Health Advocate

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Medicaid Managed Care: Modernized Federal Regulations are Long Overdue

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Key Resources

Recommendations for the Modernized Model Federal Regulations, available here.

Medicaid Managed Care Model Provisions Series

Issue One: Beneficiary Grievances and Appeals, available here.

Issue Two: Enrollment and Disenrollment, available here.

Issue Three: Network Adequacy, available here.

Issue Four: Accessibility and Language Access, available here.

Coming in October's Health Advocate:

Reproductive Health

Overview

In 1965, when the Medicaid program was created, American health care bore little resemblance to the complex system we have today. One of the most significant changes has been the expanding role of managed care. In its early years, Medicaid was almost exclusively a fee-for-service system in which providers were reimbursed directly by state Medicaid agencies for each service provided. Now, nearly three quarters of Medicaid beneficiaries receive services through some type of managed care arrangement. Nearly all state Medicaid agencies now contract with managed care entities, which can reimburse providers, perform utilization review, respond to patient and provider complaints and set standards for coverage of services.

In addition to the requirements that generally govern Medicaid programs, the federal Medicaid statute and regulations impose additional requirements on managed care plans and states that have managed care systems. The federal regulations govern various critical aspects of Medicaid managed care, including enrollee rights and protections, quality assessment and performance improvement, network adequacy, and grievances and appeals.[1]

Much has changed in the Medicaid program since the regulations were promulgated in 2002. Not only has the number of beneficiaries enrolled in managed care dramatically increased, but the health care system in general has evolved. Millions more people with disabilities and Limited English Proficiency (LEP) are required to enroll in managed care plans. The number of Medicaid enrollees receiving long-term services and supports through managed care has more than tripled between 2004 and 2012.[2] Clinical practices have changed and technological capabilities have increased dramatically. Providers and managed care plans are increasingly subjected to performance measurement. The federal government has allowed states to impose cost sharing requirements on managed care enrollees. At this point, advocates, states and

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[1] 42 C.F.R. pt. 438.

[2] Paul Saucier et al., The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update at 1 (July 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

plans have had a decade of experience in which the limitations of and problems with the current regulatory regime have become apparent.

In addition to changes within Medicaid programs, the Affordable Care Act (ACA) has transformed the health system and will lead to millions more Americans enrolling in managed care. The ACA created health insurance Exchanges, which are marketplaces where uninsured individuals can purchase Qualified Health Plans (QHPs). Many managed care companies are offering plans both in Medicaid and through the Exchanges. Therefore, it is necessary to ensure that the regulations governing QHPs are aligned with the Medicaid managed care regulations.

The regulations badly need modernizing and updating. Recognizing this, the federal Centers for Medicare & Medicaid Services (CMS) has announced that they are revising them.[3] We do not know when these revised regulations might be issued. However, advocates need to be ready to provide meaningful input on them to CMS when the time comes.

To this end, the National Health Law Program has developed a complete set of modernized model federal regulations. In this issue of *Health Advocate*, we will focus on five problems with the current Medicaid managed care system and describe our suggested regulatory fixes to address these problems.

Problem #1: Lack of transparency about enrollee rights and quality of care.

The regulations require that state Medicaid agencies and managed care plans make available a variety of information to current and potential enrollees, such as information about provider networks, grievances and appeals and other enrollee rights. CMS also suggests that other information be provided, including quality measures such as those in the Healthcare Effectiveness Data and Information Set (HEDIS). There are problems, however. Much of the required information is available only upon request, and there is no requirement to make it available electronically. (A number of states have decided to post much of this information on line.) With regard to quality measures, it can be difficult to find information that is consistent across plans or across years. Also, there can be significant movement by health plans in and out of a Medicaid market from one year to the next, so it is difficult to use these measures as a proxy for overall system performance from one year to the next. Moreover, HEDIS measures are not oriented towards long-term care or other services for people with disabilities. Finally, anyone wanting to understand the underlying basis for a quality measure would need to have documents from the company producing them (in the case of HEDIS, the National Committee for Quality Assurance (NCQA)), and these documents are quite expensive.

Accordingly, NHeLP has recommended that CMS require managed care plans to use the core adult and child quality health care measures established by the ACA, as well as non-clinical measures including the quality of long-term care and cultural competence. In addition, we have recommended that states and plans be required to post all mandated information about enrollee rights and quality of care on line. [4]

Problem #2: Inadequacy of provider networks.

One of the defining characteristics of managed care is that enrollees are limited to using a restricted set of providers (called a "provider network" in capitated managed care arrangements). Thus, it is crucial that managed care plans have adequate provider networks. The federal regulations require plans ensure that their networks are adequate and

[3] U.S. Gen. Servs. Admin., Office of Mgmt. and Budget, Office of Info. and Reg. Affairs, REGULATORY AGENDA, http://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201404&RIN=0938-AS25.

[4] *See* Model Regulation 42 C.F.R. §§ 438.10, 438.240.

that enrollees have access to all covered services.[5] But, while they generally require travel times and geographic distribution of providers enable adequate provider access, the regulations do not specify travel distances, geographic distribution or the types of providers that must be included. Advocates and beneficiaries have reported serious problems obtaining the care they need, particularly reproductive health and specialty care.

Accordingly, NHeLP has recommended that CMS prescribe specific standards for timeliness of services, travel times to appointments and types of providers that must be included in the network, including essential community providers and reproductive health providers.[6]

Problem #3: Imposition of cost sharing that hinders access to necessary services.

