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Q&A

Assuring Accountability and Stewardship in Medicaid Managed Care: Public Reporting Requirements for States and MCOs [1]

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Question: My clients are enrolled in managed care organizations (MCOs). They are Medicaid beneficiaries. The state Medicaid agency pays the MCOs a pre-set amount of money each month to provide certain services to them. Although the MCOs have been paid ahead of time to provide the services, some of our clients do not understand how to use their MCO and some are experiencing delays in getting needed care. According to the information our clients have received, they must obtain all but emergency care through their MCO or Medicaid will not cover the cost of the care. What can be done to monitor and improve the *accountability* of Medicaid managed care in our state? What can be done to ensure *stewardship* of public funds so that the government will get top value for our taxpayer dollars?

Answer: The federal Medicaid laws include a number of consumer protections designed to assure that MCOs serve the individuals who are enrolled and are accountable to the taxpayers for the public funds they receive. Depending on the problems your clients are having, you can use these laws to enhance understanding of how managed care is meeting the needs of covered populations and to improve the operation of managed care for them. It is important for advocates to familiarize themselves with the applicable laws and to engage in ongoing monitoring on behalf of enrolled patients.

Discussion: This Q&A focuses on states' use of prepaid managed care systems to provide services to Medicaid beneficiaries. After providing a brief overview on Medicaid's use of prepaid managed care, the Q&A will explore some of the federal laws that states and MCOs are supposed to comply with and that you and your clients can use to ensure accountability and stewardship.

Background on Medicaid managed care

Under traditional Medicaid rules, beneficiaries have the freedom to obtain services from any qualified, Medicaid-participating provider. *See* 42 U.S.C. § 1396a(a)(23) (the "freedom of choice" rule). Medicaid beneficiaries have long been allowed to voluntarily enroll in qualified

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managed care plans since the early days of the program and, thus, opt to surrender their freedom of choice.

In response to Medicaid managed care scandals in California, and Illinois,[2] the Medicaid Act was amended in 1976 to establish standards for managed care organizations and other prepaid entities wishing to participate in Medicaid. The legislation prohibits federal funding to states unless MCOs and MCO contracting adheres to minimum accountability and stewardship protections. *See* 42 U.S.C. § 1396b(m). Among other things, the contracts between the state and each MCO must assure that the MCO does not discriminate on the basis of health status or need, that beneficiaries have rights to disenroll, that the state can audit and inspect the MCO's books and records, and that the MCO will maintain adequate patient encounter data to identify the providers who deliver the services to patients. *Id.*

In the early 1980s, Congress and the Administration enacted legislation to encourage increased enrollment in Medicaid managed care plans. The Omnibus Budget Reconciliation Act of 1981 (OBRA-81) added section 1915(b) to the Social Security Act (42 U.S.C. § 1396n(b)). Section 1915(b) allows states to obtain permission from the US Department of Health and Human Services (DHHS) to waive otherwise mandatory Medicaid provisions so that beneficiaries can be required to enroll in MCOs. Under the law, DHHS must find the proposed program to be cost effective, efficient, and not inconsistent with the purposes of the Medicaid program. Systems that restrict freedom of choice cannot apply to emergencies or family planning services and cannot "substantially impair access to services of adequate quality where medically necessary." 42 U.S.C. § 1396n(b)(2). Moreover, restrictions cannot "discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services." *Id.* at § 1396n(b)(4).[3]

Significant changes were also introduced by the Balanced Budget Act of 1997 (BBA-97). The BBA-97 provisions authorize states to implement mandatory managed care for most Medicaid populations through a simple state plan amendment. *See* 42 U.S.C. § 1396u-2. *A* waiver is not required. Some populations are excluded from the state plan option, however. States must still obtain waivers to require the following populations to enroll in Medicaid managed care:

- Children under age 19 with special needs if they are eligible for Supplemental Security Income; described in community-based care programs under title V; eligible through the "Katie Beckett" option; or in foster care, adoption assistance or out-of-home placement;

- Qualified Medicare Beneficiaries or persons dually eligible for Medicare and Medicaid; or

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[2] S. Rep. No. 95-749, 95th Cong., 2nd Sess. (1978) (investigative report); H. Rep. No. 94-1513, 94th Cong., 2nd Sess. (1976) (Conference Committee Reporting to accompany H.R. 9019), *as reprinted in* 1976 U.S.C.C.A.N. 4371. *See also* Andreas Schneider & Joanne Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 Nw.U.L.Rev. 90, 126-38 (1975).

[3] The DHHS also has authority to approve demonstration waivers, which can include managed care programs. *See* 42 U.S.C. § 1315 (section 1115 of the Social Security Act).

