Medicaid Managed Care Final Regulations and Health Equity

Issue Brief No. 1[1]

Prepared By: Mara Youdelman

This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, intended to ensure health equity. The concept of health equity is that all individuals must have the opportunity to attain their full health potential. In Medicaid, that means all individuals, including historically underserved populations, must have equal access to healthcare services when enrolled in Medicaid managed care. A number of new and revised provisions require strong support for health equity by requiring nondiscrimination for all potential enrollees and enrollees as well as providing language access and supports for individuals with disabilities. We also include recommendations advocates can employ to guarantee robust implementation of these provisions to achieve health equity in their states. These recommendations are highlighted throughout and also listed at the end of the issue brief.

Nondiscrimination in Enrollment (§ 438.3(d), (f))

The final regulations include a broad provision that prohibits enrollment discrimination by MCOs, PIHPs, PAHPs, PCCMs and PCCM entities.[2] 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 regulation 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. The specific inclusion of all of these categories is of critical importance, especially sexual orientation and gender identity discrimination, which only recently have been recognized by HHS as encapsulated in sex discrimination.

[1] This is the first in a regular series of issue briefs focusing on selected provisions in the final rule.
[2] "MCO" is a Managed Care Organization; "PIHP" is a prepaid inpatient health plan; "PAHP" is a prepaid ambulatory health plan; "PCCM" is a primary care case manager; and "PCCM entity" is an organization that provides certain functions in addition to primary care case management. For more on these definitions, see 42 C.F.R. § 438.1.

Inherent in this provision, HHS recognizes that the state plan must promote access to and delivery of services as well as ensure care and services are provided consistent with the best interest of beneficiaries.[3] Further, prohibiting discrimination is "necessary to ensure access and provision of services in a culturally competent manner."[4] These protections are consistent with the ACA's broad nondiscrimination provision, Section 1557.

The proposed rule required plans to comply with applicable laws prohibiting discrimination: Title VI of the Civil Rights Act of 1964 (prohibiting discrimination on the basis of race, color and national origin); Title IX of the Education Amendments Act of 1972 (prohibiting sex discrimination in education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 (as amended).[5] The final regulation also requires compliance with Section 1557 of the Affordable Care Act (ACA), which prohibits federal fund recipients—which includes all Medicaid managed care plans—from discriminating on the basis of race, ethnicity, national origin, gender (including gender identity and sex stereotyping), age and disability.[6]

MCOs, PIHPs, PAHPs, PCCMs and PCCM entities are also explicitly prohibited from discriminating against an individual eligible to enroll on the basis of health status or need for health care services.[7] This provides individuals additional protections if they would not otherwise be protected by the civil rights statutes cited above. This could include, for example, individuals with chronic conditions who do not have disabilities as defined by the Rehabilitation Act or Americans with Disabilities Act.

Further, all contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities, including between plans and subcontractors, must comply with anti-discrimination laws and regulations (and HHS must approve MCO, PIHP and PAHP contracts).[8] Thus, while the anti-discrimination laws apply directly to the covered entities, they will not be able to contract the anti-discrimination requirements away when using subcontractors to carry out activities required by the entity itself.

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[3] Social Security Act § 1902(a)(19), 42 U.S.C. § 1396a(a)(19).
[4] *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 88 Fed. Reg. 27,498, 27,538 (hereinafter MMC Final Rule) *available at* https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[5] 42 C.F.R. § 438.3(f)(1).
[6] 42 C.F.R. § 438.3(f)(1). Final regulations implementing Section 1557 are expected soon. NHeLP submitted significant comments on the proposed rule which are available at http://www.healthlaw.org/publications/search-publications/1557-comments-final#.VyD-cXo0EsQ. For more information on Section 1557, see NHeLP's *Health Advocate: Nondiscrimination and the ACA, available at* http://www.healthlaw.org/publications/search-publications/Health-Advocate-Nondiscrimination-ACA#.VyD-gXo0EsQ.
[7] 42 C.F.R. § 438.3(d)(3).
[8] 42 C.F.R. § 438.10(a).

State Advocacy Tip

Advocates should ensure all contracts with covered entities and their subcontractors include strong nondiscrimination provisions. These provisions should prohibit activities that discriminate or have the effect of discriminating, against individuals on the basis of race, ethnicity, national origin, language, immigration status, gender, gender identity, sexual orientation, age, and disability.

Information Requirements (§ 438.10)

This section takes effect for contracts beginning on or after July 1, 2017. Until that time, states and entities must comply with current § 438.10.

