respondent stated that the rules seem to indicate that the MCOs are to reimburse providers retroactively, while the contracts clearly indicate that claims generated from retroactively enrolled Medicaid beneficiaries are not eligible for payment. More clarity is needed on this issue.

RESPONSE: The Department does not support this recommendation. The eligibility requirements and assignment to managed care have not changed for members who are presumptive or retroactively eligible. As is the case today, in the future MCOs will not cover members who are presumptive or retroactively eligible with the exception of children on hawk-i and children born to mothers on Medicaid. These allowances for retroactive managed care coverage allows for continuity of care and maximized coverage for those two memberships.

COMMENT 3: Adequate decision making time- The respondent raised the concern that the 10 day timeframe from the date of the tentative assignment letter to request enrollment with a different managed care organization isn't enough time for people to make a decision about which MCO is the best choice for them.

RESPONSE: The Department does not support this recommendation. Federal regulations require at least a ten day notice. While a member has a minimum of 10 days from the date of the tentative assignment letter, depending on where that day falls in the month, members may have up to 45 days to make a choice. After that initial choice period members have an additional 90 days to change managed care plans.

COMMENT 4: **New Reimbursement subrule request** 73.3(6) *Benefit reimbursement after enrollment.* After the effective date of managed care enrollment, except as provided in paragraph 73.3(5)"b", the managed care organization shall reimburse providers for covered program benefits equal to or exceeding rates pursuant to 441— Chapters 74 to 91, as applicable for eligible members.

RESPONSE: The Department does not support this recommendation. Section 6.2.2.6 and 6.2.2.7 of the Department contracts with the managed care organizations requires MCOs to reimburse providers at a rate that is equal to or exceeds the Agency designated floor which, in many cases, is the current Iowa Medicaid fee-for-service (FFS) rate.

73.4 Disenrollment

The Department received 5 comments related to Disenrollment. 1) Good Cause 2) Retroactive Eligibility 3) 90 day, any reason 4) Resolution 5) Process and Status after Disenrollment

COMMENT 1: Good Cause Respondent supports the definition of "good cause" as it will allow people receiving services flexibility as their needs change.

RESPONSE: The comment is supportive of the rule.

COMMENT 2: Retroactive Eligibility The respondent made the recommendation to require that the MCO retroactively cover any services provided during the member's lapse in eligibility as well as requiring retroactive eligibility and coverage during a short lapse in coverage (ie: within 90 days of regaining program eligibility).

RESPONSE: The Department does not support this recommendation. If a member is disenrolled and then later retroactively enrolled after a lapse in coverage, the member ~~is~~ will be considered eligible for Medicaid fee for service benefits and services will be reimbursed through Iowa Medicaid prior to assignment to a managed care organization. To preserve continuity of care, ~~a~~ the reinstatement of a member's eligibility within 60 days would be covered by the MCO

COMMENT 3: 90 Day, Any Reason-Request for additional wording to make it clear that during the first 90 days, this request for disenrollment can be made for any reason.
73.4 (1) (a)"During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, in writing or by a telephone call to the enrollment broker's toll-free member telephone line."

RESPONSE: The Department accepts this recommendation and will make the following change.
73.4 (1) (a)"During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, **for any reason**, in writing or by a telephone call to the enrollment broker's toll-free member telephone line."

COMMENT 4: **Resolution** –The respondent requested to define experience resolution and provide explain the actions prior to moving onto the enrollment broker.

RESPONSE: The Department does not support this recommendation. Resolution is defined by that member's satisfaction with the outcome of the managed care grievance or appeal process. Members must go through the MCO grievance process prior to requesting disenrollment from the enrollment broker. This allows the MCOs to resolve identified issues internally to preserve continuity of care and coordination as much as possible prior to third party intervention.

COMMENT 5: Process and status after disenrollment -Concern that the proposed regulation does not provide for what happens to the member after the member is disenrolled from an MCO.

