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Welcome to the Upholding Medicaid Managed Care Quality Requirements: A Litigation Update conference call. My name is Robert and I will be your operator for today's call. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session. I would like to turn the call over to Ms. Elizabeth Priaulx.

Thank you for joining us for our webcast today. I wanted to let you know this webcast is being funded as part of the aging and disability partnership for managed a long-term services and supports. A partnership that is being funded by the agency for community living. And before we begin with an introduction of the speakers, I want to let you know that a transcript and audio of this webcast will be posted at the two websites that I just put into the chat function of the webcast. The easiest one to find beingwww.ndrn.org/events. It will be posted within 10 days of the webcast, so if you like the webcast, encourage all of your friends to come back on and listened to it later. Our speakers have decided that they will speak, and at the end we will take questions. I want to encourage anyone who has questions to type them into the chat function area as we go along. The ones that we can answer as we go along, we will do so. Otherwise, we will answer the chat questions at the same time that we answer questions via the telephone line. So I am happy to welcome our two speakers, Ms. Sara Summers, who is the managing attorney of the national health Law program and -- we know them as NHELP. She specializes in litigation and litigation support intended to advance access to quality healthcare low income and underserved people. NHELP works with the health and poverty Law advocates across the country. Sarah engages in litigation, research, writing and training on the Medicaid program and the Affordable Care Act. She is co-author of the advocates guide to the Medicaid program. Which I hope you all have. If you don't, you can contact me or Sarah after this conference. And asked to receive it. You need that guide if you are Medicaid guide -- advocates. She represented children in special education and Medicaid cases. Wayne Turner, our second speaker, is a staff attorney with the national health Law program. We just described what it is. And he works to secure health rights for low income and vulnerable populations. He focuses on federal reform efforts, implementation, quality and consumer protections in Medicaid managed care and the EPS city program. -- the EPSTC program. He was a staff attorney and his projects included DC voting rights and budget autonomy, Blue Cross Blue Shield reform, and improving end-of-life care for DC residents. He also served as a co-facilitator for the children healthy working group, the DC promise neighborhoods initiative, which is a program to improve health outcomes and academic performance of DC public school children. Before beginning his law career, he was active in HIV eight -- aides protest movement and for cofounded the DC chapter of the AIDS coalition to unleash power. Wayne graduated magna cum laude from the University of District of Columbia. So those are our two wonderful speakers. And without further ado, I will let them take it away.

Thanks so much, Elizabeth. This is Sarah Summers from the national health Law program. Going to start out by giving you an overview of what's coming up in this presentation. First, for some of you this will be a review. But we're going to go through an overview of some of the basics of Medicaid managed care and get some of the terminology established. Then talk about network advocacy which is one of the most important requirements. Then I'll turn it over to Wayne, who will

