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Medicaid Managed Care

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Key Resources

Issue Briefs

- Managed Care Informing and Disclosure Requirements (August 2012), available here.
- Medicaid Managed Care and Disability Discrimination Protections (May 2012), available here.
- Accountability and Stewardship in Medicaid Managed Care (June 2007), available here.

Fact Sheets

- Medicaid Managed Care: Enrollment and Education, available here.
- Medicaid Managed Care: Services, available here.
- Medicaid Managed Care: Financing, available here.
- Medicaid Managed Care: Grievances and Appeals, available here.

Ongoing NHeLP Managed Care Activities:

- Regular Health Advocate teleconferences.
- Regular updates on our Health Advocates listserv.
- Managed care workgroup and listserv.

Coming in October's Health Advocate:

A Primer on Dual Eligibles

In 2010, about three quarters of Medicaid beneficiaries received services through some type of managed care arrangement. Most were enrolled in capitated managed care plans, which receive a set payment per Medicaid enrollee in exchange for providing services.[1] More than 26 million are enrolled in capitated plans with "comprehensive risk contracts." These contracts require a managed care plan to incur a loss if it spends more on services than it receives through the capitated payments.[2] Conversely, such a plan will make a profit if providing services costs less than the payments. Thus, there is a clear incentive to limit coverage of services for individuals enrolled in capitated, risk based plans.

In recent years, states have more frequently required seniors and people with disabilities to enroll in capitated, risk based managed care plans. This includes beneficiaries enrolled in Medicare and Medicaid (dual eligibles).[3] In 2012-13, hundreds of thousands of Medicaid beneficiaries with disabilities will be enrolled in such plans – including thousands of dual eligibles. Because this population has extensive, chronic health needs, it is relatively costly to serve. In fact, in 2009, 43% of Medicaid expenditures were made for individuals under age 65 with disabilities, despite the fact that these enrollees comprise only 15% of the total Medicaid enrollment.[4] Thus, advocates fear that, if inadequately funded, plans may deny coverage of necessary services in order to save money.

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[1] CMS, Medicaid Managed Care Enrollment, July 1 2010, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf

[2] CMS, "Number of Managed Care Entity Enrollees by State" (July 1, 2010), https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010MCE-Enrollees.pdf.

[3] *See, e.g.,* KAISER COMM'N ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY (Sept. 2011), *available at* http://www.kff.org/medicaid/upload/8220.pdf (last visited Sept. 4, 2012) ("KCUM, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS").

[4] KAISER COMMISSION ON MEDICAID AND THE UNINSURED, DISTRIBUTION OF PAYMENTS BY MEDICAID ENROLLMENT GROUP 2009, http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2 (last visited Sept. 4, 2012): KAISER COMM'N ON MEDICAID AND THE UNINSURED, DISTRIBUTION OF MEDICAID ENROLLEES BY ENROLLMENT GROUP 2009, http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2, (last visited May 31, 2012). Moreover, in 2009, while enrollees over age 65 comprised only 10% of the Medicaid population, but accounted for 23% of Medicaid spending. *Id.*

Health advocates need a basic understanding of how Medicaid managed care works in order to ensure that managed care systems comply with the law. Managed care systems should be established and operated so that Medicaid enrollees get the services they need. This issue of the *Health Advocate* focuses on three crucial issues in Medicaid managed care – provider network adequacy, adequacy of rates, and transparency of information—and provides suggestions for advocacy as states implement or expand Medicaid managed care.

Advocacy Tip: The Managed Care Contract

Every managed care plan participating in Medicaid signs a contract with the state Medicaid agency. The contract describes the rights and responsibilities of the state and plan. It is a crucial source of information about the plan and it can be a key source of protections and rights for enrollees. Advocates should obtain copies of managed care contracts or requests for proposals for contracts in order to understand the terms of the agreement between the state and the plan.

