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NATIONAL HEALTH LAW PROGRAM

Fact Sheet # 2

Medicaid Managed Care: Services

April 2012 update

Introduction

Medicaid managed care plans operate in 47 states and the District of Columbia, enrolling a total of 71% of all Medicaid enrollees. When Medicaid expands in 2014, many of the newly eligible enrollees are expected to enroll in Medicaid managed care plans. This series outlines the principles of managed care services to help beneficiaries and advocates get the most out of Medicaid managed care and hold the plans and state Medicaid agencies accountable.

This Fact Sheet addresses the following topics: outreach and informing for children and adolescents, family planning, maternity care, emergency services, access to providers, and carve outs for special needs services or populations.

Outreach and Informing Under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment requirements

The Law Says:

- States must conduct aggressive outreach to children and their families (42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.56; CMS, *State Medicaid Manual*, §§ 5010, 5121).
- Each potential enrollee must be effectively informed of EPSDT, immunizations, the benefits of preventive care, and their choice of providers (42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.56; CMS, *State Medicaid Manual*, § 5121).
- EPSDT outreach and informing:
  - should be conducted within 60 days of the initial determination of Medicaid eligibility and annually thereafter; and
  - must be made by methods understandable to deaf, blind, and non-English speaking individuals. (42 C.F.R. § 441.56; CMS, *State Medicaid Manual*, § 5121).
- High risk groups (e.g. pregnant women, adolescents, foster children) must receive targeted outreach. (CMS, *State Medicaid Manual*, § 5121).
- The states must offer recipients transportation and scheduling assistance prior to the due date of each periodic screen (42 C.F.R. §§ 441.56(a)(2)(iv), 441.62; CMS, *State Medicaid Manual*, § 5150).

There Can Be Problems:

- Many children and families go without checkups and adequate medical care because they are not informed about the broad range of services that are available.
- Managed care plans avoid providing outreach targeting areas and populations.
- Contracts with managed care plans fail to specify performance measures.
- States fail to enforce their contracts with managed care plans and there are few consequences, if any, when managed care plans fail to enroll targeted populations and provide adequate services.

Consumer Protections Are Needed Now:

- States must require managed plans to conduct outreach and enrollment to at-risk populations according to the EPSDT requirements in federal law.
- States must include meaningful enforcement mechanisms in their contracts with managed care organizations such as financial penalties to help incentivize compliance.
- States must verify outreach activities by conducting site visits and audits.

Family Planning

The Law Says:

- Medicaid enrollees have the right to select the provider of their choice for family planning services (42 U.S.C. § 1396a(a)(23)).
- Managed care organizations cannot prohibit or restrict in-plan health care providers from advising patients about their health status or need for medical treatment or advocating on the patient's behalf, even if services necessary to address the need are not covered (e.g. abortion). (42 U.S.C. § 1396u-2(b)(3)(B); 42 C.F.R. § 438.102(a)(2)).
- Enrollees in managed care plans can continue to seek family planning from any Medicaid participating provider, even if it is a non-plan provider (42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51(a)).
- This right may only be waived pursuant to an 1115 demonstration with specific permission from CMS (42 U.S.C. § 1315; 42 C.F.R. § 431.51(a)(3), (4)).

There Can Be Problems:

- Managed care plans often fail to inform enrollees of their right to choose an out-of-plan provider for family planning services.
- Out-of-plan providers may have difficulty getting reimbursed for services provided to Medicaid managed care enrollees.
- Managed care plans may not offer the full scope of contraceptive methods and supplies as are offered by out-of-plan providers under fee-for-service Medicaid. For example, the pharmaceutical benefit package may exclude contraceptives.
- Adolescents who are assigned the same primary care provider as their parents may have confidentiality concerns that would impede their access to the in-plan services for family planning and STD screening and treatment.