Individuals with Limited English Proficiency

The rule requires MCOs, PAHPs, PIHPs 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 regulation does 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."[9] HHS allows the state to determine what constitutes a "significant" number or percentage, thus standards could vary significantly across states. In our comments on the proposed regulation, we urged HHS to use a standard of 5% or 1,000 individuals in a single language group as a threshold for translating documents.

State Advocacy Tip

Advocates should encourage their states to adopt a definition of "prevalent" that, at a minimum, equates with longstanding HHS guidance to translate documents when a non-English language group comprises 5% or 1,000 LEP individuals in an entity's service area.

[9] 42 C.F.R. § 438.10(a) (emphasis added).

While this section includes a number of definitions, it does not define "interpreter" and thus lacks guidance as to who may competently serve in that role. In the Preamble, however, HHS notes the regulation should be read to include an implicit requirement that oral interpretation and written translation must serve their purpose. HHS further states such services will only serve their purpose if the services are competently provided. The discussion also refers to HHS' LEP guidance for more information about interpreter competency.[10]

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, states must include taglines on *all* documents for potential enrollees and MCOs, PIHPs, PAHPs and PCCM entities must include taglines on all documents for enrollees. A "tagline" is a brief statement in an individual's language (on an English document) that notifies LEP individuals how to obtain language services.[11] While the regulation only requires taglines in prevalent languages, HHS encourages states and managed care plans to add taglines in additional languages beyond those it determines are prevalent. One goal of taglines is to inform the widest array of LEP individuals of the availability of language services and since oral interpreting must be provided in all languages. Therefore, it is important that LEP individuals who may not have documents translated into their language understand oral interpreting is still available. Thus NHeLP generally recommends taglines in at least the top 15 languages in a service area.

State Advocacy Tip

Advocates should encourage their states to require taglines on all English documents and notices in at least the top 15 languages in entities' service areas (or at least the top 15 in the state).

[10] Final MMC Rule at 27,727. HHS' *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (Aug. 8, 2003), *available at* https://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf.

[11] For example, the tagline on documents in the Federally Facilitated Marketplace states: "**This Notice has important information.** This notice has important information about your application or coverage through the health insurance Marketplace. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call XXX-XXX-XXXX. . ." See CCIIO, *Technical Guidance: Guidance and Population Data for Exchanges, Qualified Health Plan Issuers, and Web-Brokers to Ensure Meaningful Access by Limited English Proficient Speakers Under 45 C.F.R.§ 155.205(c) and § 156.250* (Mar. 30, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf.

Provider directories must include the cultural and language capabilities offered by a provider or a skilled medical interpreter and whether the provider has completed cultural competence training. NHeLP had recommended that HHS include guidelines for when a provider could list her language capabilities since a provider may self-identify as bilingual but not have sufficient proficiency to provide services directly in a non-English language. HHS did not adopt our recommendations. We also suggested changing "skilled interpreter" to "competent interpreter" (and including a definition of it) since being an interpreter requires not just certain skills but also specialized knowledge and abilities. While HHS did not make this change, the discussion noted above about competency of interpreters and translators should help ensure interpreters are competent when providing services.

State Advocacy Tip

Advocates should encourage their states to adopt standards requiring providers to demonstrate proficiency before being listed in provider directories as having particular linguistic skills.

Individuals with Disabilities

The final rule also requires taglines in large print on all documents for potential enrollees, at a minimum of 18 point font. 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."[12]

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. We had suggested additional requirements for provider directories to include whether an office or facility exceeded minimum physical accessibility requirements, had auxiliary aids and services available, or had expertise serving people with disabilities. These recommendations were not adopted and could be an opportunity for state advocacy.

[12] 42 C.F.R. § 438.10(a).

State Advocacy Tip

Advocates should encourage their states to include information in provider directories addressing whether an office or facility exceeds minimum physical accessibility requirements, has auxiliary aids and services available, or has expertise serving people with disabilities.

Provider Discrimination Prohibited (§ 438.12)

MCOs, PIHPs and PAHPs may not discriminate against a provider on the basis of the provider's race, color, national origin, disability, age, or sex. The discussion of this section mentions using the final 1557 regulations for definition of sex. We expect these final regulations soon and hope they will include both gender identity (as included in the proposed 1557 regulation) and sexual orientation (recommended for inclusion in the final regulation).