talk about oversight on monitoring and take it back to talk about some of the ways that we can work on ensuring accountability in our state Medicaid system. First of all, the overview. And for those of you who aren't lawyers, I apologize. We're going to keep rattling off of citations to a minimum. For those of you who are lawyers, there will be citations in the slides throughout the presentation. First on the basics of Medicaid managed care, about 74% of Medicaid enrollees are enrolled in some kind of managed care plan. In 2011 for which the most recent figures are available, this was -- enrollees were in managed care in all states except for Alaska, Wyoming and New Hampshire. I see at least one person from New Hampshire in the participant list. You know that that is something that is changing in that state. There are some states with very high enrollment. More than 95% in some cases -- 1 00%. Hawaii and Idaho, Missouri, Oregon, South Carolina, Tennessee and Vermont and even though there are predominately managed care states their systems look very different for reasons we will talk about as we go along. The managed care legal authority there are different sources of authority. For those of you who are attorneys it's important to understand what the source of your states legal authority is for establishing managed care because the sources of legal authority have different implications for the kind of requirements and protections that come with it. Is a basic Medicaid provision that allows individuals to have free choice in participating providers. In order to require people to enroll in managed care, it's necessary to get around that requirement in some way. Traditionally for many years in the Medicaid program, states needed to apply for waivers. Through this provision of the Medicaid Act that would allow them to waive the free choice of provider requirements. And requires people to enrolled in managed care plans. This authority is still used today although less so because there are other ways to do it as well. In addition, there is an authority under the Social Security act which is -- sometimes called 1115 waivers or demonstration and pilot waivers. These are projects that allow states to waive certain requirements of the Medicaid Act to test a previously untested theory under Medicaid as long as it is consistent with the objectives of the Medicaid Act. Many states managed care programs -- Tennessee and Arizona -- are established under this section 1315 or 1115 authority. More recently, states have been able to not actually apply for a waiver but just operate as part of their Medicaid State plan. To be able to get around the free choice of provider and established managed care. Other requirements that govern managed care organizations are found in this provision of the Medicaid Act. And then there are Medicaid relations and part 438 of 42 US code that has extensive and detailed requirements governing managed care contracts and state and managed care obligations under the various kinds of managed care. Let's get some of the managed care terminology straight. Fee for service. Fee for service is not managed c are. That's a traditional system in which a provider accepts a fee for an individual for an individual procedure. Managed-care organizations are one kind of managed care. That's what we usually think of as HMO type of managed care. These are systems in which the managed care plans get a payment based on the number of enrollees and agreed to provide certain services in exchange for that payment. There are also another kind of managed care plan known as a prepaid health plans. These are plans that are also paid a separate for providing services. I'll explain the differences between these two in our next s lide. In Medicaid there are prepaid inpatient health science and inpatient prepaid ambulatory health plans. There's also a type of managed care known as primary care case management. This is a system in which a primary care provider is paid a nominal fee in order to coordinate care for people who are enrolled in the primary care case management s ystem. Sometimes it's called managed fee-for-service. Generically, all of these plans are sometimes referred to as managed care entities. And I'm focusing on this because there could be some confusion when people talk about MCOs. There sometimes speaking we -- speaking generically but with regard to the Medicaid managed care system at Lilly with regard to the Medicaid regulations, managed-care organizations are something specific. Managed-care plans or entities can be used to refer to them in the generic. The in network versus out-of-network, people are probably familiar with that because of some kind of managed care in their own health system. In network means in network providers, an individual is getting services from a provider enrolled in the network. Out-of-network is when an enrollee needs to get outside the network to get a service that for some reason is not available within the plan. Some more terminology. Mandatory versus voluntary managed-care. The reason -- this is --

this presentation -- a lot of the advocacy and information lately is focusing on mandatory managed care. Because that is where people need the most protection. If you don't have to enroll in managed care and there are other alternatives, problems are such a threat. If you are required to get into the system, then it's very important to have transparency, accountability and protections for the enrollees. Under the State plan option, some people can't be required to enroll in managed care, like for example children with special needs, duly eligible Medicaid beneficiaries. And some Native Americans. Those populations can be required to enroll if you use a waiver authority. As I said before the 1115 waiver or the traditional kind of managed care waiver. One thing to keep in mind is that the Centers for Medicare and Medicaid Services that oversee the Medicaid program have said that giving people the option to opt out of managed care means that it's voluntary. Some of you may know that in practice, that is not necessarily quite the same as allowing people to opt in. But that's something that is considered by CMS to be voluntary. If you can get out what you've been an old. Capitation. This is the characteristic of MCOs and prepaid health plans. This means that the plan receives a set rate for each enrollee that's enrolled in the plan. And it's not dependent on how much service they use or don't use. It comes from per capita -- so it is a payment per head. Risksharing is what distinguishes MCOs from PHP's. MCOs have risk, full or partial risk contracts. That means that they accept the capitated payment based on the number of enrollees. They're taking the risk that the services may cost more than what they got in the capitated payments. And as a result of that, if the services they cover -- provide cost more, than what they got through the capitated payments, they are on the hook for it. It means they take a loss. I the same token it means that if they spend less than they got under the capitated payments, that means they are going to keep that as the difference either as profit or surplus. So that is a key characteristic that advocates may be concerned about, particularly when you have high needs populations because there's a strong incentive to limit coverage of services. This incentive is supposed to help states predict costs and control their budgets but in practice, it can be problematic because it can mean that radically necessary care is not covered. Carveouts, means that services -- means that those populations or services aren't included in the plan. Some states may carve out people with developmental disabilities or people with mental illness. Plans may carve out services, dental services are frequently carved out. Mental health services and long-term care services were traditionally carved out for many years. Those services are more frequently being kept within the system. Provider incentives, these can be a part of managed care systems. There can be a withholding of certain payments for providers if they don't stay under a certain level of -- dollar amount of services or a certain number of services. You can also be bonuses for limiting cost or keeping people out of the hospital. Performance measurement, it's a really important concept. In Medicaid in general but certainly in managed care. There are a number of performance measures that managed care plans and states are either required or encouraged to keep. One prominent example is HEDAS, a system of measures of delivery of care and quality of care that plans may choose to collect. Many states do collect HEDAS measures on their plans. So you can see for example, your plans performance on the measure of how many small children are getting child visits within the plan. You can compare the ideas that you'd be able to compare plan to plan or be able to compare Medicaid programs across the state. There are other performance measures that we can talk about as we go along. Finally, grievances versus appeals, and appealing Medicaid is an appeal of an action -- an action is a reduction, denial, termination or suspension of services. Or a denial of eligibility or some actions taken with regard to institutionalization. Essentially you are losing something. Having something reduced. Grievances are an expression of dissatisfaction with an aspect of the Medicaid program that is not an action. For example, providers bad behavior or rudeness or difficulty in getting into the office. The grievance is the providence of the managed care system in regular Medicaid. You have -- and managed care Medicaid -- you have the right to appeal. Onto the next slide. There's information for consumers that is required to be provided affirmatively or that consumers may ask for. Consumers have the right to receive from either the plan or the state or someone made a point in the chat -- you can appeal actions or inaction's. I think the way that the Medicaid regulations require is that the failure to act on something is an action. So maybe that is splitting hairs, but if for example your request for services is not acted on within a

