NATIONAL HEALTH LAW PROGRAM

Upholding Medicaid Managed Care Requirements

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Upholding Medicaid Managed Care Requirements

- Overview of Medicaid Managed Care
- Network Adequacy
- Oversight and monitoring
- Accountability

Overview of Medicaid Managed Care

Medicaid Managed Care

- 74% of Medicaid population
- All states but AK, NH, WY
- High enrollment (>95%): HI, ID, MO, OR, SC,TN, VT

SOURCES: Kaiser Family Found (www.kff.org); CMS (www.cms.gov)

Managed Care Legal Authority

- 42 U.S.C. § 1396n(b) (managed care waivers)
- 42 U.S.C. § 1315 (demonstration waivers)
- 42 U.S.C. § 1396u-2 (state plan option)
- 42 U.S.C. § 1396b(m) (MCO stds.)
- MC regulations: 42 C.F.R. pt 438

Managed Care Terminology

- Fee for service
- MCO – Managed Care Organization
- PHP – Prepaid health plans
- PCCM – Primary Care Case Management
- MCE – MCOs and PCCMs
- In-network v. Out-of-network

Managed Care Terminology

- Mandatory v. Voluntary
  - Exempt individuals: children with special needs, dually eligible, some Native Americans
  - May only require exempt individuals to enroll using waivers
- Capitation
- Risk sharing (full or partial risk)
- Carve out (populations, services)
- Provider incentives (withholds, bonuses)
- Performance measurement (*e.g.*, HEDIS)
- Grievance v. Appeal

Information for Consumers

Consumers have the right to receive:

- Current list of plan providers
- Disenrollment information
- How to obtain family planning services not available due to religious/moral objections of plans
- Instructions on filing grievances/appeals (§ 438.100)
- (mandatory enrollment) chart comparing
  - plan benefits
  - cost sharing (if any)
  - quality and performance indicators (§ 438.10(i))

Information, cont'd

- States must ensure that plans have:
- written policies describing enrollees' rights and that providers and staff adhere to those policies (§ 438.100(a))
- Policies, procedures, benefits, and all other information must be provided in clear, easy to understand language (§ 438.10)

Nondiscrimination

- MC contracts must prohibit discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and re-enrollment. (42 U.S.C. § 1396b(m)(2)(A)(V); 42 C.F.R. § 438.700(b)(6))
- Plans must comply with the ADA, Section 504, and other civil rights laws.
- States must take into consideration the extent to which locations are physically accessible. (§ 438.206(b)(1)(v))

Enrollee Rights and Protections

Right to:

- Disenroll due to poor quality or lack of access
  - (§ 438.56(d)(2)(iv))
- Timely access to services, including specialists
  - (§§ 438.206, 438.208)
- Participate in health care decisions (§ 438.100(b)(2)(iv))
- Receive information on available treatment alternatives (§ 438.100(b)(2)(iii))
- Be treated with respect and dignity (§ 438.100(b)(2)(ii))
- Adequate provider networks (§ 438.207)

Network Adequacy

Network Adequacy (MCOs and PHPs)

- Plans must make covered services accessible to enrollees to the same extent available to others in the geographic area. (§§ 438.206(a))
- Plans must provide access to out of network providers if none available in network. (§ 438.206(b)(4))
- Plans must show capacity to serve enrollees in the service area.
  - Must offer an appropriate range of preventive, primary care, and specialty services.
  - Must document at time of contract and other significant changes.
  - State must certify to CMS. (§ 438.207)

Network Adequacy

- States must ensure access to women's health specialists. (§ 438.206(b)(2)).
- Children and adolescents must have access to pediatric and family nurse practitioners and midwives. (42 U.S.C. § 1396d(a)(21)).
- PCCM contracts must provide for access to sufficient numbers of health professionals to ensure prompt delivery of services. (§ 438.6(k)).

Advocacy on Network Adequacy

- Require plans to:
  - Specify the ratio of certain providers to enrollees
  - Establish specific geographic standards
  - Provide appointments within a certain time period
  - Take affirmative steps to ensure access for people with disabilities.

Medicaid Managed Care Oversight and Monitoring

What is the MCAC?