The prohibited discrimination includes the participation, reimbursement or indemnification of any provider acting within the scope of his or her license or certification under applicable state law. The preamble clarifies that provider discrimination is prohibited because all Medicaid managed care contracts must comply with all applicable federal and state laws (including Title VI, Title IX, the Age Discrimination Act, the Rehabilitation Act, the Americans with Disabilities Act, and Section 1557 of the ACA).[13]

Long Term Supports & Services (§§ 438.68, 438.70, 438.110, 438.208)

A number of provisions in the final rule address the needs of individuals receiving long term supports and services, including older adults and individuals with disabilities.

Network Adequacy

The regulation allows states to develop their own time and distance standards based on the state's "unique service, beneficiary and geographic considerations."[14] Further, if pediatric LTSS providers offer necessary services that an adult LTSS provider cannot appropriately provide, states should consider how to address pediatric LTSS providers in the network adequacy standards.[15] The regulation also clarifies that "behavioral health" providers include both mental health and substance abuse providers.

[13] MMC Final Rule at 27,750.
[14] *Id.* at 27,665.
[15] *Id.* at 27,666.

Stakeholder and Member Engagement

Another provision adds representatives of beneficiaries or enrollees to the list of individuals who should be a part of a state stakeholder group and a managed care plan's member advisory committee.[16] Having additional beneficiary-focused membership should help focus better attention to the specific needs of underserved populations.

Coordination and Continuity of Care

MCOs, PIHPs and PAHPs must coordinate services and ensure continuity of care. For example, enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring must have direct access to a specialist as appropriate for the enrollee's condition and identified needs. Further, MCOs, PIHPs and PAHPs must follow a person-centered planning process as outlined in home and community-based regulations.[17]

We will provide further analyses of these sections in separate issue briefs addressing network adequacy and long term supports and services.

NHeLP

State Advocacy Tip

Advocates should participate in the development of time and distance standards. Advocates should also identify and nominate qualified individuals to serve on a state's stakeholder group and a managed care plan's member advisory committee.

Enrollee Rights (§ 438.100)

The final rule adds specific reference to the same laws referenced in § 438.10 to ensure consistency so that enrollees have the same rights to nondiscrimination once enrolled as potential enrollees have during the enrollment process. Thus, the state must ensure that MCOs, PIHPs, PAHPs, PCCM and PCCM entities comply with Title VI, Title IX, the Age Discrimination Act, the Rehabilitation Act, the Americans with Disabilities Act, and Section 1557 of the ACA.

Marketing Materials (§ 438.104)

Marketing materials must comply with the information requirements (see § 438.10 above) and must not discriminate. For example, entities could not target marketing only to parts of their service area to exclude, for

[16] *Id.*at 27,656.

[17] For more on the person-centered planning process in the HCBS regulations, see 42 C.F.R. § 441.301(c)(1), (2).

example, certain racial groups. Marketing materials must be approved by the state before dissemination. Unfortunately, HHS did not adopt recommendations to explicitly require that a state's review of marketing materials include : 1) an evaluation of language, reading level, comprehensibility, cultural sensitivity and diversity; and 2) ensure the materials do not target or avoid populations based on perceived health status, disability or for other discriminatory reasons. In discussing the final rule, HHS said that they agreed with the suggestions but believe the requirements were already addressed and that it expects the state review to include the full scope of standards in the rule and state contract. Further, HHS notes that all contracts must comply with § 438.3(f) regarding anti-discrimination laws and policies so that marketing materials could not target or avoid specific populations.[18]

Availability of Services (§ 438.206, § 440.262)

This section requires MCOs, PIHPs and PAHPs to provide services in a culturally competent manner to all enrollees, regardless of LEP, diverse cultural and ethnic backgrounds, disability, sexual orientation, gender, or gender identity. And each entity must ensure its network providers provide physical access, reasonable accommodations and accessible equipment for enrollees with physical or mental disabilities. Further, an MCO, PAHP or PIHP must have a network sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. This section becomes effective with contracts on or after July 1, 2018 and states must comply with existing § 438.206 until that date.

In addition to this provision for managed care, the final regulation also adds a corresponding standard requiring the state to ensure cultural competence and non-discrimination in access to services under fee-for-service.

Coverage and Authorization of Services (§ 438.210, § 438.420)

The final regulation revised the definition of "medical necessity" by replacing the term "health impairments" with "an enrollee's disease, condition, or disorder that results in health impairment and/or disability". HHS notes the change more accurately reflects their intent.[19]

Individuals with ongoing or chronic conditions who require LTSS must have services authorized in a manner that reflects the enrollee's ongoing need for these services or supports. So an individual who meets these criteria should not have to have services reauthorized after short periods as would other enrollees and should have longer authorization periods that are consistent with the enrollee's ongoing needs. This section also explains authorization for LTSS services.[20] Finally, the final rule codifies CMS' May 2013 MLTSS guidance throughout the final regulation.[21]

[18] MMC Final Rule at 27,504.
[19] *Id.* at 27,632.
[20] *Id.*
[21] *Id.* at 27,651-54.