particular amount of time. Then you can make an appeal about that as well. Anyway, onto information, consumers have the right to receive a current list of plan providers. That includes names, addresses and whether they can accept patients who have limited English proficiency. Information about enrollment and disenrollment generally, you have the right to disenroll annually and under certain such circumstances. Consumers are entitled to information about how they can obtain family-planning services that aren't available sometimes due to religious or moral objections. Instructions on filing grievances and appeals has to be made available as well. In mandatory enrollment, through state plans, there's also a requirement for a chart comparing -- comparing cost-sharing, quality and performance indicators. To be made available in a chart form for comparison purposes. These provisions are all found in the Code of Federal Regulations, 438.100. This additional information that needs to be required. Plans have to have written policies that describe the rights and that providers and staff have to require that providers and staff adhere to the policies. Policies, procedures and benefits and all other information has to be provided in clear, easy to understand language. This includes -- has to be provided in -- interpreted and translated and provided in a manner that people with visual impairments and other disabilities can access. These requirements come both from the Medicaid managed care regulations themselves and then from Civil Rights Act that govern Medicaid and Medicaid managed care plans.

Hold on a minute. There we go. Sorry about that. Speaking of nondiscrimination, that's a requirement for states and managed care plans. The statute in the regs require that contracts have to prohibit discrimination on the basis of health status or requirements for services and enrollment, disenrollment and reenrollment and obviously this is a very important protection particularly for people with chronic conditions and disabilities. If the managed care plan could disenroll you because you are expensive, just because you needed services, well, there would be -- a big incentive to do that and it would happen often. Plans are generally required by contract and also required by the virtue of the fact they receive federal funding to comply with civil rights laws including Section 504 because their recipients of federal funding. ADA generally by contract and under some circumstances, by Title III of the ADA and also governed by other laws including Title VI of the civil rights act which probably -- prohibits discrimination based on race, color, national origin. And states are required also to take into consideration the extent to which they are locations that are physically accessible for people with disabilities. That roundabout wording is from the regulation. And this is phrased in the indirect terms. So it is something that is an example of one of the requirements that is enforced by virtue of making sure that it is included in contracts and assurances. Okay. In addition to the informational requirements we talked about, there are other rights and protections that enrollees have. First of all, they have the right to disenroll due to poor quality services or lack of access to services that they need. Right to timely access to services including specialists that they need. We have the right to participate in healthcare decisions. The right to receive information on available treatment alternatives and again this is an important concept not just because some treatments might not be covered as a part of the plan or might not be practically available but because of four enrollees who are enrolled in health plans or health systems where there are religious or moral objections to certain kinds of family-planning services you have the right to be treated with respect and dignity. You have the right to have an adequate provider network. That's our transition to talk about the next section which is network adequacy.These network adequacy requirements apply specifically to MCOs and prepaid health plans. Plans are required to make covered services accessible to enrollees to the same extent they are available to others in the geographic area. There are also required -- access to out-of-network providers for covered services if none are available in the network. They also have to show that they have the capacity to serve the enrollees in the service areas. They're required to offer an appropriate range of preventive primary care and specialty services. This has to be documented at the time of contract and other significant changes. And states also have to certify that this plan capacity exists in certifications to CMS. States have to ensure access to women's health specialists. This is a good time for me to mentioned that we have a recent fact sheet describing in detail managed care implications for Medicaid enrollees who need reproductive health services.

