

# Health Advocate

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## Medicaid Managed Care Final Regulations Released

Prepared by: Sarah Somers

### Key Resources

[Issue Brief #1: Medicaid Managed Care Final Regulations and Health Equity \(May 6, 2016\)](#)

[Issue Brief #2: Medicaid Managed Care Final Regulations and Grievances and Appeals \(May 12, 2016\)](#)

[Medicaid and CHIP Programs: Medicaid Managed Care Final Rule, 81 Fed. Reg. 27497 \(May 6, 2016\)](#)

[NHeLP Comments: Proposed Medicaid and CHIP Managed Care Regulations \(July 27, 2015\)](#)

[Health Advocate, Medicaid Managed Care: Modernized Federal Regulations Have Finally Been Released \(June 2015\)](#)

**Coming in June's Health Advocate:**

**Prevention and Role of USPSTF**

### Introduction

On April 25, the U.S. Department of Health and Human Services (HHS) released the final rule overhauling the Medicaid managed care regulations for the first time in nearly 15 years. The final rule retains most of the requirements of the proposed rule.<sup>1</sup> There are, however, some notable changes. Moreover, the regulations allow states significant flexibility in operating their Medicaid managed care programs. Therefore, state advocates will want to engage with their Medicaid agencies as they implement these new requirements.

In this issue, we summarize some of the major provisions in the final rule that are new to Medicaid. We also discuss a number of requirements that HHS changed in the final rule. Finally, we identify opportunities for advocates to improve their state's Medicaid managed care program and ensure Medicaid beneficiaries have access to the information and services to which they are entitled.

### Access to services

Capitated Medicaid managed care plans must ensure that all services covered under their state's Medicaid program are available and accessible to managed care enrollees.<sup>2</sup> For many years, HHS has required capitated plans to demonstrate they have provider networks that provide a sufficient array of preventive, primary care, and specialty services for the enrollees in the service area. States are required to ensure that network providers are accessible to enrollees in all geographic regions with reasonable travel times. In previous iterations of the regulations, HHS did not establish specific time and distance standards, nor did it require states to do so.

Now, however, the regulations require states to develop time and distance standards for specified types of providers: (1) adult and pediatric primary care; (2) OB/GYN; (3) behavioral health (for both mental health and substance use); (4) adult and pediatric - specialist; (5) hospital; (6) pharmacy; and (7) pediatric dental.

<sup>1</sup> For discussion of the proposed rule, see Sarah Somers, *Medicaid Managed Care: Modernized Federal Regulations Have Finally Been Released*, HEALTH ADVOCATE, v. 38, June 2015.

<sup>2</sup> In this issue brief, the term "capitated managed care plans" refers to Managed Care Organizations (MCOs) and Prepaid Inpatient and Ambulatory Health Plans (PIHPs and PAHPs). General references to "managed care plans" mean MCOs, PIHPs, PAHPs, primary care case managers (PCCMs) and PCCM entities. For more information about the definitions of these plans, see 42 C.F.R. § 438.2 (2016).

In another welcome change from the proposed rule, HHS added a requirement that states must ensure capitated plan networks include enough family planning providers to ensure that enrollees have timely access to those services. HHS also required these plans to explain in their enrollee handbook that enrollees do not need a referral to see the provider of their choice – in-network or out-of-network – for family planning services and supplies. Capitated plans are also required to produce treatment or services plans for all enrollees who require long-term services and supports (LTSS). They must do so for those with other special health care needs only if required by the state.

States must permit enrollees to disenroll and switch to another managed care plan or FFS when a provider is terminated from their managed LTSS network, but only when loss of the provider would result in a disruption in their residence or employment.

## Grievances and Appeals

The final rule made very few changes to the proposed grievance and appeal regulations. Significantly, over the objection of NH<sub>e</sub>LP and other consumer advocates, HHS maintained the requirement that enrollees exhaust a plan-level appeal before they can get access to an impartial state fair hearing. The obstruction is somewhat mollified by the introduction of “deemed exhaustion” if the health plan fails to follow appeal procedures. This change will require a number of states to develop exhaustion requirements, so policy and contract developments will need to be monitored carefully.

Notably, HHS retained the proposed requirement that plans must continue coverage of services pending an appeal decision, regardless of when an authorization period ends. If an enrollee requests services within that authorization period, the plan may not end coverage at the end of that authorization period.