- Native Americans (unless the managed care entity is operating as part of Indian Health Services).

Id. at § 1396u-2(a)(2).

Since the early 1980s, Medicaid managed care arrangements have grown significantly. In 1981, only 1.3 percent of the total Medicaid population was enrolled in some sort of managed care program. By 1997, this percentage swelled to approximately 48 percent of all beneficiaries and, by 2006, 65 percent of beneficiaries were enrolled in a managed care program. CMS, *2006 Medicaid Managed care Enrollment Report Summary Statistics as of June 30,* 2006 at 1, *available at* http://www.cms.hhs.gov/.[4] All states except Alaska and Wyoming enrolled at least some Medicaid beneficiaries in some sort of managed care program. Most beneficiaries are enrolled in prepaid plans—in a commercial MCO, a Medicaid-only MCO, and/or a prepaid inpatient health plan. *Id.* at 4-5.

The National Health Law Program has monitored managed care at the state and local levels since the 1980s. Over that time, we have addressed problems with MCOs enrolling individuals improperly, marketing to people with disabilities and/or limited English for whom service delivery sites are not accessible, failing to provide services that individuals' treating doctors prescribe; offering inadequate provider networks to serve the enrolled population, and denying or terminating services without giving proper notice and the opportunity for the individual to challenge the denial. A few recent examples show the kinds of problems that can occur:

- The District of Columbia contracts with four MCOs to provide services, including Early and Periodic Screening, Diagnosis and Treatment for children under age 21. The CMS-Form 416 shows states' annual EPSDT performance. According to the Form, dental services for children aged three years and older actually decreased between FY2005 and FY2006 in three of the four MCOs. Dental service levels were below 60 percent in all MCOs, with one MCO failing to provide any dental services to 65 percent of its enrolled children.[5]

- In Miami-Dade County, a pilot project approved by CMS and initiated by then-Governor Bush enrolls Medicaid children in prepaid dental plans. A report from the State's contractor found that the number of children who received dental care through the Medicaid program dropped 40 percent during the first year. Other reports showed a dental group, which was paid $4.25 a month for each of 790 children, provided services to only 45 children (5.7 percent) during the first six months of 2005. Thus, the group was paid $20,145 for treating 45 children.[6] An analysis from the College of Dental Medicine

[4] CMS is the abbreviation for the Centers for Medicare & Medicaid Services, the federal Medicaid agency.

[5] Testimony of Jane Perkins, National Health Law Program, to the US House of Representatives Committee on Oversight and Government Reform Subcommittee on Domestic Policy (May 2, 2007), *at* http://domesticpolicy.oversight.house.gov/story.asp?ID=1292.

[6] *See* John Dorschner, *A new study reports that a pilot project in Miami-Dade to privatize the dental care of poor children resulted in a huge drop in treatment,* Miami Herald (Jul. 30, 2006); *see* Elizabeth

at Columbia University found that the State of Florida lost value by paying the same amount for less care and less quality.[7]

There have also been repeated acknowledgements by the federal government that MCOs need to be carefully monitored when they are receiving public funding to provide services to Medicaid beneficiaries. For example, as recently as January 18, 2001, the federal Medicaid agency, citing a Government Accountability Office (GAO) study, notified State Medicaid Directors that overall utilization of dental care by children remains low. The agency informed states that "it is especially important to assure that dental utilization data are obtained by the State from the managed care organizations." Health Care Financing Administration [now called CMS], US Dep't of Health & Human Services, *Dear State Medicaid Director* (Jan. 18, 2001), *available at* http://www.cms.hhs.gov/smd/downloads/smd011801a.pdf.

Medicaid Act Requirements for Managed Care Programs

The remainder of this Q&A describes a number of Medicaid provisions that require States and Medicaid-participating MCOs to collect and report information on access, availability, services, and quality.[8] This information must be provided to members of the public in a timely manner and in accessible formats. For instance, a Medicaid regulation requires each State, enrollment broker, and MCO to provide "all informational materials … relating to enrollees and potential enrollees in a manner and in a format that may be easily understood." 42 C.F.R. § 438.10(b)(1). Written materials must be available in alternative formats and in a manner that accounts for the needs of persons who are, for example, visually limited or have limited reading proficiency. *Id.* at § 438.10(d)(1). "All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats." *Id.* at 438.10(d)(2).