And that's available on our website. And I will talk more about the other managed care materials we have left. As you can tell as I emphasize this as we go through there are special issues, special implications for women who need family-planning services. As a part of managed care and additional barriers that can come up other than those that just face the typical Medicaid service requests. Children and adolescents are also required to have access to pediatric and family -- nurse practitioners and midwives. And in primary care case management systems, which have different requirements than the MCOs and P HP's, the contract have to provide for access to sufficient numbers of health professionals to make sure that they get service on a reasonably prompt basis. All right. So those of you who are in managed care systems might be thinking at this time, I don't think all of that is happening. There are these strong requirements in the Medicaid managed care statute and in the regulations and almost certainly the contract. But it may not be happening. It may not actually be happening on the ground. And so there are different -- we have a paper that we're going to release at the end of this week about network adequacy. It has some specific pointers and specific standards you can point to but in general, some of the pointers for network adequacy advocacy are for advocates to try to work with their state to have the plans specify a ratio of certain providers to enrollees and there's research and examples of what appropriate ratios would be. Contracts can provide a lot of protection for individuals when they establish specific geographic standards like travel time. How long it takes you to actually get to a particular specialists there can be requirements -- to provide appointments within a certain time period and there are many affirmative steps that can be taken to try to ensure access for people with disabilities. We have more material on advocacy in that area. So with that, I'm going to hand it over to Mr. Turner.

Thank you very much, Sarah. Sera provided with -- provided us with a good overview of some of the enrollee rights and protections. So now we're going to look at some of the legal requirements and framework for monitoring the compliance of managed care organizations with these requirements. And for conducting oversight over these groups. There are some limits with some of these legal requirements. In some ways, they need to be updated and expanded. At the same time, a lot of people are not aware of them and so some of these oversight and monitoring opportunities just aren't being taken advantage of. And so it certainly creates an opportunity for advocates. So with that, let's start with the medical care advisory committee, MCAC. This is a requirement that every state must have a medical care advisory committee. This is a board that is e stablished, that advises the state Medicaid agency on Medicaid policy and operations. Also part of the requirement in federal law is that consumer groups have to be represented on the MCAC. That means not only advocacy groups or patient groups or legal service providers, but also Medicaid enrollees themselves need to have a place at the table. In order to -- the membership of the MCAC, it also consists of public health officials and state officials so it's really a place to bring everybody at the Medicaid table together in one spot. But there's no requirements or thresholds of -- that the needs to be one third membership in consumers, there's nothing like that in the Medicaid statute. But there's some court cases that say that adequate consumer participation should be around 45%. But again those are in pretty limited cases. And again, in order to get on the MCAC, you need to be appointed. Federal law says that the head of your Medicaid agency is the one who appoints those members or a higher state official like a governor. And generally the appointments are on a rolling basis. So there's some sort of continuity in terms of the MCAC membership. But we see that -- moving onto the next slide that MCAC have to have an opportunity to participate in the policymaking. And in program administration. And please keep in mind that the MCAC is not a policymaking body. It's an advisory body. But the federal law requires MCAC's to be involved and providing advice on the policy development. And there's additional federal requirements in the law that says that the state Medicaid agency must consult with the MCAC when it's reviewing the marketing materials for Medicaid managed care plans. The MCAC can look at these managed care plan marketing materials to see if they are readable, understandable, but also to provide input if these marketing materials are may be deceptive. Now, there were some recent regulations that actually expanded the authority of MCAC's. Now MCAC's can provide an opportunity for public

