April 4, 2014

Cindy Mann
Deputy Administrator and Director
Center for Medicaid, CHIP, and Survey and Certification
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Cindy:

As you know, service delivery in the Medicaid program has evolved significantly over the past decade. Managed care enrollment has swelled to include nearly three-quarters of the Medicaid population. States are increasingly likely to require people with disabilities to enroll in capitated plans. In addition, as a result of the Affordable Care Act (ACA), half of the states have expanded their Medicaid programs to include childless adults – many of whom will be covered through managed care.

The National Health Law Program has been working on Medicaid managed care issues since the 1980s. We have closely followed the development of managed care models, monitored implementation of managed care, and provided technical assistance to our network of state advocates. Drawing upon this experience, we have written extensively about managed care, created tools for consumer advocates, commented extensively on federal regulations and policies, and engaged in litigation to enforce constitutional and federal statutory requirements.

As we have discussed with you on previous occasions, it is clear that it is time to modernize part 438 of 42 C.F.R. Accordingly, we write to propose revisions to the current regulations.

Our proposed revisions are designed to modernize the regulations in several areas:

Serving People with Disabilities and Limited English Proficiency

When managed care was first introduced into the Medicaid program, it was primarily intended to serve children and caretaker relatives. Most plans covered only primary and acute care. In contrast, the current trend is to enroll more people with disabilities and dual eligibles into capitated managed care plans.[1] Medicaid managed long-term services and supports (MLTSS) have grown significantly in the past decade; the number of Medicaid enrollees receiving MLTSS more than tripled between 2004 and 2012.[2] Specialized knowledge and experience is required to administer managed care programs for these populations. This is, however, a new area for many states as well as managed care plans. They will need to make significant efforts to ensure that they comply with the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and other civil rights law. It will also be necessary for them to establish networks of providers capable of meeting the needs of enrollees with disabilities, particularly the need for person-centered, home and community-based LTSS. And, they will need to take steps to ensure that information and services are accessible to enrollees with visual and hearing impairments and other disabilities.

The U.S population is also becoming increasingly diverse and includes more immigrants and citizens who speak a primary language other than English. Managed care plans are obligated to comply with Title VII, including the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons.[3] This means that they must ensure that people who have LEP have access to linguistically accessible services and information.

In addition, Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age or disability under any health program receiving federal financial assistance. HHS has announced that regulations implementing this provision will be issued in the fall. Notably, section 1557 is the first federal legislation to outlaw discrimination on the basis of sex. Moreover, HHS has confirmed that it forbids discrimination against transgender people or based on gender identity. This is a momentous development for health care civil rights that will greatly benefit Medicaid beneficiaries. Significant education and firm direction from CMS and others will be necessary to ensure that States and managed care plans conform to the requirement. Thus, modern Medicaid regulations must incorporate the anti-discrimination prohibitions and explicitly prohibit gender identity discrimination.

In sum, these modernized regulations provide additional specifications and special protections to ensure that people with disabilities and LEP can actually access information about the managed care plans and obtain appropriate services.

Availability of Services and Continuity of Care

When Medicaid managed care began to take hold in the 1980s, the idea of having a medical home for Medicaid beneficiaries was one of the primary selling points for policy makers, advocates, and State Medicaid administrators. The concept of the centralized medical home for beneficiaries promised to increase quality while decreasing costs. Unfortunately, this promise was not realized. In practice, managed care all too often serves as a mere utilization review mechanism, and enrollees do not receive the coordinated care that they need. Moreover, the failure of plans and State Medicaid agencies to ensure continuity of care exacerbates problems caused by lack of care coordination.

In addition, network adequacy in Medicaid managed care has been a concern for patients, providers, and policy makers. Advocates have repeatedly complained that networks do not have the necessary primary care and specialty providers to provide meaningful access to necessary services. This is particularly true for individuals with disabilities and chronic conditions.

