Medicaid Managed Care Regulations and Older Adults

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Introduction

The National Health Law Program has focused on the legal provisions governing Medicaid managed care for nearly three decades. As the Medicaid program has evolved to include a greater number of older adults and individuals with disabilities in managed care, many regulations and policies have grown stale and no longer reflect the needs of various covered populations or twenty-first century clinical practices and technological capabilities. To address these deficiencies, NHeLP has developed a complete set of model federal regulations[1].

In this paper, we examine model provisions that are important to older adults. We encourage policy makers and advocates to use these model provisions to update existing regulations, policies, and managed care contracts.[2]

Background on Older Adults Enrolled in Managed Care

Over the last twenty years, enrollment in Medicaid managed care grew from roughly 30 percent of total Medicaid enrollment to more than 70 percent of Medicaid enrollment.[3] With more than 6 million Medicaid enrollees age 65 and older, Medicaid managed care provisions need to be updated to better protect the needs of an aging population. Medicaid managed care entities must be able to properly address the unique health care needs and challenges older adults may experience. For example, older adults are more likely to live with chronic conditions, require long-term care, and see multiple health care providers. Older adults may also require materials to be provided in an accessible format and they may need assistance to help them fully understand complex rules and policies. Therefore, older adults will require robust enrollment, network adequacy, due process, and marketing protections. Federal policy sets minimum requirements that states and Medicaid managed care organizations must meet, but these policies do not sufficiently address the health care needs of older adults. This paper identifies several key areas of Medicaid managed care policy that are particularly important for older adults and uses NHeLP's proposed provisions to offer recommendations on how to change current policy to better serve older adults enrolled in Medicaid managed care.

The recommendations below are based on NHeLP's comprehensive set of proposed modernized Medicaid managed care regulations. These proposed provisions have been provided to HHS, and it is our hope that the Department will adopt many of them as they revise the current Medicaid managed care regulations.

NOTE: Citations to current regulations appear in footnotes, while citations to NHeLP's proposed model regulations appear in [brackets].

1. Recommendations for Enrollment & Disenrollment

With more states automatically enrolling low-income older adults into Medicaid managed care, the protections surrounding enrollment, plan selection, disenrollment, and exemption from enrollment are becoming more important. We offer the following recommendations on ways to improve enrollment and disenrollment protections:

- **Ensure that older adults have sufficient time to select a plan.**

Selecting a managed care entity can be complicated and confusing, and can have far-reaching effects on an enrollee's ability to access health care. For example, older adults might need to confirm that their medical providers are "in-network," particularly if they are specialists, or they may need to confirm that the plan provides good coverage for their needed treatments. Selecting a plan is not a decision that should be rushed. However, current federal policy does not establish a minimum time period in which individuals must select a plan, which would help ensure that they have sufficient time to properly select a managed care plan that will work for them. NHeLP's model provisions add a requirement that gives older adults and other enrollees a minimum of 45 days to select a plan, if enrollees have different managed care entities to choose from and will be enrolled automatically in a plan if they do not make a selection. [§ 438.52(e)].

- **Require states to clearly communicate how an older adult can change plans.**

As older adults' health care needs change over time, they often require support to understand the process used to change managed care plans if that becomes necessary. In some cases, they may need to change plans because they were auto-enrolled into a plan that does not meet their needs. To help make sure that older adults and other enrollees understand the process for changing managed care plans, NHeLP's model provisions add a requirement that states must inform Medicaid enrollees who are required to enroll in managed care of the process by which they can switch their enrollment from one plan to another. [§ 438.56(c)(2)].

- **Disenroll older adults from a plan if the state made a mistake in enrollment or if the plan engaged in prohibited marketing.**

Federal Medicaid rules require states to allow enrollees to disenroll from a managed care entity for any reason during specific time periods and for cause at any time.[4] Cause for disenrollment exists if, an enrollee moves out of the service area, an enrollee is unable to access services covered by the contract, or is unable to access providers who have experience treating the enrollee's health care needs, among other reasons.[5] These are important protections, but they offer no remedy in the event of mistake, misinformation, or impermissible marketing. To better protect older adults and other enrollees, NHeLP's model provisions propose disenrolling individuals enrolled in a managed care plan if the state incorrectly assigned the enrollee to a plan that the enrollee did not select on the enrollment form, if the state provided incorrect information to the enrollee, if the enrollee selected an entity that engaged in prohibited marketing practices, and for other reasons. [§ 438.56(c)(1)].