Consumer Protections Are Needed Now:

- Each Medicaid managed care enrollee, including adolescents, should be notified in writing, upon enrollment, and at least annually thereafter, that they can access family planning services either from within or outside the plan.
- Health plans must notify members, orally and in writing, of the family planning services offered by the plan and of the services that the plan or the state will pay other providers to furnish.
- Managed care contracts should exclude family planning from the capitated rate and pay for these services on a fee-for-service basis.
- Health plans should coordinate services with family planning providers.
- Contracts should specify that plans pay family planning clinics directly or specify that the state agency will continue to reimburse clinics directly on a fee-for-service basis.
- Strict time frames for reimbursing out-of-plan family planning providers should be imposed.

- Health plans and family planning clinics should counsel and inform enrollees that medical records might be forwarded to their health plans and how the medical records will be used.
- The state should impose confidentiality protections on medical records and restrict plan use of these records to billing and treatment. Special procedures and rules should be developed to allow review of medical records for quality assurance and data reporting activities and simultaneously to maintain confidentiality.
- Special confidentiality protections should be imposed on adolescent medical records, prohibiting notices regarding family planning and STD screening and treatment from being sent to the home.
- For adolescents with negative pregnancy tests, health plans should be required to provide or make referrals to family planning providers that furnish adolescent pregnancy prevention programs.

Maternity Care

The Law Says:

- Pregnant women are entitled to physician and inpatient hospital services, including prenatal, delivery, and post-natal care (42 U.S.C. §§ 1396d(a)(5)(A), 1396d(a)(14), 1396a(a)(10)(C)(ii)(II), and 1396a(a)(10)(C)(iii)).
- Women and adolescents entitled to Medicaid because of their pregnancy status must be provided with all pregnancy-related services and other services related to conditions that may complicate the pregnancy (e.g., diabetes, dental problems) (42 U.S.C. § 1396a(a)(10)(i)(VII)).
- Providers can certify pregnant women presumptively eligible pending formal Medicaid application or finding of eligibility (42 U.S.C. § 1396r-1).
- Managed care plans must maintain access to services of adequate quality (42 U.S.C. § 1396u-2(c); 42 U.S.C. § 1396n(b)).

There Can Be Problems:

- Managed care plans and providers may not have the experience and expertise necessary to treat high-risk pregnant women.
- A lag time often exists between enrollment into a plan and the first prenatal visit.
- Enrollment in a managed care plan may disrupt an ongoing relationship between a pregnant enrollee and a doctor or midwife.
- Hospitals discharge women and their newborns from the hospital within hours of delivery. This is problematic because:
    - the baby may be discharged before appropriate neonatal screenings can be done;
    - complications, such as jaundice may take 24 to 48 hours to develop, necessitating a return to the hospital;
    - new mothers may not be given guidance about breastfeeding, encouraging them to use infant formulas which are more expensive and have been shown to be less healthy.
- Lack of guidance in breast feeding has been associated with malnutrition.
- Presumptive eligibility is being lost in managed care.

Consumer Protections Are Needed Now:

Managed care contracts, rules, and guidelines need to:

- provide for an expedited enrollment process for pregnant women to avoid delays in prenatal care;
- require that initial prenatal appointments be given no more than 15 days following the appointment request;
- allow pregnant women with an already established relationship with a prenatal care provider to continue that relationship under fee-for-service;

- require that mothers and their newborn infants be allowed to remain in the hospital for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after a cesarean delivery. If the plan provides coverage for post-partum follow-up home care within 72 hours of discharge, the physician, in conjunction with the new mother, may decide to discharge the mother and infant earlier;
- require that the health plan adopt minimum standards established by the American College of Obstetricians and gynecologists for maternity care and the American Academy of Pediatrics for newborns and to perform a risk assessment at the initial encounter with a plan physician; and
- require that all high-risk pregnant women be given the option to select or, if a selection is not made, be assigned to an obstetrician to provide primary care services for the pregnancy related services.

Emergency Services

The Law Says:

- Medicaid covers emergency services (42 U.S.C. § 1396u-2(b)(2) ; 42 C.F.R. § 440.170(e)).
- Hospital emergency departments that participate in the Medicare program cannot turn away or "dump" anyone who presents with an emergency condition (42 U.S.C. § 1395dd). This will affect almost every hospital that takes Medicaid.