Advocates have long sought this change. Many plans in Medicaid programs around the country had a practice of terminating services at the end of an authorization period, even if the resolution of the appeal was months away. This caused serious problems for individuals with disabilities or chronic needs. Thus, this change is a welcome and long overdue improvement. Advocates remain concerned, however, that plans will terminate services at the end of an authorization period, leaving enrollees without adequate time to appeal before the period ends. Thus, it is important to monitor implementation of this requirement.

## Family planning services

Capitated managed care plans may place appropriate utilization controls on family planning services as long as enrollees are free to choose the method of their choice. Advocates asked HHS to explicitly state that such plans must cover all FDA-approved contraceptive drugs and devices, voluntary sterilization procedures, patient education and counseling on contraception, and follow-up services without prior authorization, restriction, or delay. Although HHS did not add this requirement to the text of the final regulations, the preamble does address when states and capitated plans may adopt utilization controls for family planning services and supplies. For example, HHS instructed that states and plans may not adopt step therapy requirements for family planning services and supplies. In general, HHS made a strong statement prohibiting utilization controls that “effectively deprive” enrollees of “free choice of equally appropriate treatments.”

## Language, disability, and other civil rights protections

The final regulations include a broad provision that prohibits enrollment discrimination by all types of managed care plans. This protects potential enrollees on the basis of race, color, national origin (including language and immigration status), sex, sexual orientation, gender identity, and disability. The regulations also prohibits any policy or practice that has the *effect* of discriminating on the basis of race, color, national origin, sex, sexual orientation,

gender identity, or disability. All managed care plans are also explicitly prohibited from discriminating against an individual eligible to enroll on the basis of health status or need for health care services.

The rule requires capitated plans and PCCM entities to provide oral interpreting for limited English proficient (LEP) individuals in *all* languages. These entities must provide translated written materials in “prevalent” languages. Unfortunately, the final regulations do not provide standards for “prevalent” and only defines it as “a non-English language determined to be spoken by a *significant* number or percentage of potential enrollees and enrollees that are limited English proficient.” HHS allows the state to determine what constitutes a “significant” number or percentage; thus standards could vary significantly across states.

Under these final regulations, certain documents must be translated into all of the prevalent languages in a state. These include provider directories, enrollee handbooks, appeal and grievance notices, denial and termination notices. In addition, taglines must be provided on *all* documents for potential enrollees. A “tagline” is a sentence or two in a non-English language or large print that notifies LEP or visually impaired individuals how to request language services. Provider directories must include the cultural and language capabilities offered by provider or skilled medical interpreter and whether provider has completed cultural competence training.

Additionally, auxiliary aids and services must be provided to all individuals upon request and at no cost. Further, interpreting and TTD/TTY must be available for individuals with disabilities.

HHS also added a definition of “readily accessible,” which means “electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.” Provider directories must identify whether the provider’s office or facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

## Quality

States must require capitated plans to have an ongoing, comprehensive quality strategy. HHS had proposed a requirement that states draft and implement a written quality strategy plan, including Medicaid Fee-For-Service (FFS). This requirement did not make the final regulations. HHS explained that, after considering the comments, it decided the significant time and resources needed to develop a strategy that included FFS would make it more difficult for states to engage in other required quality efforts.

The final rule also adds new definitions for “health care services” and “outcomes” and changed the definition of “quality.” These definitions now include services and measure concepts beyond medical services, such as satisfaction or goal achievement from supportive services. This is particularly helpful to populations with behavioral and LTSS needs. Moreover, in a welcome addition to the requirements of the proposed rule, states must require plans to address health disparities in their MMC quality strategies based on race, ethnicity, sex, primary language, age, and disability status.

## Transparency, monitoring, and stakeholder involvement

States are required to establish a managed care monitoring and reporting system. They are also required to produce an annual report of the results of their monitoring and oversight activities, including financial performance, accessibility of services, and grievances and appeals. Though NHLP and others advocated for HHS to establish additional monitoring requirements, such as direct testing of provider directories, HHS did not do so.

States are now required to publicly post contracts for all types of plans, information on ownership and control, documentation showing access and availability of services including provider networks, and the results of periodic audits. However, the proposed rule required posting encounter data, information on the actuarial soundness of

capitation rates, compliance with MLR requirements, solvency reviews, and annual reports of overpayment recoveries. The final rule does not include these requirements.

States and managed care companies are required to establish stakeholder groups for Long Term Services and Supports (LTSS). NHeLP and other advocates urged HHS to provide detailed requirements for stakeholder groups, including composition, meaningful participation, and state support for stakeholder group activities. HHS, however, retained language from the proposed rule that prescribes only broad requirements for such groups.