- **Allow older adults to disenroll if there is a treatment need or breakdown in their relationship with their doctor.**

Older adults often have fluctuations in health status and/or develop new health care needs over time. Sometimes, an individual's current managed care plan may not adequately cover a new treatment that becomes necessary. NHeLP has proposed a provision requiring that such an individual have good cause to disenroll from the plan if that is the only way to access a needed service. [§ 438.56(e)(2)(iv)]. Likewise, a strong patient-physician relationship is important in the delivery of health care for older adults. Current federal policy does not adequately protect older adults, other enrollees, or providers in the event of an irreconcilable breakdown in this relationship. For this reason, NHeLP's model proposal provides enrollees with good cause for disenrollment, in such circumstances, if the enrollee used the Medicaid managed care entity's resolution system to no avail. [§ 438.56(e)(2)(v)]. NHeLP also recommends a broad provision that covers other reasons which may constitute good cause for disenrollment. [§ 438.56(e)(2)(vii)].

- **Allow older adults to disenroll from their managed care plan on an expedited basis in certain circumstances.**

Federal policy requires an approved disenrollment to go into effect no later than the first day of the second month after the month in which the disenrollment request was filed.[6] However, there are certain situations when disenrollment should occur more quickly (for example, when the individual has a complex medical condition), but unfortunately there is currently no federal policy allowing expedited disenrollment. NHeLP's model proposal includes a new provision to allow older adults and other enrollees to disenroll on an expedited basis in certain situations. Under this provision, an expedited disenrollment would become effective the first day of the month in which the request is processed. [§§ 438.56(f), (g)].

The model provisions propose that expedited disenrollment be allowed in a number of circumstances. For example, expedited disenrollment is proposed for an enrollee with a complex medical condition, if the enrollee's disenrollment request is submitted with: (1) verification of the complex condition, (2) the enrollee's treatment plan, and (3) the duration of treatment by a physician participating in fee-for-service Medicaid. There are several other circumstances in which our model proposal allows an enrollee to obtain expedited disenrollment from the plan, including: if the enrollee is enrolled in a Medicaid home and community-based

waiver program, if the enrollee moved outside the plan area, if there has been an irreconcilable breakdown in the patient-physician relationship, if the state enrolled the individual in the incorrect plan, if the state provided misinformation, or if the plan engaged in prohibited marketing practices. [§ 438.56(g)].

- **If enrollment in a Medicaid managed care entity will disrupt care of a complex condition, older adults should be able to remain with their current treating provider (whether that provider is participating in traditional fee-for-service Medicaid or a Medicaid managed care plan).**

Continuity of care is particularly important for older adults and other enrollees with complex conditions, and special care must be given to individuals currently receiving treatment for a complex condition. Our model provisions allow an enrollee who is required to transition into Medicaid managed care to request to remain in traditional Medicaid for up to 12 months, if the enrollee is currently receiving fee-for-service Medicaid treatment for a complex condition from a Medicaid provider who is not contracted with the plan. [§ 438.57(a)].

- **Protect older adults from discriminatory disenrollment.**

Current federal rules prohibit a Medicaid managed care entity from requesting disenrollment because of an adverse change in the enrollee's health status, the enrollee's utilization of services, diminished capacity, or disruptive behavior resulting from special needs.[7] The rules also require states to make sure that plans comply with several existing laws including title VI of the Civil Rights Act of 1975, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and select titles of the Americans with Disabilities Act.[8] These are important provisions, but to ensure more comprehensive protection, NHeLP's model proposal adds a requirement that prohibits a managed care entity from requesting disenrollment because of an enrollee's age or disability. [§ 438.56(b)(3)]. The model provisions also require states to ensure that plans follow § 1557 of the Affordable Care Act, which prohibits discrimination based on several factors, including age. [§ 438.100(d)].