Now, in many states, including New York and California, large populations of people with disabilities have been moving from fee-for-service into capitated managed care systems for the first time. This threatens many long-standing relationships with providers and may be detrimental to beneficiary health. At the same time, 27 states including the District of Columbia have expanded their Medicaid programs, adding millions of previously uninsured individuals to Medicaid managed care. Further, researchers project that 40% of enrollees in subsidized Marketplace coverage will become eligible for Medicaid within 12 months, resulting in large numbers of low-income people shifting between Marketplace plans and Medicaid managed care.[4] Accordingly, it is more important than ever to ensure continuity of care, with regard to both providers and services.

As you know, CMS has focused much attention on this issue and has instructed that States to ensure that "MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract."[5] In addition, it has stressed the importance of a comprehensive, integrated service package that incorporates both behavioral and physical health services and is provided in a proper amount, duration, and scope through a person-centered process.[6] MCOs must also deliver these services in a manner consistent with the ADA community integration requirements and the *Olmstead* decision.[7] These excellent recommendations should be a part of the regulatory scheme governing network adequacy.

It is also crucial to ensure that enrollees have the right to disenroll when they are not receiving the care that they need or to be exempted from plan enrollment altogether. This has been a troubling issue in many states, including California, where over 200,000 individuals with disabilities have enrolled in capitated managed care plans since 2011. In response to serious problems with continuity of care, California has recently developed regulations and other guidance governing network adequacy and continuity of care to ensure that vulnerable populations can retain relationships with their treating providers and that they have meaningful access to appropriate providers.

Thus, our recommendations for modernizing the rules draw from California statutes and regulations, as well as the Medicare Advantage rules. This includes prescriptions for specific time and distance standards; specific provider-to-enrollee ratios (including specialists and providers of community based long-term services and supports) and adding or enhancing provisions governing enrollment, disenrollment, and exemptions. We have also added provisions based upon CMS' guidance on providing MTLSS through 1115 demonstrations and 1915(b) waivers.[8] This will make it clear that these principles apply to all Medicaid managed care entities and systems that provide LTSS, not just those operated pursuant to 1115 or 1915(b).

In sum, our suggested revisions will help realize managed care's original goal to create a coordinated, efficient, and medical-home-based system that provides quality care. At the same time, the updated regulations will require Medicaid managed care plans to use best practices consistent with modern standards of care for LTSS.

Developments in Delivery Systems

Medicaid managed care models have changed and developed significantly since part 438 was finalized in 2002. Among other things, enrollment in Prepaid Ambulatory Health Plans (PAHPs) has vastly expanded. In 2003, one in ten Medicaid managed care enrollees were in PAHPs. In 2011, one in five enrollees - more than 12 million - were enrolled in PAHPs.[9]

In our comments on the regulations in 2001, we strongly advocated against exempting PAHPs from many of the obligations and consumer protections that apply to MCOs and Prepaid Inpatient Health Plans. At the time, we predicted that enrollment in PAHPs would increase and, accordingly, many more enrollees would lack crucial rights and protections.

The enrollment trends have borne this prediction out. Therefore, we believe that appropriately modernized managed care regulations would ensure that the more than 12 million PAHP enrollees have the same protections as other managed care enrollees.

Grievance and Hearing

We have met and corresponded with you about the serious due process problems that are arising when managed care plans terminate or reduce a previously authorized service. [10] As we discussed, when the enrollee appeals such a decision, plans regularly terminate the service at the end of an authorization period, despite the fact that a treating provider has prescribed services to meet the enrollee's ongoing need. This is particularly problematic for the growing numbers of individuals with disabilities and chronic conditions enrolled in capitated plans; to make matters worse, there has been a trend towards establishing shorter periods of authorization.

The regulations provide for continuation of service coverage pending an appeal; however, they have been interpreted to allow plans to end coverage if the initial authorization period has expired.[11] As we have explained, this violates constitutional due process requirements and is inconsistent with the Supreme Court's instructions in *Goldberg v. Kelly.*[12] Moreover, when this regulation was promulgated, Medicaid managed care plans primarily provided primary and acute care for families and children. These services could reasonably be expected to be time-limited. Now, however, Medicaid managed care provides chronic and long-term care for millions of people whose health conditions are never going to improve. Thus, allowing plans to terminate services while an appeal is pending is particularly detrimental to these vulnerable Medicaid enrollees and does not belong in today's Medicaid managed care system. Accordingly, we recommend deleting the language at § 438.420 (b)(4) and (c)(4) that has led plans and States to cease coverage of services pending appeal because an authorization period has ended.