hearings on demonstration projects. These are called 1115 demonstration projects. It's where certain parts of the Medicaid Act can be waived, kind of like an experimental pilot program and the MCAC's are one of the ways that the public can engage in public comment. When we are thinking about the MCAC's, you might not have heard of the MCAC in your area. They are -- there's some really robust, active MCAC's where there's a high degree of consumer engagement. And then there's MCAC's which barely meet or may be really hard to find because there's no public reporting or public notice requirements on when the meetings are. And so really, that's one of the challenges with MCAC's. Trying to enforce some of these legal requirements has been proven to be very difficult and the courts really differ on whether the MCAC requirements in federal law are legally enforceable. The court cases that are out there, yeah, the MCAC needs to be consulted, but they don't have to give consent. So if a state Medicaid agency wants to do something in the policy world, they don't have to get permission from the MCAC. There are quite a few court cases out there where courts have blocked state Medicaid agencies from implementing a new policy or a new program because the state failed to consult with the MCAC. And finally, we have this quote that I will read through -- the scope of MCAC's authority covers the entire field of d ecision-making. So you see it's not just limited to certain parts. So really, all parts of the Medicaid program should be fair game for the insight and advice of the MCAC members. With that, you're going to think about, what kinds of things should the MCAC be looking at? Other advocates should be looking at -- so we'll go through pretty briefly, some of the federal requirements of how states are required -- required to manage the managed care companies. States are required to monitor the plan's enrollment practices. There've been cases out there where managed care companies tried to cherry pick, trying to get enrollees who have fewer health needs than people who may have greater health needs and might be more expensive. To the managed care company. Otto refinement rates, something -- people don't select a managed care company they just got automatically assigned to one -- one of the things that that tells us, -- if you have high auto assignment r ates, people don't understand what the plans are offering -- there can be a lot of information if you're looking at Otto assignment rates. Sarah mentioned -- the right of the managed care enrollee to disenroll from a managed care company in certain circumstances like poor quality of care. Well, that's actually something that states are required to m onitor. So states are looking at information and required to analyze it to assess how well managed care plans are doing. States are also required to look at the grievances and appeals that are filed against managed care plans. And the federal law says that the states have to consider that information when developing a quality improvement strategy. The states are required to monitor the networks that managed care plans claim to have. To make sure that those providers are really available. Now, here is one of the limitations with all of these monitoring requirements. There's no public reporting of any of these things. So this information might be obtainable through something like a Freedom of Information Act request, but states aren't required to publicly post on their website or at the time of enrollment, information about the number of grievances filed against a particular plan. But these are pieces of information that can be very beneficial for advocates and -- to help assess how well their managed care plans are doing. But the one other problem with some of these requirements is that although it's a requirement, states are always doing these things. -- aren't always doing these t hings. Unless you ask for the information, you wouldn't necessarily know that. There's a few other reporting requirements. With Medicaid managed care. One is that the states are supposed to seek input from the enrollees. This is a federal requirement that states are supposed to be seeking out and engaging in people who are enrolled in the plans and other stakeholders. That's to develop a written quality improvement strategy. I've never seen one of these strategies but I'm glad that that requirement is there in the law. Is another requirement that says that the health plans themselves are supposed to be surveying their current enrollees and their past enrollees to determine what the degree of satisfaction of services is. And again, that would be interesting information to see but there's no requirement that says that the plans or the state Medicaid agency have to make that publicly available to anyone. Now, there are some plans that can be obtained publicly. There's a provision in Medicaid that says that states can contract with an outside independent entity to conduct an external quality review. And so these reports must be made available upon request. Now, some

states do a really good job in posting their annual quality reports on their website. Sometimes even the plans themselves post them. But a lot of states, you have to be aware of this requirement and know what to ask for in order to obtain one of these reports. The reports themselves, don't always lend themselves to a lot of important information. And sometimes you will see ratings for some of these managed care plans saying they're good to excellent when you talk to the actual -- you know that that's not the case. Now, there's one other requirement about on the managed care plans themselves, they are supposed to be monitoring their own quality in assessment. And they're supposed to be evaluating the job that they are doing and improving quality. And they are supposed to be implementing these performance improvement projects. Again, there's no requirement that these performance improvement projects be acknowledged publicly or that the enrollees can get access to this kind of information. Interestingly, in Medicare and Medicare Advantage, the Department of Health and Human Services has a hidden away site where you can actually look at the performance improvement project for the Medicare Advantage plans, but in Medicaid, there's no similar public reporting component. Now, there's other opportunities for oversight that I think sometimes we may forget about. So one of them is state legislature, your state legislatures are convening budget hearings, oversight hearings of the agencies. Remember, the Medicaid agency is housed usually in the executive branch of government. So the legislative branch has oversight role. There's an opportunity to create some working relationships with members of your state legislature so that you can ask questions and help obtain some of the i nformation, particularly if your state Medicaid agency is not forthcoming with it. Is a federal government agency called the government accountability office. That's actually an arm of Congress. They conduct all kinds of studies and audits and investigations in order to get that ball rolling. It generally comes from a request from Congress. Again, if you are seeing patterns or problems in your state Medicaid agency, perhaps if you see patterns and problems across several states, there's an opportunity to bring that to the Government governmentaccountability office's attention to launch their own investigation and report. Finally, we have the Office of the Inspector General for the Department of Health and Human Services. The Inspector General mostly what they do is program integrity work looking at following the money. They publish a work plan and the 2013 work plan -- it actually has investigations looking at some of these policy issues that we are concerned about, looking at access issues, beneficiary grievances and appeals processes, looking at the managed care entities marketing practices. These are ongoing investigations. Happening right now. When you get a good solid report from the Office of the Inspector General, that can arm you with some good information to bring about some important change. With that I'm going to pass it back to Sarah. Thank you.