RESPONSE: The Department does not support this recommendation. The rules clearly state the process, the timelines, and the appeal processes related to member disenrollment. The rules also define mandatory membership in managed care which does apply to members who request disenrollment from a MCO. As such, members will be offered the opportunity to actively select an MCO of their choice if the criteria for disenrollment are met.

73.5 Covered Services
Comment: The Department received 2 similar comments expressing concern over using the requirements in Chapter 90 related to Case Management and requested removal of them.

RESPONSE: The Department does not support this recommendation. The currently approved and recently submitted 1915(i) State Plan Amendment and the 1915(c) waiver applications reflect the current requirements in Chapter 90 and must be adhered to unless otherwise revised in these federal documents and then approved by CMS.

73.6 Amount Duration Scope
The Department received 2 comments related to Amount, Duration and Scope. 1) Medically Necessary Service 2) Practice Guidelines / UM

COMMENT 1: **Medically Necessary Service** -Requests language that would prohibit MCOs from denying a required, medically necessary service solely on the basis of cost.

RESPONSE: The Department does not support this recommendation. The MCOs are currently required by contract with the Department and in this subrule of the proposed rules to cover medically necessary services. As such, the MCOs are not allowed to deny a medically necessary service based on cost.

COMMENT 2: Practice Guidelines / UM-Requests that DHS ensures any practice guidelines adopted by the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members and the general public as required by federal regulation.

RESPONSE: The Department does not support this recommendation. Managed care organizations may develop their own prior authorization and utilization management criteria but that criteria must be approved by the Department and is published in their provider manuals which are made available to the public. The Department will not approve prior authorization or utilization management criteria that prevents members from receiving services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished.

73.7 Emergency Services
The Department received one comment on Emergency Services related to coverage of diagnostic testing and procedures in emergency conditions.

COMMENT 1: Recommend the addition of an administrative rule protection enumerating that MCOs must also cover the diagnostic testing and procedures used to determine if an emergency condition exists.

RESPONSE: The Department does this not support this recommendation. Screening for the presence of an emergency condition is covered in subrule 73.7(2) d of the proposed rules and Section 3.2.5 of the Department's contract with the managed care organizations which requires MCOs to cover medical screening examinations, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, provided to a member who presents to an emergency department with an emergency medical condition.

73.8 Access
The Department received two comments on Access. 1) Medicaid Enrolled Providers 2) Nurse Call Line

COMMENT1: Medicaid Enrolled Providers Request to amend proposed rule to state that the managed care organizations shall give all enrolled Medicaid providers meeting the conditions of participation for Medicaid the opportunity to be part of its provider network.

RESPONSE: The Department does not support this recommendation. The MCOs are required to have an "any-willing provider status" for the first six months and two years, depending on the provider type. This means that any qualified provider that would like to contract with one or more MCO~~s~~ during the six month and two year transition periods must be allowed to do so. Further, the MCOs may not close their network after the six month and two year transition period unless network adequacy is met and the Department approves a closed network.

Until a provider has signed a contract with a MCO the in network reimbursement level for the first 90 days. After the first 90 days, out-of-network providers will receive 90 percent of the in-network reimbursement level unless other arrangements are made between the MCO and the out-of-network provider. The Agency defined Iowa Medicaid floor is only available to providers that have chosen to contract with that MCO. Ideally, current Medicaid providers will enroll with MCOs to receive the full in-network reimbursement level and to maximize care coordination effectiveness for Iowa Medicaid members.

COMMENT 2: Nurse Call Line-Requests that nurses are Iowa nurses on the nurse call line or at least licensed in a state that belongs to the compact.

RESPONSE: The Department does not support the recommendation. The MCOS are required to follow HMO licensure requirements with the Iowa Insurance Division. These requirements state that licensure is required in Iowa.

73.9 Incident Reporting
The Department received 4 comments on Incident Reporting. 1) Maintain standardized system 2) Central Reporting Portal

COMMENT 1: **Standardized System-**Three responders requested the continued use of the current standardized system due to concern with variance between MCOs and the system they may utilize.