We strongly prefer complete deletion of these sections. There are, however, other options for ensuring that utilization review policies do not trump constitutional protections or create illegal obstacles to the implementation of the constitutional protections. As an alternative, we suggest adding a new subsection, § 438.420(e), which could take one of the following forms:

Alternative 1 (based on legislation recently enacted in New York):

> **When a non-governmental entity is authorized by the State agency pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of long-term services and supports, a beneficiary may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to 42 C.F.R. § 431.230, as if the prior**

authorization or prior approval determination were made by a government entity, without regard to expiration of a prior service authorization.

Alternative 2 (based on assumption that managed care plans are selecting and enrolling high quality providers):

MCEs shall provide that when an in-plan prescribing clinician orders any item or service of long-term services and supports, if that item of service is, in the opinion of the in-plan clinician prescribed to meet an ongoing need, the item or service will not be disrupted pending further medical review and modification of the prescription or, as appropriate, plan of care.

Alternative 3 (based on Minnesota policies):

If the enrollee timely appeals the reduction or termination of previously authorized items or services and the treating physician or another in-plan prescribing clinician orders the items or services to be continued at the previously authorized level, the state agency must (directly or through its contractors) must continue to provide services at the level equal to the level ordered by the physician until the state agency renders its final decision.

In addition, given that 20% of Medicaid managed care enrollees are in PAHPs, it is simply unfair that they should be denied the right to file grievances. Accordingly, we recommend revising the regulations to allow PAHP enrollees access to the grievance system.

Quality Measurement and Improvement

Medicaid managed care regulations have long required States and health plans to engage in quality measurement and improvement activities. However, these requirements are general, non-prescriptive, and do not require minimum performance levels. The Affordable Care Act places new emphasis on quality measurement by requiring a national strategy to improve the delivery of health care services, patient health outcomes, and population health.[4] As part of that strategy, core health quality measures specific to adult and child populations allow States and CMS to monitor plan performance and health outcomes and encourage meaningful comparisons across plans and states.[13]

Therefore, we recommend that CMS modernize the regulations by requiring that states use at least the core adult and child health quality measures established pursuant to the Affordable Care Act, including clinical and non-clinical measures. In addition, we recommend measures and performance improvement projects focusing on the provision of LTSS to ensure that plans are covering appropriate, high-quality services through a person-centered process. CMS should require plans to achieve minimum performance

levels on all of these measures. Moreover, CMS should increase transparency in all aspects of quality measurement, including a stronger independent external review process. Health care consumers and other stakeholders should have the ability to consider plan quality and improvement by having full access to data and assessment tools. Making performance and quality data available to consumers, particularly at the time of plan selection, will increase accountability, incentivize compliance, and improve health care quality.

Transparency and Accountability

Statutory and regulatory Medicaid provisions require States and managed care plans to provide a wide variety of information to current and potential enrollees. Much of this information, however, is available only upon request. Yet, every State Medicaid agency has a website and it is almost certain that every managed care plan has one as well. Indeed, it is common governmental and business practice to maintain a website containing important information about services and programs. Accordingly, States and plans should be required to post information on their website and update it on a regular basis. In fact, many State agencies and plans already do this.[14] Requiring posting on a website would not only provide more timely and accurate information to enrollees and potential enrollees, it would also be more efficient and cost less than copying and mailing. Further, it would improve the quality of information. For example, maintaining a web-based version of a provider manual would be much more accurate than printing a manual. These manuals cannot reasonably be kept up to date if they are paper-based. Therefore, we are recommending that CMS prescribe posting of required information on State and plan websites.