Thanks so much, Wayne. As you may notice if you are a chat watcher, I have placed some links in the chat box to some recent NHELP publications. Two of them are recent issues of our monthly newsletter, the health advocate. And in the health advocate, there are links within them to get more NHELP Medicaid managed care publications. One of them is part of an ongoing series we've had about accountability and transparency and managed care. And some of you -- again, I can see a lot of familiar names in the chat -- some of you may be aware of a project that the national program did a few years ago. I guess it's been about three y ears. We called it the sunshine and accountability Project. As part of that project, we partnered with advocates in six different states. We asked -- we had the advocates ask the states and the plans operating in their states to send information that was required to be provided by the federal r egulations. And it was very interesting spectrum of reactions that we got. And in each of the states, the state Medicaid agency itself did not balk at providing any of the information, but depending on the state, it was some states -- they had a -- a lot of the measures posted on the Web. Other states sent it to the head of kids in forms of raw data and it took some work to actually put it together and look at it. The plans on the other hand, there was a very wide spectrum of reactions from the plan. Some plans especially some of the larger plans provided the information without any further a do. Some plans that weren't accustomed to operating in Medicaid managed care systems reacted very negatively and were not willing to turn over the information despite the fact it was required. We are planning on doing more work in this

area and updating some of that information. So stay tuned for more information about that. Anyway, accountability. We see all these requirements and what are some ways that advocates -- or the state Medicaid agency can actually make them real? One of the key accountability means is the good old due process requirement. The right to file a grievance and the right to file an appeal. Courts recognized over the years going back to the 90s, how important it is to have a robust due process system in the managed care context. Because of the pecuniary incentives that MCOs have for terminating care, these strong due process protections are important. And as I mentioned, in the beginning of this, the risk-based contracts and capitated system can create a very strong incentive to deny care, because that means that more of the capitated payments are left over as profit.It's important to remember that ultimately, it's the Medicaid agency that has the ultimate responsibility under the statute for ensuring that the system operates as it supposed to operate, that it complies with the law, the plans comply with the law and that enrollees actually get services they are entitled to. This is from a decision earlier this year, a case in which NHELP and disability rights of North Carolina were counsel. In this case, the court recognized that the single state agency has the ultimate responsibility, the buck stops there. And they can't cede responsibility by giving them to other agencies. This nice quote at the end, one head chef in the Medicaid kitchen is enough. The head chef is a single state agency, Medicaid agency. The other chefs are the plans and contractors. States have power to enforce contractual requirements. And other legal requirements as well. These sanctions are spelled out in the regulations. They can suspend new enrollment. Enrollees can be granted the right to disenroll without cause. Payments can be suspended. Under some limited circumstances there can be civil monetary penalties and even appointment of temporary management. What's the basis for sanctions? For example, substantial failure to provide required services. Can give rise to sanctions. Imposition of premiums or charges in excess of those permitted under the law. Discrimination on health status. Including discouraging people from enrolling. This is harder to monitor, but it's a crucial protection for people. Misrepresent or falsify i nformation, obviously to CMS and the state and also to enrollees. Something that was very frequently violated in the earlier days of Medicaid managed care in the '90s. And then in addition, other violations of Medicaid statutes that govern managed care entities. So what are some other actions that can be taken to bring plans into line? Receivership? This is going on in the District of Columbia right now. I don't know if there's anybody from DC on this webinar but they've had a great deal of problems with financial difficulties. One of the plans has been placed into receivership. You can also be a termination of managed care contracts and under some circumstances, CMS can sanction MCOs at the request of the states. So bring this all together, some of the differences between fee for services and managed care as far as holding them accountable, the complaint is based on the statutes and the rules. In managed care, you can also have a grievance that's based on other aspects of the contract. Fee-for-service, usually the onus is on the provider in the service context to try to get the payment. A lot of times, the complaints are involving a failure to pay. In managed care, failure to provide service because the service has already been paid for. Fee-for-service, and have the choice of provider. Managed care, you're locked into one provider or one network. And limited number of providers that are there. Fee-for-service, in the case of service denial, the provider can be your advocate. Because they have an interest in getting paid. Managed care, that's not necessarily true. The provider doesn't necessarily have the incentive. There can be barriers and disincentives for doing that as well. In fee-for-service, you have the direct right to go to a fair hearing. In managed care systems, it's possible you may have to exhaust at the plan level which can slow you down. Or it can be futile in some cases. So there are a lot of positive things about managed care. The most important positive is probably the fact you could actually have care coordinated. You don't have duplicates of care, you don't have care that's potentially harmful to the recipient. It's particularly helpful for people who have chronic conditions or disabilities. The potential is there. For there to be an emphasis on covering less expensive preventive services and ensuring that people don't get sick down the line. That is not always the case but that is one of the motivators behind setting up a system like that. The belief is that there's the potential to get people to change behaviors, more continuity of care, more ongoing engagement with your provider, for example to help weight control or quit smoking. Is a big positive, it's more predictable -- you are not