1. Obtain and Disseminate Information about each Medicaid- participating MCO's Provider Networks and Services.

The BBA-97 and its implementing regulatory provisions require MCOs to make available to enrollees and potential enrollees in the MCO's service area information concerning:

- The names, locations, qualifications, and availability of health care providers that participate in the specific MCO, including non-English language spoken by current contracted providers and information on providers who are not accepting new Medicaid patients;

Shenkman, PhD, Institute for Child Health Policy University of Florida, *Evaluation of the Miami-Dade County Prepaid Dental Health Plan Year 1 Baseline Report* (June 27, 2006).

[7] Burton L. Edelstein, DDS, MPH, Professor of Dentistry and Health Policy & Management, Columbia University, *Miami-Dade County Prepaid Dental Heath Plan Demonstration: Less Value for State Dollars* 3 (Aug. 2006).

[8] *See* 42 U.S.C. §§ 1396b(m) and 1396u-2. CMS generally intends for these provisions, particularly those related to beneficiary protections and quality assurance, to apply to Medicaid-funded managed care entities participating through 1915(b) and 1115 waivers. *See* 67 Fed. Reg. 40,989, 40,994 (June 14, 2002).

- The responsibilities of the MCO for coordination of care;

- Services and Items available through the MCO and any cost sharing;

- Benefits available through the Medicaid program that are not covered by the MCO, including how and where the enrollee can obtain those benefits, any cost sharing, and how transportation is provided,

- Quality and performance (see no. 2, below), and

- The procedures available to challenge problems with enrollment and services in the MCO.

42 U.S.C. §§ 1396u-2(5)(B), (C); 42 C.F.R. §§ 438.10(e), (f). This information must be provided to enrollees annually and upon request and to potential enrollees in a time frame that allows them to use the information as they make enrollment decisions. 42 C.F.R. § 438.10(e). The information can be provided in summary form but "the State must provide more detailed information upon request." *Id.*

Another Medicaid law requires each MCO to provide the state and DHHS with adequate assurances that the MCO has the capacity to serve the expected enrollment in the service area, including assurances that the MCO

> (A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and (B) maintains a sufficient number, mix, and geographic distribution of providers of services.

Id. at § 1396u-2(b)(5); 42 C.F.R. § 438.207.

Individuals enrolled in or considering MCO enrollment should be encouraged to request the information described above. In particular, information should be obtained about the MCO service area; the identity, location, qualifications, and availability of participating providers; and available services.

Attorneys can also request this information from the MCO and state Medicaid agency on a client's behalf. It may be necessary to file a public records act to obtain details of the assurances required by section 1396u-2(b)(5).

Once received, all of this information should be review and analyzed. It should be summarized for clients, the state Medicaid agency, CMS, state and federal legislative delegates, and the media. This information should be obtained and reviewed periodically.

2. Obtain and Disseminate Information about each MCO's Performance.

There is a range of publicly available data on MCO performance. Much of this data should be made available upon request; some data will be available on the internet. However, you may need to obtain some of this data through a public records act.

The state Medicaid agency should be able to provide you with the following data:

- *State standards for access to care*. Each state that contracts with MCOs must develop and implement standards for "access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity." 42 U.S.C. § 1396u-2(c)(1)(A).

- *Quality improvement plans and activities*. Each state that contracting with MCOs is required to have a written strategy for assessing, reviewing, and improving the quality of managed care services offered by MCOs. *See* 42 C.F.R. §§ 438.202, .204, .240(e). Each MCO must conduct "performance improvement projects" that focus on clinical and non-clinical areas and that measure performance objectively. *Id.* at §§ 438.240(b), (d). Projects must be completed so that the information learned can be used to produce new quality information each year. *Id.* at § 438.240(d).

- *External independent quality reviews and reports*. According to the Medicaid Act, these reviews are to be conducted annually "of the quality outcomes and timeliness of and access to the items and service for which the organization is responsible under the contract." 42 U.S.C. § 1396u-2(c)(2)(A); *see* 42 C.F.R. §§ 438.310-.364. At the very least, the external independent review must produce a detailed technical report that describes how the report was conducted, including an assessment of each MCOs "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" and recommendations for improving quality in each MCO. 42 C.F.R. § 438.364. The results of the annual external independent review must be provided, upon request, to enrollees, potential enrollees, participating health care providers, recipient advocacy groups, and other interested parties. *See* 42 U.S.C. § 1396u-2(c)(2)(A); 42 C.F.R. § 438.364(b). "The State must make this information available in alternative formats for persons with sensory impairments, when requested." 42 C.F.R. § 438.364(b).