There Can Be Problems:

- Managed care enrollees often use emergency departments to obtain non-emergency services when they encounter barriers in accessing managed care plan services.
- Medicaid managed care enrollees with true emergencies may have trouble obtaining prior authorizations from their health plans for treatment by the emergency room.
- Emergency providers may experience difficulty and delay in getting reimbursed by managed care plans.

Consumer Protections Are Needed Now:

Managed care contracts, rules, and guidelines need to:

- incorporate federal emergency standards and specify that emergency services will be provided 24 hours a day, seven days a week;
- define emergency medical condition as Medicare does, that is:
    - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention reasonably could be expected to result in:
        - placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
        - serious impairment to bodily functions; or
        - serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, an emergency medical condition is defined as:
    - inadequate time to safely transfer the patient to another hospital before delivery; or
    - the health or safety of the woman or unborn child may be threatened by a transfer.
- Payments must be sufficient to cover the necessary screens to determine whether an emergency exists.

- Payments for treatment of emergency medical conditions must be based on the medical signs and symptoms of the condition upon initial presentation to the emergency department, not the retrospective findings of a medical work-up.
- Plans should establish a 24-hour toll free advice line that patients can call to obtain advice from qualified medical personnel on whether to go to the emergency department. The advice line should be staffed by qualified personnel who speak languages other than English.
- Managed care plans must have the capability to triage individuals and schedule appointments directly from the emergency department staff that an individual's condition can wait. This capability should be available 24 hours a day, seven days a week.
- Health plans should be required to educate their members to use primary care services and emergency services.
- States should monitor emergency department use by managed care enrollees. Continued or increased emergency department visits are an indicator of access problems within the plan.
- States should periodically poll those individuals who were turned away to see whether they were able to have their conditions treated in a more appropriate setting.

Data Reporting Pursuant to EPSDT

The Law Says:

- States must report to HHS by age group and eligibility category:
  - the number of children provided child health screening services;
  - the number of children referred for corrective treatment, the need for which is disclosed by screening services;
  - the number of children receiving dental services; and
  - the state's results in attaining the participation goals set for that state.

  (42 U.S.C. § 1396a(a)(43)(D); CMS, *State Medicaid Manual,* § 5320).

There Can Be Problems:

- Because managed care plans do not submit a bill for each service, there has been a decrease in the availability of encounter-level utilization data for the states. Thus, information about the nature of the receipt, eligibility, and service use by eligibility group is lost.
- Data is not reported or is not used by the state agency or made known to advocates, and thus it becomes stale.
- Reports do not show if children are receiving the full array of screens required by EPSDT, including a full well-child physical examination and screening for lead.
- Without this data, states, advocates, and consumers cannot monitor whether children are receiving appropriate, required services.
- Managed care plans are being paid with tax-payer dollars, but without this data, there is no way to tell if they are providing what they are being paid for.

Consumer Protections Are Needed Now:

- All plans in the state should report uniform encounter-level data by gender and race/ethnicity of the recipient.
- Plans should report data in a way that is consistent with the form the states are required to use to report EPSDT data to CMS (the 416 form).
- Reporting by age should be broken out into age groups that are set out in the CMS-416 form. The needs of pre-adolescents versus older adolescents vary. To address their specific needs the data should reflect each group's experience separately.
- States should provide financial penalties or rewards to plans to provide accurate data and to show through that data that they are meeting the needs of their members.