In addition, we are aware of numerous instances where private contractors and subcontractors, including managed care plans, are refusing to disclose crucial information, such as the clinical coverage standards they have used to deny care, claiming that they constitute proprietary information. Information seekers must resort to state public records acts or litigation – not always successfully.[15] Denying Medicaid beneficiaries access to this type of information deprives them of the ability to determine whether they are entitled to coverage and to challenge service denials. This violates the due process principles governing the Medicaid program. Moreover, it is inconsistent with the standards of openness that govern public problems. Such secrecy is entirely inappropriate for entities receiving millions of dollars in public funds in exchange for performing public functions. Accordingly, the regulations should require that contractor clinical standards and other information related to utilization review standards be made available to the public.

Conclusion

We believe that the revisions that we have made will help update the Medicaid regulations to better meet the needs of current Medicaid enrollees in managed care, including those with special needs, while creating the necessary additional accountability and transparent critical to an effective Medicaid managed care system. We would be happy to provide further support for our recommendations if you need it and would be willing to meet with you to discuss this proposal further.

Thank you for considering this. If you have any questions or need any further information, please contact Sarah Somers (somers@healthlaw.org; (919) 968-6308 ext. 102), Managing Attorney, at the National Health Law Program.

Sincerely,

Jane Perkins
Legal Director

[1] *See, e.g.,* Margaret E. Burns, *Medicaid Managed Care and Cost Containment in the Adult Disabled Population*, 47 MEDICAL CARE 1069 (Oct. 2009); KAISER COMM'N ON MEDICAID AND THE UNINSURED, PEOPLE WITH DISABILITIES AND MANAGED CARE: KEY ISSUES TO CONSIDER at 3 (Feb. 2012).
[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.
[3] 68 Fed. Reg. 47311 (Aug. 8, 2003).
[4] Benjamin D. Sommers *et al., Medicaid And Marketplace Eligibility Changes Will Occur Often In All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. w1 (2014).
[5] CMS, *Guidance on Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports,* 3 (May 20, 2013), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.
[6] *Id.*
[7] *Id.*
[8] *See id.*
[9] CMS, *Medicaid Managed Care Enrollment Report* at 5 (July 2011), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf; Kaiser Family Foundation, *Medicaid Managed Care Enrollment by Plan Type,* http://kff.org/medicaid/state-indicator/enrollment-by-medicaid-mc-plan-type/.
[10] *See* Letters from Jane Perkins, Nat'l Health Law Prog., to Cindy Mann, CMS (Sept. 24, 2012), (Aug. 12, 2013); (Nov. 13, 2013).
[11] 42 C.F.R. § 438.420(b)(4), (c)(4).
[12] *See* Letter from Jane Perkins to Cindy Mann, 4-5 (Sept. 24, 2012); *Goldberg,* 397 U.S. 254 (1970).
[13] 42 U.S.C. §§ 1320b-9a, 1320b-9b (as added by Pub. L. No. § 111-148, Title IV, § 4306 (March 23, 2010).
[14] *See, e.g.,* Cal. Dep't of Health Care Servs., *Medi-Cal Managed Care: Quality Measurement and Improvement Reports*, http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx; Florida Agency for Health Care Administration, *Florida Medicaid Quality in Managed Care,* http://www.fdhc.state.fl.us/medicaid/quality_mc/index.shtml; TennCare, *HEDIS Reports*, http://www.tn.gov/tenncare/pro-hedis.shtml.
[15] *Compare, e.g., Salazar v. Dist. of Columbia,* 596 F. Supp. 2d 67 (D.D.C. 2009) (requiring disclosure of clinical coverage criteria), *and Health Net of Conn. v. Freedom of Info. Comm'n,* No. CV064010428S, 2006 WL 3691796 (Conn. Super. Ct. Nov. 29, 2006) (holding that managed care plan was subject to state freedom of information laws), *and Lukes v. Dep't of Public Welf.,* 976 A.2d 609 (Pa. Comm. 2009) (requiring release of contracts between managed care plans and State Medicaid agency), *with Dental Benefit Providers, Inc. v. Eiseman,* __ A.3d __, 2014 WL 631259 (Pa. Comm. Feb. 19, 2014) (refusing to order disclosure of subcontractor rates).