- *EPSDT performance reports for each participating MCO*. Congress has mandated that states report annually on EPSDT performance, *see* 42 U.S.C. § 1396a(a)(43)(D), and CMS requires states to report using the Form-416., *see* CMS, *State Medicaid Manual* § 2700 and part 5. It stands to reason, then, that MCOs should be gathering (or able to gather) the data called for by the Form so that the state will be able to complete it accurately.[9]

- *HEDIS reports for each Medicaid-participating MCO*. CMS has encouraged state managed care programs to report using performance measures contained in the Health

[9] For more information, see National Health Law Program, *Measuring Preventive Health Performance—A Primer for Child Advocates on the Medicaid EPSDT Reporting Form* (Oct. 2003).

Plan Employer Data and Information Set (HEDIS), which is published by the National Committee for Quality Assurance. The 2007 HEDIS measures for Medicaid include childhood immunization status, breast cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, antidepressant medication management, annual dental visit, and mental health utilization. *See* NCQA, HEDIS 2007 Summary Table of Measures and Product Lines, *at* http://www.ncqa.org/Programs/HEDIS/2007/MeasuresList.pdf. It is important to note, however, that MCOs that are performing well under the HEDIS standards are not necessarily complying with the Medicaid Act. The Medicaid Act provisions are much more detailed and exacting. Moreover, completed HEDIS summaries do not show "real time" performance of MCOs but rather are reporting data that is a few years old.

- *Grievance and appeal data for each Medicaid-participating MCO*. State Medicaid agencies and Medicaid-participating MCOs must develop and implement grievance and appeal processes that assure the timely and fair resolution of disputes. *See* 42 U.S.C. §§ 1396a(a)(3), 1396u-2(b)(3); 42 C.F.R. §§ 431.200-.250, 438.400-.424. MCOs must maintain records of grievances and appeals, *see* 42 C.F.R. § 438.416, and the state must have procedures for monitoring MCOs' processing of grievances and appeals, *id.* at § 438.66(b). Unlike most other types of managed care data, grievance and appeal information provides enrollees, potential enrollees, and the public with valuable information about how an MCO is covering services in "real time" because service-oriented complaints will typically involve an ongoing dispute about an MCO's refusal to cover a prescribed service.

As with the provider participation and service information discussed previously, once obtained this information should be summarized and deficits reported to clients, the state Medicaid agency, CMS, state and federal legislative delegates, and the media. This information should be obtained and reviewed periodically.

3. Obtain and Disseminate Information about each MCO's Financial Incentives.

States and contracting MCOs use financial incentives, such as per-member-per-month prepayment (capitation), to affect physician prescribing behavior and discourage utilization of health services. In addition, the commercially-traded MCOs into which many Medicaid beneficiaries are enrolled have an incentive, indeed a fiduciary responsibility, to maximize profits for their shareholders. As a result, it is important to monitor the financial incentives that states and MCOs are using in an effort to guard against under-utilization and/or profiteering.

MCOs must publicly disclose financial incentives, particularly where physician incentive plans are involved. A physician incentive plan is "any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to any plan enrollee." 42 C.F.R. § 438.6(h) (incorporating Medicare definition found at § 422.208); *see* 42 U.S.C. § 1396b(m)(2)(A)(x). MCOs must provide information about these compensation arrangements to any Medicaid beneficiary who requests it.

42 C.F.R. § 438.6(h) (incorporating requirements found at § 422.210).[10] The MCOs must disclose whether their contracts include physician incentive plans that affect use of referral services, the type of incentive being used (e.g. capitation, withhold, bonus), whether stop-loss coverage is provided,[11] and a summary of survey results, if surveys are used.[12] *Id.*

This information is to be made available upon request. In an earlier guidance document, CMS had suggested that MCOs use the following language:

> If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangement with our physicians that can affect the use of referrals and other service that you might need. To get this information, call our Member Services Department at (telephone number) and request information about our physician payment arrangements.

Health Care Financing Administration [now CMS], *Guidance on Disclosure of Physician Incentive Plan Information on Beneficiaries* (1997) (on file with author).

You should review the information that is being distributed to Medicaid beneficiaries to make sure that it informs them of their right to request financial incentive information. You can work with clients to request the information. This information, along with the data you obtain about provider enrollment and quality performance, may enable you to identify patterns related to the use of payment incentives and the provision of services.

4. Obtain and Disseminate Information about the Commercially-traded MCOs in your service area.

At least 24 states are contracting with commercial MCOs. See CMS, *2006 Medicaid Managed care Enrollment Report Summary Statistics as of June 30,* 2006 at 20-51. Some of these MCOs are publicly traded, and these arrangements should be separately monitored. Publicly-traded health plan profits are going up, while the percentage of revenue they spend on patient care continues to go down.[13] The medical cost ratio, also called the medical loss ratio, medical care ratio, or benefit ratio, is a key number for monitoring purposes.[14] Ten years ago, many health plans had medical cost ratios in the 90s, meaning that 90 percent of premium dollars

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[10] *See generally, e.g.,* Shea v. Esensten, 107 F.3d 625, 629 (8th Cir. 1997) ("When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's [Employee Retirement Income Security Act] fiduciary duties.")