RESPONSE: The Department does not support this recommendation. The MCOs are required to implement incident reporting mechanisms and are being reimbursed to do so. The trigger for incident reporting and requirements will be standardized across plans as these requirements are currently in the approved 1915(i) State Plan Amendment and 1915(c) waivers.

COMMENT 2: Central Reporting Portal –The respondent recommended that the MCO add language to the subrule requiring that the critical incident reporting and management system shall be the central reporting portal for reportable incidents with the managed care organizations then reporting reportable incidents to the appropriate regulatory or enforcement agencies.

RESPONSE: The Department does not support this recommendation. The MCOs are required to implement incident reporting mechanisms and are being reimbursed to do so. The trigger for incident reporting and requirements will be standardized across plans as these requirements are currently in the approved 1915(i) State Plan Amendment and 1915(c) waivers.

73.10 Discharge Planning
The Department had 3 comments regarding Discharge Planning. 1) Additional Compliance 2) Nursing Home Discharge 3) Discharge Approvals

COMMENT 1: **Additional Compliance –** The respondent recommended to amend proposed 73.10 to include additional code / rules governing involuntary discharge or transfer.

RESPONSE: The Department does not support this recommendation. Section 4.3.5, 13.1.13.11, 14.6.6 and Exhibit F of the Department's contract with the managed care organizations lays out the MCOs' discharge planning and reporting requirements. In addition each of the MCOs is contractually required to follow all applicable state and federal regulations, including those that pertain to discharge planning.

COMMENT 2: Nursing Home Discharge- Requesting to know how discharge policies and procedures developed by the MCOs work with the general federal requirements regarding nursing home discharge. Also notes that the time frames and criteria in the federal law are not the same as those set out here.

RESPONSE: The Department does not support this recommendation. Section 4.3.5, 13.1.13.11, 14.6.6, and Exhibit F of the Department's contract with the managed care organizations lays out the MCOs' discharge planning and reporting requirements. In addition each of the MCOs is contractually required to follow all applicable state and federal regulations, including those that pertain to discharge planning.

COMMENT 3: **Discharge Approvals**-The respondent expressed concerns that discharges have to go through the Managed Care approval process and would like to see a mechanism so that there can be the prompt appropriate treatment for these folks.

RESPONSE: The Department does not support this recommendation. The MCOs are required to coordinate seamless transition for these members such that there is no gap in care and that services are fully coordinated prior to discharge to support the member in the community.

73.11 Level of Care
The Department received one comment on Level of Care.

COMMENT: The respondent had an inquiry as to who will have access to level of care and needs-based eligibility assessments and reassessments. DHS needs to ensure that any practice guidelines adopted by the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members, and the general public as required by federal regulation.

RESPONSE: The MCO contract requires the managed care plans to provider members and providers with information around all practices, including adopted assessments and practice guidelines. The MCOs are required to follow level of care criteria established by the Department and approved by CMS. The MCOs are also required to utilize Department approved assessment tools. The MCO contract complies with all federal regulations.

73.12 Appeals
The Department received two comments relating to Appeals. 1) Notice and Timeframes 2) Contractor / MCO

COMMENT 1: Notice and Timeframes-Requests that this section should make it clear that MCOs must provide written notice to members of any appealable action consistent with 42 CFR 438.404. It should also establish a reasonable timeframe of no less than 20 days and no more than 90 days within which the member may appeal, consistent with 42 CFR 438.402(b)(2).

RESPONSE: The Department does not support this recommendation. Section 8.2.9 of the Department's contract with the managed care organizations requires the MCOs to give members written notice of any action, not just service authorization actions, within the timeframes for each type of action as described in state and federal rules, regulations, and policies. Information specific to authorization actions is found in Section 11.2.7 of the Department's contract with the managed care organizations.

COMMENT 2: Contractor / MCO -Requests amending proposed rule 73.12(1)(f), the wording does not match that of the federal regulations at 42 CFR 438.400(b)(6). For clarity and consistency, the word "contractor" should be replaced with "MCO."