Ensuring Adequate Provider Access

The Law Says:

- Access to services of adequate quality must be maintained (42 U.S.C. § 1396n(b)).
- Managed care organizations and prepaid health plans must make covered services accessible to the same extent that services are accessible to recipients not enrolled in the plan. (42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.206(a), 438.207(a)(2), 438.210).
- Managed care organizations and prepaid health plans must assure HHS and the state that they have the adequate capacity to serve the expected enrollees including an appropriate range of services; access to primary and preventive care; and a sufficient number, mix, and geographic distribution of providers. (42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. §§ 438.206(b)(1), 438.207(a), (b)).
- States must ensure that managed care organizations and prepaid health plans provide female enrollees with direct access to women's health specialists within the network for necessary covered care. (42 C.F.R. § 438.206(b)(2)).
- If managed care organization or prepaid health plan networks are unable to provide necessary services, they must cover the services out of network. (42 C.F.R. §§ 438.206(b)(3)).
- Primary care case management contracts must provide for sufficient numbers of health professional to ensure prompt delivery of services. (42 C.F.R. §§ 438.6(k)).
- Patients have the right to a second opinion from a qualified health professional; if none are available within the network the managed care plan must arrange for one outside the network at no cost to the enrollee. (42 C.F.R. § 438.206(b)(3)).
- Children and adolescents are required to have access to pediatric and family nurse practitioners and nurse midwives (42 U.S.C. § 1396d(a)(21)).

There Can Be Problems:

- Managed care plans may over-report the number of individual doctors and physician groups actually signed up to participate in the plan network.
- Providers may place low quotas on the number of Medicaid patients they will take so that they are rarely accepting new patients.
- Managed care plans may have separate and unequal provider lists for their Medicaid and private pay patients.
- Managed care plans may not contract with essential community providers (such as community health clinics , local health departments, and school-based health centers) that have served a high proportion of Medicaid and other low-income patients, are culturally and linguistically appropriate, are geographically accessible, are user-friendly for adolescents, and have ongoing, long-term relationships with their patients.
- Managed care plans may not have a sufficient number of pediatric and obstetric primary care providers, or pediatric and adolescent specialists in their network.

- Managed care plans may designate pediatricians as "specialists" and not primary care providers, limiting their access.
- Managed care plans may exclude pediatric and family nurse practitioners and nurse midwives from their network of providers.

Consumer Protections Are Needed Now:

Managed care contracts, rules, and guidelines need to:

- ensure that children's and adolescents' primary care providers/gatekeepers either are pediatricians or providers demonstrating significant pediatric/adolescent training and experience, using a standard of 50% of the provider's current practice being children and/or adolescents;
- set primary care patient-to-provider ratios, and set specific pediatric provider ratios, according at least to the recommended levels of the American Academy of Pediatrics;
- require plans to demonstrate their ability to provide all EPSDT services under contract;
- require that plans have the appropriate pediatric and adolescent medicine specialists in their network;
- prohibit plans from having separate provider lists for their Medicaid and their private pay patients;
- require that plans provide quarterly reports to the state agency and to the public showing the number, location, and current capacity of pediatric, adolescent, and obstetric providers who are contracting with plans;
- require that plans contract with or include in their provider networks essential community providers;
- list mid-level providers (such as nurse practitioners and nurse midwives) and how they are used in the plan. Their permitted activities should comply with their training, education, and state licensing rules.
- Advocates can urge their state agency to withhold capitation payment for each individual who has not had their first primary care assessment or has not chosen or been assigned to an appropriate primary care provider. This will provide the incentive for plans to make primary care providers available in a timely manner.

Protecting the Patient-Provider Relationship

The Law Says:

- No payment can be made, directly or indirectly, to a physician or to physician groups as an inducement to reduce or limit medically necessary services; and
- Physicians or physician groups placed at substantial financial risk for services which the physicians do not provide:
    - must be provided "stop-loss" insurance; and
    - enrollees and previous enrollees must be surveyed by the health plan to determine the degree of access and satisfaction with these services (42 (U.S.C. §§ 1396b(m)(2)(A)(x), 1395mm(i)(8)).

There Can Be Problems:

Some health care plans may force their doctors to sign contracts containing "gag rules" - prohibitions or requirements as to what the doctor may discuss with his patients. Examples include:

- prohibitions against informing the patient that the doctor is under financial pressure to delay or withhold services;
- requirements that the doctors must obtain permission from the health plan before being able to even recommend or discuss a treatment option; or
- prohibitions on doctors from disclosing to their patients any information about available treatment that is not covered by the health plan.
- Managed care plans' hiring decisions may be adversely affected by the amount of services provided by a physician, the number of referrals made to specialists, and the "high risk" patient load of the providers.