suddenly surprised by billions of dollars of services.Services can be better integrated and there is the potential for innovative [Indiscernible]. Last but not least, it's a treasure trove of data. This is a better -- plans are inherently set up to collect data and there's a lot of data available through systems like this. Obvious concerns which we've gone over -- the failure to provide information about covered services and rights, you don't get the information in the first place even though required, you don't even know if you are an enrollee which may not be getting -- but you are entitled to. Inadequate networks, a problem with her about cross the states. Application of improper coverage standards, for example coverage standards narrower than those provided for in the managed care contract itself. That can be problems with dispute resolution. There can be a lack of access to due process in the first place. So we have time for questions. I see there may be a question or two already in the chat. So Elizabeth, I will let you take it.

Actually, Sarah, I think it's fine if you want to just read them. And that way you can choose which ones you are able to answer. If you don't have the answer, what we can do is we could have a follow-up with whoever asked the question, because we hardly would expect the speakers to have the answers to every question on the spot. So --

Here's a question from Anne in Florida. What are states that have a good job with their MCAC's? Wayne, you may want to answer that.

I am happy to take that. Actually, some of you may know one of our colleagues here in the DC office, Leo, in his time before coming to NHELP in DC he worked with the Pennsylvania health Law Project. In that role, he served as legal staff and support for the consumer subcommittee on the Pennsylvania MCAC. They call it the medical assistance advisory committee. And hearing Leo describe the transformation in the Pennsylvania MCAC from basically a group of people sitting around having lunch to a consumer driven agenda, where there's actually robust consumer participation from all across the state and face-to-face, one-on-one meetings to troubleshoot issues with the head of the State Medicaid agency. So certainly, Pennsylvania doesn't stand out as an example. But that didn't happen just overnight. It took advocates, really, years to turn around that MCAC to build an increasing role for the consumers. And really, to win the trust and the buy-in from the state Medicaid agency. Because ultimately, having the Medicaid agency on your side really made a big difference for those consumers. So I would say Pennsylvania is a great example.

Yes. I've also heard that Pennsylvania is very good. Here's a question from Elizabeth. What are the standards for the objective quality review? And what's the best way to influence what is quality measures are? Besides at -- I think it got cut off -- do you have a response to that, Wayne?

My initial response is there are no standards. [Laughter]

Right.

I will let you take that. I've read many of these reports. And they are all over the map in terms of what they report on and how they present the information. Some of these reports name the managed care plans by name. Some of them give them a code number so you don't know who is doing well on what. Sarah mentioned earlier the HEDAS measures, one of the measures that many of these plans use. There's some -- there's no uniform set of quality measures that all plans use to evaluate themselves. So it varies across the states and even within a jurisdiction. I think there's also some question about some of these external quality review organizations. They are credited. They bid for these contracts so that they conduct these independent review reports. And so it seems that -- one of my questions has continued to be, who is watching these watchdogs? Some of the reports I've read have had very limited value from a consumer perspective. Sarah, do you want to talk more about the quality measures themselves?

Let me say a little bit about the HEDAS measures, healthcare effectiveness data and information set. There are a whole slew of information measures. And -- under the auspices of something called NCQA, national committee on quality assurance, they are a not for profit -- the information that they assemble is proprietary. You can get certain reports that NCQA put out about the HEDIS measures. If you really want to get all the in depth detail about all of the measures for all of the plans in the states, there's a very expensive product that you can buy called the quality compass. If you go to NCQA, you go to their website, you can see the variety of things they have available. Periodically they solicit input from various practitioners, Medicaid agency people, federal people about what new measures should be added. HEDIS has traditionally not had long-term care. There more measures related to mental illness. There's a clinical aspect of it and aspect just of what the state Medicaid agency might require. If you want to read more about how they come up with coverage standards, on their website -- I see questions -- does the MCO have to provide coverage standards available to recipients? Some of the information that the state or any managed care plans have to provide include the amount, duration and scope of benefits that are available under the contract, how you get those benefits including any prior authorization requirements. And the extent to which enrollees -- including family planning -- out-of-network providers, is that what you're asking, Ben? Type it in the chest -- just for more detail, the information requirements are at 42 CFR 438.10. And then there is others in the 438.6 which governs some of the contract as well. I see some other people are trying to type questions.