HHS made two definitional changes regarding LTSS. The regulation specifies that an MCO, PIHP or PAHP must "authorize LTSS based on an enrollee's current needs assessment and consistent with the patient-centered service plan."[22] Further, the general LTSS definition was modified to state that LTSS means "services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting."[23]

Provider Selection (§ 438.214)

MCOs, PIHPs and PAHPs must ensure that their provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment. This should ensure inclusion of providers who treat individuals with disabilities even if their treatment may be costly.

HHS also noted that, since all contracts must comply with § 438.3(f), contracts with providers also must also observe anti-discrimination laws and regulations including Title VI, Title IX, the Age Discrimination Act, the Rehabilitation Act, the Americans with Disabilities Act and Section 1557 of the ACA.

Managed Care State Quality Strategy (§ 438.340(b)(6))

Each state contracting with MCOs, PIHPs, PAHPs and PCCM entities must have and implement a quality strategy to assess and improve the quality of healthcare and services furnished by the entity. The provision specifically requires the quality plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on race, ethnicity, sex, primary language, age, and disability status ("disability status" for this purpose is defined as an individual qualified for Medicaid on the basis of a disability).[24]

States must provide demographic data of enrollees' race, ethnicity, sex, primary language, age and disability status to the entities. The entities are not required to collect this or any additional data themselves and the Medicaid regulations prohibit states from asking for any data on an application that is not relevant for an eligibility determination.[25]

Unfortunately, the provision did not add requirements to collect and share demographic data on gender identity and sexual orientation but this is an opportunity for state advocates to work to improve demographic data collection in their states (although this may be limited by § 435.907(e)).In response to comments

[22] 42 C.F.R. § 438.210(b)(2)(iii)).
[23] 42 C.F.R. § 438.2.
[24] 42 C.F.R. § 438.340(b)(6).
[25] 42 C.F.R. § 435.907(e).

recommending greater data collection, HHS stated "it is not appropriate to mandate submission of data elements that the state may not have a way to collect unless volunteered by the applicant."[26]

State Advocacy Tip

Advocates should encourage states to collect more robust demographic data of applicants. This should include: 1) using standards to collect race and ethnicity adopted by the Institute of Medicine; 2) collecting data on gender identity and sexual orientation; and 3) identifying whether sufficient data on disability status is collected such as the six questions used on the American Community Survey.

Handling of Grievances and Appeals (§ 438.406)

Each MCO, PIHP and PAHP must provide reasonable assistance to ensure enrollees can complete forms and take other procedural steps related to a grievance or appeal. This includes providing interpreter services, toll-free numbers that have adequate TTY/TTD and interpreter capability, and auxiliary aids and services. Further, the notice of resolution must be in a format and language that complies with the Information Requirements above (see § 438.10).

Further, any needed translation or alternative formats may not impede enrollees' ability, or reduce enrollee's time, to request continuation of benefits in compliance with 438.10.[27] We believe this requirement would result either in a tolling of timeframes while translation or alternative formats are created or additional time to comply with any relevant time limits.

Conclusion

The final regulation includes a number of specific provisions promoting health equity and prohibiting discrimination. A number of opportunities exist for state advocates to strengthen or clarify the final regulations including:

- ensuring all contracts with covered entities and their subcontractors include strong nondiscrimination provisions. These provisions should prohibit activities that discriminate or have the effect of discriminating, against individuals on the basis of race, ethnicity, national origin, language, immigration status, gender, gender identity, sexual orientation, age, and disability;

[26] MMC Final Rule at 27,738-9.
[27] *Id.* at 27,636.

- adopting a definition of "prevalent" that, at a minimum, equates with longstanding HHS guidance to translate documents when a non-English language group is 5% or 1,000 LEP individuals in an entity's service area;
- requiring taglines on all English documents and notices in at least the top 15 languages in entities' service areas (or at least the top 15 in the state);
- requiring providers to demonstrate proficiency before being listed in provider directories as having particular linguistic skills;
- including information in provider directories addressing whether an office or facility exceeded minimum physical accessibility requirements, had auxiliary aids and services available, or had expertise serving people with disabilities; and
- participating in the development of time and distance standards; and
- identifying and nominating qualified individuals to serve on a state's stakeholder group and a managed care plan's member advisory committee.

For more information on implementing these tips, please contact the National Health Law Program.