2. Recommendations for Improving Access to Providers and Services

Medicaid managed care plans often are paid on a capitated basis, meaning they are paid a set amount per enrollee and are not reimbursed based on the specific services provided. This may create a financial incentive for plans to limit the care they provide to enrollees. This is particularly true for older adults who are more likely to require long-term care or need ongoing, expensive care for complex chronic conditions. Given the financial incentive to limit care, there is an even greater need for strong protections to make sure that managed care plans have adequate provider networks and that enrollees have access to needed care and services. Recommendations on ways to improve the protections surrounding access to providers and care are further discussed below.

- **Ensure that managed care plans have a provider network that can meet the health care needs of older adults.**

The federal rules require states to monitor Medicaid managed care plans to ensure adequate access to services. States must take into account several factors when considering network adequacy including: the expected

number of enrollees, the expected utilization of services, the numbers and types of providers included within the network, the number of providers who are not seeking new Medicaid patients, and the geographic location of the in-network providers.[9] These criteria, while important, do not go far enough. For example, older adults may require a wide range of care and services, and for this reason NHeLP's model proposal adds an explicit requirement that plan networks must include specific services that may be needed by older adults such as: inpatient hospital services, outpatient services, lab testing, nursing home services, nurse-midwife services, nurse practitioner services, case management services, and home and community-based services. [*See* § 438.206(b)]. Our model proposal also adds a requirement that networks must consider enrollees' needs regarding long-term services and supports, mental health, and substance use. [§ 438.206(b)(2)(v)]. In addition, our model provisions explicitly require plans to provide or arrange for specialty care when necessary, including community-based long-term services and supports. [§ 438.206(b)(3)].

Finally, NHeLP's model proposal requires managed care plans to have *written* access standards to ensure adequate capacity and access to licensed health care providers. [§ 438.206(b)(5)]. For example, there should be specific standards for waiting times ensuring that enrollees are able to be seen for an urgent care appointment within 48 hours and within 15 business days for a non-urgent appointment. [§§ 438.206(b)(5)(i)(A), (B)]. The model includes numerous additional access protections, such as geographic standards ensuring that in-network providers are convenient to the home and work addresses of plan enrollees. [§ 438.206(b)(5)]. Traveling long distances can be difficult for older adults who may have to arrange for transportation to and from medical appointments, which is one reason it is critical for in-network providers to be in areas that are convenient for enrollees.

- **Ensure that older adults and other enrollees have access to out-of-network services and providers during coverage transitions.**

Current Medicaid managed care rules include a general requirement for plans to make out-of-network providers available for enrollees at no extra charge if the network is unable to provide necessary services covered under the contract between the managed care organization and the state.[10] However, maintaining continuity of care and proper coordination between the plan, providers, and enrollee can be especially difficult during transitions *between* fee-for-service and managed care, as well as *between* managed care plans. Our model proposal therefore allows enrollees to receive care out-of-network if the service or type of provider they need is not available in-network when enrollees move from fee-for-service to managed care, or from one managed care organization to another. [§ 438.62(a)]. Older adults often require specialized care and our model provisions further require that in determining whether a specific service is available within the network, plans should consider training, specialization, and cultural and linguistic competencies. [§ 438.62(a)(1)].

In addition, our model proposal requires that an enrollee be able to receive out-of-network care for up to 12 months following enrollment in a plan if the enrollee is completing services that the enrollee was receiving from an out-of-network provider at the time of enrollment. [§ 438.62(a)(4)]. NHeLP has also recommended updating the regulations so that enrollees can receive out-of-network care for the duration of treatment for terminal illness. [§ 438.62(a)(5)].

- **Ensure that older adults are not forced into plans that are unable to provide needed care after disenrollment.**

Current federal policy requires state Medicaid agencies to only contract with plans that agree to maintain a provider network that is sufficient to provide enrollees with adequate access to care and services.[11] However, if an individual properly disenrolls from one plan that does not meet her needs, she should not be forced into another plan which is already at capacity. In these cases, NHeLP has proposed a provision that makes fee-for-service Medicaid available for enrollees if other managed care plan options have reached enrollment capacity. [§ 438.56(c)(2)].