Consumer Protections Are Needed Now:

Managed care contracts, rules, and guidelines need to:

- ban gag rules;
- incorporate and adhere to federal physician incentive rules and regulations;
- limit physician risk sharing (i.e. risk pools rather than individual capitation);
- provide financial incentives to reward good quality care and good health outcomes;
- require full disclosure of physician incentives and of all necessary diagnostic tests and treatments, whether or not provided by the plan and before any prior authorization request is made to the plan;
- require grievance procedures;
- require monitoring tools (e.g. data collection and analysis, patient satisfaction surveys);
- set capitation fees that take into account patients' varying health care needs and incentives to provide primary care; and

- require independent second opinions when services are denied.
- Consumers should ask providers about what types of incentives and contract rules are being applied to their doctor-patient relationship.

To Carve-Out or Not to Carve-Out Special Needs Services or Populations

What is a Carve Out?

There are three types of carve-outs:

- Total: exemption of certain groups from managed care and provision of all of their services through fee-for-service.
- Partial: inclusion of the special needs group in the managed care plan but provision of the services associated with their special needs under fee-for-service.
- Two managed care systems: as in the case of mental health, one system for physical health needs and the other for mental health.

Why Consider a Carve Out?

- Advocates, parents, and individuals with special needs may want managed care to include or exclude individuals with special needs or their services. There is no definitive answer which strategy is best. It can depend on a number of factors in your state.

There Can Be Problems:

- Individuals with special needs in fee-for-service may have access to special services, but their primary health needs are not being met.
- Individuals in managed care with "carved-out services" or in two managed care systems may have trouble coordinating referrals and services. This is especially true where lines of responsibility are unclear.
- Managed care plans may veto services that are deemed necessary by the carve-out service provider (e.g., individuals in managed care for their physical health needs may have difficulty obtaining prior authorization for prescription drugs recommended by their county mental health provider).
- Managed care plans may not have qualified case managers/gatekeepers to determine when referrals and treatments are necessary.
- Carving out nursing facility or other institutional long-term care services can create an incentive for managed care plans to deny coverage of community-based services that would prevent institutionalization.

What Is Right For Your State?

In determining whether and what form of carve-out is right for a particular state, the following issues should be addressed:

- Do individuals with special needs have access to primary care under a fee-for-service system? Can enrollment in a managed care plan improve this care?

- For those systems where special needs populations are completely carved out, how will access to primary care services be ensured?
- Does the managed care plan have primary care physicians that are qualified to recognize childhood illnesses and conditions?
- Will the managed care system allow specialists to case manage/gatekeep special needs services?
- What are the qualifications of the individuals making prior authorization decisions over special needs services?
- How much does the plan annually spend on mental health, substance abuse, and other categories of special needs?
- What are the health plans' records in placing individuals in community-based, rather than institutional care settings?
- What is the availability of community-based treatment options under the fee-for-service public system?
- What are the case management arrangements like for people who have to navigate separate systems?
- Who has the final say for whether a patient receives services?
- Are the health plans' and the carve-out systems' respective responsibilities clearly delineated?
- Is there a clear and timely mechanism to resolve disputes over whether the managed care plan or the carve-out system has payment and/or responsibilities for services?
- How will the enrollees notice and fair hearing rights be guaranteed so that an appeal can be made when a service is denied, reduced, or terminated?
- Are independent second opinions available?
- Will the health plan have any role in developing and adhering to individually developed treatment plans by expert treatment teams?
- How will the managed care capitation payments be set, and will they take into account the higher primary and special health care needs of people with chronic or disabling conditions?
- How will the carve-out services or programs be financed?
  Will there be "stop-loss" protections (e.g. insurance for providers to help pay for services after costs for treating a child has exceeded a certain level above the capitation rate)?

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