The final rule does provide for an enhanced role for Medical Care Advisory Committees and the LTSS stakeholder groups, requiring their consultation in developing quality improvement strategies, performance improvement plans, the develop of quality star ratings, and reporting on state oversight activities.

### **Disenrollment**

HHS originally proposed that states be required to provide potential enrollees with at least 14 calendar days of FFS coverage in order to actively select the managed care plan in which they would enroll. State Medicaid directors and plans reportedly pushed back against this requirement, concerned that it would be administratively burdensome and disrupt continuity of care. The requirement did not make it into the final regulations.

### **Payments for services in Institutions for Mental Diseases (IMD)**

The proposed rule allowed states to make payments to capitated plans for enrollees who stay up to 15 days in an IMD. This is a reversal of previous policy and is an exception to the Medicaid rule prohibiting payment for services in an IMD. Some advocates objected to this provision, arguing that it would encourage institutionalization and remove an incentive for Medicaid agencies and plans to arrange for community-based services. Despite objections, HHS included this provision in the final rule. HHS does state that a plan may not force the enrollee to receive services at an IMD. However, in practice, there may be no meaningful choice of community-based services available. Moreover, individuals in crisis and their families are often not in a position to demand services other than an IMD. Meanwhile, plans and state agencies have less incentive to develop and provide community-based options.

### **Medical Loss Ratio and actuarial soundness**

The Medical Loss Ratio (MLR) represents the proportion of managed care plan expenditures dedicated to payment for services and quality activities in comparison with spending on administrative expenses and profits. Like the proposed rule, the final regulations require plans to calculate and report their MLR. They also impose consistent standards for calculating and reporting MLR and requires states to assess actuarial soundness and calculate payment rates. States are not required to establish an MLR requirement. If they do, however, it must be at least 85 percent. This requirement did not change from the proposal, despite opposition from many plans. Notably, many states already impose minimum MLRs, generally around 85 percent.

The actuarial soundness requirements are closely related to the MLR requirement. Plans will not be required to issue rebates if they fail to meet the MLR standard. But, HHS now requires that rates be set to ensure that each plan has an MLR of at least 85 percent. Rates could be adjusted downward if plans have lower MLRs.

## Conclusion

Advocates and beneficiaries should welcome this overhaul of the managed care regulations. The provisions governing notice and appeal, access to services and providers, transparency and accountability, anti-discrimination, and family planning all have the potential to significantly improve services for Medicaid beneficiaries. These regulations do, however, leave substantial discretion to states and plans in how they implement these requirements. Thus, advocates should closely monitor implementation and press for the interests of beneficiaries. Among other things, advocates should:

- Urge their states to establish a broad definition of what constitutes a “prevalent” language;
- Advocate for specific time and distance standards that will meet the needs of all beneficiaries, including those in rural areas and who need LTSS;
- Monitor utilization review procedures to ensure plans do not impose requirements that would deprive beneficiaries their free choice of appropriate treatment, particularly with reproductive health services;
- Encourage states and plans to publicly post a broad variety of information, not just information that HHS specifically requires, including encounter data, information on the actuarial soundness of capitation rates, compliance with MLR requirements, solvency reviews, and annual reports of overpayment recoveries;
- Urge states to ensure meaningful beneficiary participation in stakeholder groups.

Over the coming weeks, NHeLP will continue to release issue briefs focusing on different aspects of the final rule. These issue briefs will include specific advocacy tips on implementation of the managed care requirements. Visit [healthlaw.org](http://healthlaw.org) for more information.

## About Us

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

## Author

This month's *Health Advocate* was prepared by:

[Sarah Somers](#)  
Managing Attorney  
North Carolina Office



## Offices

**Washington, DC**  
1444 I Street NW, Suite 1105  
Washington, DC 20005  
(202) 289-7661  
[nhelpdc@healthlaw.org](mailto:nhelpdc@healthlaw.org)

**Los Angeles**  
3701 Wilshire Blvd, Suite 750  
Los Angeles, CA 90010  
(310) 204-6010  
[nhelp@healthlaw.org](mailto:nhelp@healthlaw.org)

**North Carolina**  
200 N. Greensboro Street, Suite D-13  
Carrboro, NC 27510  
(919) 968-6308  
[nhelpnc@healthlaw.org](mailto:nhelpnc@healthlaw.org)

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