- **Take steps to ensure that older adults are able to access the facilities of in-network providers.**

Seniors and other managed care enrollees should not have to worry about whether needed care is provided in an accessible facility. For example, to comply with the ADA, the U.S. Department of Justice recommends that medical providers should have adjustable-height exam tables available to examine individuals who use wheelchairs (if use of an exam table is the medical norm for the exam or treatment).[12] To help address such accessibility issues, NHeLP has recommended adding a new provision to explicitly require all providers who contract with a managed care plan to certify that their facilities are accessible. [§ 438.206(5)(v)(E)].

- **Require plans that use authorization periods as a form of utilization management to consider the impact on enrollees with special health care needs.**

Authorization periods often senselessly and harmfully restrict and limit an enrollee's ability to receive medically necessary care. For example, older adults with disabling conditions requiring regular therapy, reasonably expected to last for the rest of their lives, should not struggle to have the therapy reauthorized every two months. For this reason, NHeLP has recommended adding a provision that would require plans to consider the needs of people with special health care needs and chronic condition when determining authorization periods. [§ 438.210(b)(2)(ii)].

3. Recommendations for Ensuring Due Process

All Medicaid beneficiaries, including those enrolled in managed care, have a constitutional right to due process. This protection gives enrollees the right to written notice and the opportunity to present their case in a hearing before an adverse action is taken against them.[13] Robust due process protections are necessary to protect the constitutional rights afforded to older adults enrolled in Medicaid managed care. Recommendations on ways to guarantee due process protections for older adults are further discussed below.

- **Ensure that managed care plans do not limit older adults' ability to continue to receive services during an appeal because an authorization period ends.**

As mentioned earlier, older adults may be more likely to have long-term health care needs which require ongoing care and regularly reauthorized services. Under Medicaid regulation, if an individual is denied an authorization for such an ongoing service and files an appeal within 10 days, that individual is entitled to

continue receiving the service during the pendency of the appeal.[14] Unfortunately, the current Medicaid managed care regulations have been interpreted by some entities to only require plans to continue to cover services through the end of the current authorization period, regardless of whether it ends before the appeal is resolved.[15] This is a significant problem for older adults as managed care plans attempt to limit services for costly populations. Allowing plans to terminate coverage at the end of an authorization period is inconsistent with constitutionally mandated due process requirements. Moreover, it is bad policy that threatens the health of the increasing number of older adults who are being transitioned to Medicaid managed care, many of them with disabilities and chronic conditions that will not improve and who will require services to continue indefinitely. NHeLP's model provisions propose deleting the problematic language in the current regulations. In the alternative to deleting these selections, we suggest three alternative policy options that better protect enrollees from plans that are trying to restrict enrollees' due process right to continued services while an appeal is pending. [§ 438.420(e)].

- **Allow older adults to appeal a denied disenrollment request or exemption from enrollment request.**

Current federal policy describes what constitutes an adverse action, triggering the right to an appeal.[16] Denial, reduction, or termination of a service or payment are all examples of actions; however the denial of a disenrollment or enrollment exemption request is not considered an action. NHeLP recommends modifying existing policy to include these denials in the definition of an action, making sure that enrollees are able to appeal denials of these requests. [§ 438.400(b)]. These appeal rights would be important to older adults, who may have a medical need to be allowed a disenrollment or enrollment exemption – for example, when needed to maintain an ongoing treatment plan.

- **Ensure that older adults know that they maintain the right to a state fair hearing even if they must first exhaust the plan's internal appeal process.**

Medicaid managed care plans are required to have an internal appeals process.[17] Current federal policy allows each state to determine whether it will require enrollees to complete or exhaust the internal appeals process before they can make their case to an independent adjudicator in a state fair hearing.[18] An exhaustion requirement can be confusing for older adults who may not understand that their due process rights continue despite the exhaustion requirement. To help ensure that enrollees understand their due process rights, NHeLP's model proposal adds a requirement that, in states that require enrollees to exhaust the internal appeals process, the notice must explicitly state that the enrollee retains the right to request a fair hearing after the internal plan hearing. [§ 438.404(b)(4)].

4. Recommendations for Making Materials Accessible and Ensuring Proper Marketing Practices

Plans have an affirmative duty to make sure enrollees are able to read (or hear) and understand the information provided to them. Many older adults will likely need information to be provided in an alternative format or accompanied with an auxiliary aid.