- Advisory body that the single state Medicaid agency must establish to advise the agency about Medicaid program development
  - 42 CFR § 431.12; Soc. Sec. Act (Title XIX) §1902(a)(4)
- Consumer groups, including Medicaid recipients, ***must*** be represented on the MCAC
  - 42 CFR § 431.12(d)(2)
- Appointed by Medicaid agency director or higher state official
  - 42 CFR § 431.12(c)

MCAC's responsibilities

- Must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.
  - 42 CFR § 431.12(e)
- Medicaid agency must consult with MCAC when reviewing managed care marketing materials
  - 42 CFR § 438.104(c)
- MCAC can hold hearing to solicit public comments on §1115 demonstration projects
  - 42 C.F.R. § 431.408

Scope of authority

- Courts differ on enforceability of MCAC requirements
- Consultation required, not necessarily consent
- “the scope of [MCAC’s] advisory authority is intended to cover the entire field of state decision-making with respect to the Medicaid program, and is not limited to discrete areas of concern”
- - *Morabito v. Blum*, 528 F. Supp. 252, 263-67 (S.D.N.Y. 1981)

State Monitoring Requirements

- State monitoring of plans' enrollment practices
  - (§ 438.66; FOIA/public records request)
- Auto-assignment rates
  - (§ 438.50(f)(1); FOIA/public records request)
- Voluntary disenrollment rates and reasons
  - (§ 438.56(c); FOIA/public records request)
- Records of grievances and appeals reviewed by state as part of quality strategy
  - (§ 438.416; (FOIA/public records request)
- Network adequacy maintenance and monitoring
  - (§ 438.206(b); FOIA/public records request)

Other Ways to Monitor Medicaid Managed Care Plans

- States must seek input from enrollees and other stakeholders for a written quality improvement strategy (§ 438.202)

- Health plans must survey current and previous enrollees to determine the degree of access and satisfaction with services
  - (42 U.S.C. §§ 1396b(m)(2)(A)(x), 1395mm(i)(8))

Quality Reports and Improvement Plans

- External Review – annual, independent review of plan quality and performance (§ 438.204(d))
  - Reports must be made available upon request (§ 438.364(b))
  - Enhanced FMAP (75%) if states contract with qualified External Quality Review Organizations (EQROs) (§ 438.370)
- MCO Ongoing Quality Assessment and Improvement
  - Use objective quality indicators
  - Implement Performance improvement projects (PIPs)
  - Evaluation (§ 438.240)

Outside Oversight Entities

- State legislatures (budget and oversight hearings)
- Government Accountability Office
  - (upon request from Congress)
- OIG – 2013 Work Plan
  - Beneficiary Access to Medicaid Managed Care
  - Beneficiary Grievances and Appeals Process
  - Managed Care Entities' Marketing Practices
  - Completeness and Accuracy of Managed Care Encounter Data
  - Medical Loss Ratio—Medicaid Managed Care Plans' Refunds to States

Accountability

Managed Care Baselines: Due process

"Because of the pecuniary incentives that MCOs have for denying, suspending, or terminating care under the [managed care] system . . . enrollees need strong due process protections to protect themselves from inappropriate denials of health care."

Daniels v. Wadley, 926 F. Supp. 1305, 1308 (M.D. Tenn. 1996)

Managed Care Baseline: Accountability

- "The single state agency requirement represents Congress's recognition that in managing Medicaid, states should enjoy both an administrative benefit (the ability to designate a single agency to make final decisions in the interest of efficiency) but also a corresponding burden (an accountability regime in which the agency cannot evade federal requirements by deferring to the actions of other entities…. One head chef in the Medicaid kitchen is enough."

K.C. v. Shipman, 716 F.3d 107, 119 (4th Cir. 2013)

State Enforcement of Managed Care Contracts

- Types of sanctions, e.g. (§ 438.702)
  - Suspension of new enrollment
  - Granting enrollees the right to disenroll without cause
  - Suspension of payments
  - Civil monetary penalties
  - Appointment of temporary management

State Enforcement of Managed Care Contracts

- Basis for sanctions (§ 438.700)
  - Substantial failure to provide required services
  - Imposition of premiums or charges in excess of those permitted
  - Discrimination on health status, including discrimination or discouragement in enrollment
  - Misrepresentation or falsification of information to CMS, state, or enrollees
  - Misleading marketing materials
  - Other violations of Medicaid statutes governing MCE

State Enforcement of Managed Care Contracts

- Receivership (state laws, court order)
- Termination of contract (§ 438.708)
- CMS sanction (for MCOs) (§ 438.732)
  - Requested by state

Comparison of FFS/MC

Fee for Service	Managed Care
Complaint based on statutes and rules	Complaint may also be based on contract
Complaint involves payment	Complaint involves service
Choice of provider	Lock-in
Provider may be advocate	Can't always depend on provider
Direct access to fair hearing	May have to exhaust at plan level

Managed Care positives

- Coordination of care
- Potential emphasis on preventive services
- Potential to change behaviors
- Cost predictability
- Integration of services
- Potential for innovation
- Data

Managed Care Concerns

- Lack of information re: covered services & rights
- Inadequate networks
- Application of improper coverage standards
- Lax dispute resolution

QUESTIONS?

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