[11] Stop loss is insurance coverage that is designed to limit the amount of financial loss experienced by a health care provider. An MCO or physician group will buy this insurance so that, if liabilities exceed what is expected, the insurer will stop further losses by paying the liabilities which exceed either an aggregate total dollar amount or a per patient amount.

[12] A number of states require Medicaid-contracting MCOs to survey beneficiaries using the Consumer Assessment of Health Plans (CAHPs) survey developed by the National Committee for Quality Assurance (NCQA).

[13] *See, e.g.,* Johathan G. Bethely, *Insurance Company Health Plans Make More Money, Pay Less in 2005*, *at* http://www.healthcare-now.org/showstory.php?nid=317, accessed May 31, 2007.

[14] The medical cost ratio is medical expenses divided by premiums for the same period.

received were used for patient care. Those figures are now much lower. For example, UnitedHealth is a publicly traded plan that enrolls significant numbers of Medicaid patients (over 1,250,000 in 2005 and 1,425,000 in 2006). UnitedHealth's 2005 medical cost ratio was 78.6 percent.[15] This means that over one fifth of the insurance premium dollars paid in were not spent on health care, but rather were consumed by the insurance company itself for things such as salary, benefit, and profits. For instance, William W. McGuire, the CEO of UnitedHealth, was compensated $124,774,000 in 2005.[16]

Commercial, publicly-traded health plans are required to report financial and business information on Securities and Exchange Commission (SEC) forms. Copies of these reports can be obtained through the SEC website, at www.sec.gov/edgar/searchedgar/companysearch.html. Once on the site, you will be prompted to enter the company name. The site may return a list of companies matching the name you entered, so you will need to select the one you are most interested in. To further limit the filing results, you can designate the particular form you want to review by entering it into the "Form Type" box and selecting "retrieve selected filings." You will then go to hyperlinks to view the actual reports. The following reports may be of special interest:

- Form 10-K. This form provides a comprehensive analysis of the company's financial position. It must be filed annually with the SEC, within 60 days after the end of the company's fiscal year. The filing includes information about the medical cost ratio and Medicaid, Medicare, and military enrollment. The "selected financial data" portion of the report is particularly descriptive. Exhibits attached to the report may include the Medicaid managed care services agreement between the company and the state Medicaid agency.

- Form 10-Q. This form is filed with the SEC each quarter. It includes unaudited financial statements and provides a picture of the company's ongoing financial situation.

- Form 8-K. This form is filed with the SEC each quarter and is used to report events and information that was not previously contained in the Form 10-K or Form 10-Q. For example, the information could describe a recent acquisition or major litigation involving the company.

- Form DEF 14a. This form includes the company's proxy statements, which will show executive compensation and board of director membership.

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[15] *Id.*

[16] *See http://www.forbes.com/static/pvp2005/LIRRI3M.html* *See also* Communications Workers of America, *How Much Do They Make*, at http://www.cwa-union.org/exec-compensation/#table_start, accessed June 1, 2007 (stating that, between 1995 and 2004, Mr. McGuire pocketed at least $450 million by exercising stock options and that he had additional stock options worth $1.6 billion).

Conclusion

It is important for advocates and clients to collect information about the available managed care options, particularly as states begin to more aggressively seek to enroll people with disabilities in these programs.

Moreover, if the data reveal that a managed care plan is not improving and maintaining the quality, access and availability of services for enrolled beneficiaries, then regulators and other change agents must know. The state Medicaid agency and CMS have a number of options available to them to address deficiencies and improve stewardship of public funds, including assessing civil monetary penalties, freezing additional enrollment, introducing primary or specialty care case management as additional options for beneficiaries; and/or terminating the MCO contract or ending the managed care program altogether. *See, e.g. see* 42 U.S.C. §§ 1396b(m)(5), 1396u-2(e). Armed with this information, advocates and clients can work to keep low performing and profiteering managed care entities from obtaining contracts to mandatorily enroll beneficiaries. The National Health Law Program is available to work with you.[17]

[17] There are numerous avenues for advocacy that are beyond the scope of this Q&A. For example, it is important to monitor the state's development of managed care contracts. You can obtain copies of draft contracts and comment on them (even if you are not invited). NHeLP can assist you with comments. You can also offer client education that explains how managed care works and your client's rights in managed care. NHeLP has developed numerous fact sheets on these topics and can provide copies to you.