In addition, marketing practices can impact the choices Medicaid managed care enrollees and potential enrollees make. Older adults are sometimes targets for improper marketing, and it is essential that Medicaid managed care laws, regulations, and policy provide enrollees with robust protection against harmful marketing practices.

We also recommend the following requirements to ensure that managed care plan materials are accessible for enrollees and to prevent improper marketing practices:

- **Ensure that all written material includes a large print tagline.**

To ensure that older adults and other enrollees are able to access information, our model proposal includes a requirement that all written material include a large print tagline. [§ 438.10(c)]. A large print tagline is a critical protection for some older adults with visual impairments.

- **Ensure that auxiliary aids are available.**

NHeLP also proposes that information and notices must be provided in alternative formats, and that auxiliary aids need to be made available and used for communications. [§§ 438.10, 438.70(c), 438.404]. Some older adults may struggle to understand important plan information without the help of an auxiliary aid.

- **Ensure that written translations and oral interpretation are available.**

Managed care entities are required under current federal policy to make written information available in prevalent non-English languages and to ensure that oral interpretation is available in any language.[19] Merely requiring that plans make these services available is often insufficient because older adults may not know that these services are available or how to access them. For this reason, NHeLP's model proposal requires all written material to include taglines in at least 15 languages informing individuals that written translations and oral interpretation are available. [§ 438.10(c)(3)]. Our model proposal also requires notice to be provided in the enrollee's non-English language, if the state or managed care entity knows or has cause to know that an enrollee has limited-English proficiency. [§ 438.10(f)(7)].

- **Prevent plans from using misleading marketing materials.**

Medicaid managed care plans must not be allowed to distribute misleading or deceptive marketing materials. To further protect individuals from misleading marketing practices, NHeLP's model provisions add a requirement prohibiting plans from using materials that would be misleading in context to someone who does not have special knowledge of health coverage. [§ 438.104(b)].

Conclusion

As states enroll more and more older adults in Medicaid managed care plans, it has become clear that the current federal regulations do not adequately protect the needs and interests of an aging population. Many advocates for older adults are frustrated by the outdated policies that govern Medicaid managed care. The

recommendations contained in NHeLP's comprehensive model provisions will serve as a valuable resource for advocates and policy makers as they work to update existing Medicaid managed care policy and ensure that the program better serves older adults.

ENDNOTES

[1] We used the current federal Medicaid managed care regulations found at 42 C.F.R. part 438 as the starting point for developing our comprehensive model provisions. The regulations address state obligations, enrollee rights and responsibilities, quality assessment and improvement, external quality review, grievance systems, certification and program integrity, sanctions, and conditions for federal funding.
[2] NHeLP will also be issuing a series of issue briefs featuring selected model provisions governing five aspects of Medicaid managed care: enrollment and disenrollment, network adequacy, quality and transparency, accessibility, and beneficiary grievances and appeals. Check www.healthlaw.org for more information.
[3] *See* CENTERS FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT REPORT: SUMMARY STATISTICS AS OF JULY 1 2011 at 1, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.
[4] 42 C.F.R. § 438.56(c).
[5] 42 C.F.R. § 438.56(d)(2).
[6] 42 C.F.R. § 438.56(e)(1).
[7] 42 C.F.R. § 438.56(b)(2).
[8] 42 C.F.R. § 438.100(d).
[9] 42 C.F.R. § 438.206(b)(1).
[10] 42 C.F.R. § 438.206(b)(4), (5).
[11] 42 C.F.R. § 438.206(b)(1).
[12] U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES 2 (2010) *available at* http://www.ada.gov/medcare_mobility_ta/medcare_ta.pdf.
[13] U.S. Const. amend. XIV, §1; *see Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (holding welfare recipients have due process rights to effective notices and pre-termination, impartial hearings before benefits may be terminated).
[14] 42 C.F.R. § 438.420(a), (b).
[15] *See* 42 C.F.R. §§ 438.420(b)(4), (c)(4).
[16] 42 C.F.R. § 438.400(b).
[17] 42 C.F.R. § 438.402(a).
[18] *See* 42 C.F.R. §§ 438.402(b)(2)(ii), 438.408(e)(1).
[19] 42 C.F.R. § 438.10(c).