RESPONSE: The Department accepts this recommendation and will make the following change:
73.12(1)(f) For a resident of a rural area that has only one ~~"contractor"~~ appropriate provider of a needed service, the denial of the enrollee's request to exercise the enrollee's right to obtain services outside of the MCOs network (~~if applicable~~).

73.14 Continuation of Benefits
The Department received four comments on Continuation of Benefits. 1) Recoupment 2) Provider Notification of Appeal 3) State Fair Hearing

COMMENT 1: **Recoupment-**Two requests were made to add clarifying language that money would be recouped from the member not the service provider.

RESPONSE: The Department does not support this recommendation. The process of recovering funds for services provided during a continuation of benefits period have not changed and is detailed at 441 IAC 75.28(4) Source of recovery.

441 IAC 75.28(4) Source of recovery. Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

COMMENT 2: Provider Notification of Appeal-The respondent recommends that this rule section be amended to require MCOs to notify physicians when a patient is involved in a pending appeal, and that services provided during that pending status may ultimately go unpaid.

RESPONSE: The Department does not support this recommendation. The process of recovering funds for services provided during a continuation of benefits period have not changed. Per Section 8.2.6.8.1 and 8.15.5.5.7 of the Department's contract with the managed care organizations, members are notified at enrollment and during appeal that they may be subject to recovery for services paid during a continuation of benefits period if it is found during administrative appeal that the initial denial or modification to services was warranted. Additionally, recovery of payments made on behalf of the Medicaid member from the member is detailed at 441 IAC 75.28(4) Source of recovery.

COMMENT 3: State Fair Hearing -Recommend amendment to proposed rule 73.14(1)(b) as it is not clear what this language means. Members are entitled to the continuation of benefits until a State fair hearing decision is reached if they request the fair hearing within ten days of the MCO's notice of adverse decision. This section should be clarified to comply with 42 CFR 438.420(c)(2).

RESPONSE: The Department accepts this recommendation and will make the following change:
73.14(1) (b)
~~b. Ten days have passed from the date the managed care organization mailed the notice of an adverse decision, unless a state fair hearing has resolved the matter; or~~

b. Ten days pass after the MCO mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

73.23 Claims Payment

The Department received 16 comments on Claims Payment. 1)180-Day Claims Submission-3 Comments 2) Denied Claims-2 comments 3)Retroactive Denial of Payments 4) Uniform Billing Procedures 5) Uniform Prior Authorization 6) Network Adequacy Standards 7) Provider Payment Rates-6 comments 8) Retroactive Payment

COMMENT 1: 180-Day Claims Submission/timelines-There were 3 requestors stating that regulations should require MCOs to allow at least 180 days for not only clean claim submissions, but also resubmissions, corrections or appeals. Electronic resubmissions and corrections of claims are of equal if not more importance. MCOs should abide by the payment or denial timeline requirements in 73.23(1) for resubmissions of claims.

RESPONSE: The Department does not support this recommendation. As stated in Section 13.4.7 of the Department's contract with the managed care organizations, 100% of provider initiated adjustments must be processed within 15 business days of receipt. This requirement exceeds those outlined in subrule 73.23(1).

COMMENT 2: Denied Claims –Two respondents requested that MCOs should not be allowed to wait 90 days to deny a non-clean claim. Providers will need to know about all claim denials in the same period of time as "clean" claims.

RESPONSE: The Department does not support this recommendation. The MCOs are required to pay providers for covered services rendered to the enrolled members in accordance with the terms of the contract. The MCOs are contractually required to pay or deny 90 percent of all clean claims within 14 calendar days of receipt, 99.5 percent of all clean claims within 21 calendar days of receipt and 100 percent of all claims within 90 calendar days of receipt. A claim will be denied within the same timeframes for not having enough information (not "clean") and the denial must describe what information or supporting documentation is necessary to evaluate the claim for payment. As provided in 42 C.F.R. § 447.46(c) (2), the contractors may, by mutual agreement, establish an alternative payment schedule with in-network providers.

Comment 3: Retroactive Denial of Payments- Are MCOs allowed to retroactively deny payments for services? This should not be allowed to occur to providers and there should be a safeguard in the regulations.