Do you see the one from Karen Rosenberg?

Most Medicaid participants exhaust -- the chat is jumping around a little bit -- sorry -- exhaust the MCOs grievance procedure -- categorical but should be covered under which should be covered under the EPSTC provisions? Let me see if I am understanding this correctly. First of all, let me say it is not universal that people are required to exhaust the internal grievance procedure. That's a state option. Not all states require it. Let's say your state requires it and you are required under the normal run of business to exhaust the internal grievance procedures. But it is based on a categorical denial, we just don't cover that. For anybody. I suppose you could come up with an argument that you should get to skip over that and go to a fair hearing but I don't think there's anything specific that would let you get out of it. I think you may need to exhaust it anyway. And so if you want to talk more specifically about something like that is happened, Karen, let me know. Generally, there is not -- you're going to be in a position where you're probably going to take more time trying to get out of exhausting it than you would buy just exhausting it. And going on.

Okay. Do we want to see if we would -- if there's any questions on the phone?

Sure. Absolutely. We will now begin the question and answer session. Please press star then one on your touch tone phone. If you wish to be removed, please press the pound sign. If you are using a speakerphone, you may need to pick up the handset first. If there are any questions, please press star then one on your touch tone phone. Standing by for questions.

In the interim, maybe we could answer Ben's -- you followed up with your question?

Let me --

I am wondering if the exact clinical standards for coverage in nursing homes -- I'm -- maybe -- New Hampshire -- one of -- New Hampshire -- one of the managed care companies is not making the provider manual public given to providers in New Hampshire, one managed care company is not making the provider manual public. So --

I tell you, I don't think there's a regulation that speaks to that level of detail. But, Ben, I would be happy to talk with you about this off-line. Is my e-mail. It's probably -- probably arguments you

could come up with, but generally speaking, I don't think that there's something that gets to that level of specificity.

Okay. Do we have any questions on the phone?

I'm showing no audio questions at this time.

You guys are also technologically advanced here.

I don't see other questions in the chat, but that may just be me because I'm having trouble --

I don't see others in the chat. I would hate to end the session so quickly, but I don't see anyone typing either. So maybe -- yes -- you can see that Sarah and Wayne are tremendous resources and I am so glad, Sarah, that you put down the links for further information about managed care on the health Law.org site. And NHELP is really a quality agency. And I encourage folks to put it on your favorites list and check back there frequently. If not get onto the advocates listserv that they have. As well as -- at this point, I don't see anyone typing -- do we have any more callers?

I'm showing no one in the audio queue at this time.

And I'm going to go back to B en's question, I think the answer is that they should be required to do that. And I'd be happy to talk with you about specific requirements about -- about how to put together an argument to do that. I don't think there's one big elation just right on point. Karen Rosenberg asked if I would e-mail the list of resources I typed into the chat. I don't have the power to that but Elizabeth, you can do it?

Yes, I can.

If you need me to e-mail it, you can forward it to the list.

Yes. I believe I can do that. And I know also that the NHELP site has a good list of resources that we'll put together. Sera mentioned Leo earlier. So again, please try to go onto the NHELP website at health lot.org and click on their -- I think it actually says -- it does not just say managed care, Medicaid expansion toolbox but it covers a lot.

You guys, I'm so sorry -- I'm beating this into the ground with Ben. Because now that I'm actually looking at the question is does, it does not say nursing home, it says in Hampshire.

Right?

I messed up there.

I'm sorry [Indiscernible -- multiple speakers] my problem as in Homestead advocate, it is New Hampshire.

The plan is required to make the provider manual public. It is required to be provided in response to a request for it. I'm so sorry. I'm like on nursing home animals in my mind. Now that I see -- I realize it's a very basic question. Yes. They are required to do it and as a regulation that talks about that. For example, 42 CFR 438 10 F6 -- feel free [Indiscernible -- multiple speakers] just because I'm looking at my slides. Anyway, Ben, feel free to get in touch with me. If I could be more confusing on this, I will try.

Okay. Well, we appreciate all of you getting on the call. If you are a Medicaid advocate and have not seen the advocates guide to Medicaid, that's another thing you might want to look into. And NHELP does not even pay me to advertise for them. [Laughter] so I really want to thank the administration on community living for funding this webcast. I encourage you all to go to the website of the aging and disability partnership for managed long-term care. It's a great resource. So thank you, Sarah and Wayne and everybody who has joined us.

Thank you very much.

Goodbye.

Thank you, ladies and gentlemen. This concludes today's conference. Thank you all for participating. You may all disconnect.

Thanks.

Have a good day.

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