The Medicaid Act imposes strict limitations on cost sharing, which includes copays, deductibles and similar charges. Yet, CMS has given states permission to impose higher cost sharing amounts, which have been proven to reduce utilization of necessary services. Managed care plans are also allowed to impose cost sharing on enrollees. This feature of managed care is puzzling, as well-summarized by a past director of AHCCCS, Arizona's Medicaid program:

> Cost sharing works against the notion of managed care. Cost sharing is imposed to change beneficiary behavior or to make the beneficiary financially responsible for the service choices "they" make (like overuse [of] the emergency room). . . If you are going to put co-payments and co-insurance on AHCCCS MCO [managed care organization] members, it will work against the health plans medical management programs. The reason that AHCCCS has one of the lowest PMPM [per member per month payments] of all state Medicaid programs is our managed care model. Health plans[s] manage the utilization of members better than any cost sharing program would do. Cost sharing is for states that don't have Medicaid managed care.[7]

At any rate, the current regulations have imposed only minimal restrictions on plans, which gives them inappropriate discretion to impose cost-sharing amounts that are simply impossible for the lowest-income enrollees to pay.

Accordingly, NHeLP has urged that managed care arrangements not include cost sharing and otherwise recommended that CMS impose strict limits on cost sharing by managed care plans. CMS should prohibit contracts from approving deductibles that exceed certain nominal amounts. States and plans should be required to track and aggregate premium and cost sharing amounts. Cost sharing should not exceed the amounts imposed under the state Medicaid plan and payment of cost sharing must not be a condition to receiving the services.[8]

Problem #4: Lack of access for people with disabilities and Limited English Proficiency.

Federal laws—including Title VI of the Civil Rights Act, the Americans with Disabilities Act and the Affordable Care Act—require services be provided in a manner that is accessible for people with disabilities and Limited English Proficiency (LEP). This includes providing translations and interpreter services, and making sure that locations where services are provided are accessible. Advocates have reported chronic problems for beneficiaries with disabilities and LEP who are trying to access care. These include lack of accessible written materials or customer service lines; shortages of providers with accessible facilities or equipment; inappropriate use of friends

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[5] 42 C.F.R. §§ 438.206, 438.207.

[6] *See* Model Regulation 42 C.F.R. §§ 438.206, 438.207.

[7] *Wood v. Betlach*, No. CV–12–08098–PCT–DGC (D. Ariz.), Admin. Rec. (on file with NHeLP NC).

[8] *See* Model Regulation 42 C.F.R. § 438.108.

and family as interpreters; and grievance and appeals systems that fail to provide interpreters, translated materials or other accommodations.

Accordingly, NHeLP has recommended that CMS clarify and add specificity to standards for accessibility, limit the use of family and friends as interpreters, require plans to develop knowledge about the needs of the communities they serve and take that information into account when designing provider networks and update antidiscrimination provisions to include the new ACA ban on disability and language-access discrimination.[9]

Problem #5: Many managed care enrollees do not get continuing services when they appeal.

Medicaid beneficiaries—including those enrolled in managed care plans—are entitled to notice and an opportunity for a hearing when coverage of services is denied, reduced, suspended or terminated.[10] If ongoing services are affected, beneficiaries may request that those services continue until their appeal is resolved. This is required not only by the Medicaid regulations, but by the Due Process Clause of the Fourteenth Amendment.[11] The managed care regulations, however, appear to provide an exception to this rule for managed care plans. Plans need only continue services until the end of an "authorization period." When services are authorized for a limited time—such as sixty days—this can be quite harmful to a beneficiary with disabilities who has an ongoing need for services. NHeLP has gathered stories from advocates illustrating the harm this practice can cause. For example:

> J.B., from Florida, has advanced multiple sclerosis. She needs at least 6 hours per day of home health services. After being required to enroll into a Medicaid HMO, she suffered ongoing suspensions and disruptions of these services because the HMO required prior authorization for her home health services every 60 days, but those authorizations were often delayed. One of the reasons for these delays was that providers were dropping out of network due to alleged nonpayment. In spite of the fact that her legal services attorney requested hearings before services were terminated, the HMO let the services lapse at the end of each authorization period. Each service delay caused J.B. extreme stress. Her adult child (who also has a disability) was forced to pay for J.B.'s care out of her own pocket in order to avoid her mother's hospitalization. As the situation went on, J.B. was diagnosed with high blood pressure-a new medical condition requiring medication.

Such terminations violate the beneficiaries' Constitutional right to show that a termination is not justified before those services end. Allowing plans to cut off services at the end of a limited authorization period also breaches the single state Medicaid agency's non-delegable duty to ensure Medicaid beneficiaries receive the full range of services guaranteed to them by the Medicaid Act and Constitution. In sum, this policy has all the earmarks of a regulation that was promulgated when managed care was focused on primary and acute care for families and children, not chronic and long-term care for aged, blind and disabled populations.

Accordingly, NHeLP has recommended that CMS eliminate the regulatory provision that apparently authorizes plans to terminate services before a hearing at the end of an authorization period.[12]

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[9] *See* Model Regulation 42 C.F.R. § 438.70.
[10] 42 C.F.R. § 438.420; *see also* 42 C.F.R. § 431.230.
[11] U.S. Const. amd. XIV; *see also Goldberg v. Kelly,* 397 U.S. 254 (1970).
[12] *See* Model Regulation 42 C.F.R. § 438.420.

Conclusion

Advocates should consult the full set of modernized model regulations and the cover memo to CMS that explains the background for these recommendations. In addition, NHeLP has released a series of issue briefs that focus on various aspects of the managed care regulations and recommends requirements to address chronic problems. (*See* sidebar.)

NHeLP will alert advocates when the revised managed care regulations are released and will prepare model comments.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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