RESPONSE: The MCOs will not be able to retroactively deny and recover funds from providers for services that are medically necessary.

COMMENT 4: Uniform Billing Procedures- The respondent recommend the Department take steps to ensure uniform billing procedures by amending the draft §73.23 to clearly articulate uniform billing procedures across all MCOs, consistent with the current Medicaid billing procedures. Recommends the Department investigate models to potentially centralize the billing process.

RESPONSE: The Department does not support this recommendation. Today providers have multiple payors and billing formats. MCOs will be required to process claims timely and will be responsible for providing training and clarifying billing instructions to providers.

COMMENT 5: Uniform Prior Authorization – The respondent recommends that the state enact clear, uniform prior authorization parameters in this rule section to ease the administrative burden on physician practices. Recommends the state develop a mechanism for a single, centralized prior authorization procedure.

RESPONSE: The Department does not support this recommendation. In accordance with 42 C.F.R. § 438.210(b), the MCOs must have in place and follow written policies and procedures, subject to DHS review and approval, for processing requests for initial and continuing authorizations of services. While the number of prior authorized services and information collected for prior authorization may differ slightly between managed care and the fee-for-service environment, uniformity shall be required in what is considered to be a medically necessary service.

COMMENT 6: **Network Adequacy Standards**-The respondent recommends that the Department revise the rule to include a section on network adequacy standards and requirements that conform to the original policy released by the Department in the Request for Proposal, the waivers submitted to the Centers for Medicare & Medicaid Services (CMS) and contained in the contracts between the MCOs and the state.

RESPONSE: The Department does not support the recommendation regarding network adequacy. Exhibit B of the Department's contract~~s~~ with the managed care organizations define network adequacy and are based on federal requirements and the Iowa Medicaid landscape.

Comment 7: Provider Payment Rates -The Department received 6 similar comments related to Provider Payment. Responders recommended that all providers be considered in-network providers, and not be subject to the 90% non-participating provider penalty until there is adequate time to "transition". This transition period ranged from 90 days to 2 years.

RESPONSE: The Department does not support this recommendation. A revision to the rule is not necessary as the Department will be amending the contract with the managed care organizations to include a "safe harbor" provision. This provision will require the MCOs to pay out-of-network providers at 100% of the in-network reimbursement level for the first 90 days of the managed care implementation. After the first 90 days, out-of-network providers will receive 90 percent of the in-network reimbursement unless other arrangements are made between the MCO and the out-of-network provider.

Comment 8: Retroactive Payment- The respondent requests that the MCOs be required to retroactively adjust physician payments to in-network rates upon completion of credentialing back to the date on which a provider agreement was finalized

RESPONSE: The Department does not support this recommendation. All providers are considered deemed for the first 60 days of the managed care program so there should not be a delay in credentialing that would impact provider payments. In the first 60 days, MCOs may begin collecting additional credentialing information but this should not preclude the provider from being considered an in-network provider as long as the provider and MCO have agreed upon contract terms, rates, and a contract has been executed.

73.24 Quality Assurance

COMMENT: The respondent request that DHS standardize Quality Assurance for both providers and the sake of DHS comparisons. Without a standardized Quality Assurance program across MCOs, DHS will essentially the comparing apples to oranges.

RESPONSE: The Department does not support this recommendation**.** The critical components of a QA program must comply with the 1915(i) State Plan Amendment and 1915(c) waivers and therefore should not be substantially different. The Department will assure standardized reporting from the MCO which should minimize differing requirements for the providers.

GENERAL COMMENTS:

COMMENT:
We have a general comment with regard to MCO interactions with Medicaid members. They should be mindful of members with **limited English proficiency (LEP**) and should be providing information to them in a language they can understand.

COMMENT:
I am opposed to the managed care plan for one simple reason. It makes no sense to establish a new infrastructure to service Medicaid recipients with their benefits when the experienced staff of Department of Human Services is functioning well to deliver these services.

RESPONSE: The Department does not support the recommendations found within the general comments.