Provider Network Adequacy

States must ensure that managed care enrollees have access to all services covered under the state Medicaid plan. Among other things, capitated managed care plans must have a network of appropriate providers to ensure that enrollees have adequate access to covered services. Plans must show that the network has sufficient number, mix, and geographic distribution to meet the needs of the Medicaid population. If the services are not available in the network, the plan must cover the services out of network. States must ensure that women enrolled in capitated managed care plans have direct access to women's health specialists within the network for necessary covered care. Enrollees also have the right to a second opinion from a qualified health professional. If a qualified professional is not available within the network, the managed care plan must arrange for one outside the network at no cost to the enrollee.[5]

When establishing the network, the plans must consider the characteristics of the Medicaid populations covered by the plan, the providers that will be needed, and whether provider locations provide appropriate physical access to people with disabilities.[6]

Over the years, advocates have identified recurring problems with provider network adequacy in Medicaid. Provider lists may not be accurate or up to date. Providers listed as available may actually place low quotas on the number of Medicaid patients that they will actually accept and, in practice, rarely accept new patients. Plans may also have separate and unequal provider lists for Medicaid and private pay patients. Plans may not contract with essential community providers that provide care to Medicaid enrollees, like community health clinics, local health departments or school-based health centers. Providers may therefore not be culturally and linguistically appropriate, user-friendly for adolescents, or have ongoing, long-term relationships with their patients. Managed care plans may have an insufficient number of pediatric and obstetric primary care providers, or pediatric and adolescent specialists in their network. Perhaps most important, Medicaid agencies may fail to properly assess network adequacy before entering into contracts, or lack the capacity to measure and monitor network capacity.[7]

Advocates should urge their states to include contract provisions designed to improve network adequacy, including:

- Requirements that plans have appropriate specialists in their network, specifically setting forth the types of specialty required;

[5] 42 C.F.R. §§ 438.206-.207.
[6] 42 C.F.R. § 438.206(b)(1).
[7] *See, e.g.,* D.C. Medical Care Advisory Committee, Behavioral Health Subcommittee, "FY2011 Year-End Report and Recommendations 5-7 (Apr. 18, 2012) (available from NHeLP); Joel Ferber and James Frost, *Expanding Medicaid Managed Care to People with Disabilities and Seniors Would Be Risky and Unwise* 2-3 (August 2010) (available from NHeLP).

- Prohibitions preventing plans from having separate provider lists for their Medicaid and private pay patients;
- Requirements that plans provide quarterly reports to the state agency and to the public showing the number, location, type, and current capacity of providers who are contracting with plans; and
- Requirements that plans contract with or include in their provider networks essential community providers.

Adequacy of Rates

Medicaid rates must be adequate to ensure that beneficiaries have access to necessary services.[8] Medicaid managed care rates must be actuarially sound, meaning that they must be developed in accordance with actuarial principles that are appropriate for the population and services. Generally speaking, plans are actuarially sound if the projected payments to the plan are adequate to provide for costs of services and related costs (such as plan administration).[9] A number of states "risk adjust" their Medicaid capitation rates, meaning that they increase payment amounts to more closely reflect the actual costs of serving Medicaid enrollees. Recently, a survey showed states basing increases on a number of factors, such as age, gender, eligibility category, and health status.[10]

Despite the requirement of actuarial soundness and some ability to adjust for risks, as people with disabilities are moved into capitated managed care, advocates fear that rates will not be sufficient to enable plans to adequately serve them. Among other concerns, if risk adjustment processes are not formulated to accurately account for disability or poor health, rates may not be adjusted enough. If rates are not adequate, plans may not be able to remain in the program. Or, they may not provide all necessary services in order to cut costs.

Advocates should urge their states to:

- Require plans to specify the type, amount, or age of the data used to set rates;
- Establish and adjust capitation payments to reflect the health status of the enrolled population;
- Implement risk adjustment that relies on encounter data reflecting service for people with chronic health needs and disabilities;
- Develop comprehensive risk adjustment formulas which assess family risk factors as well as medical risk factors;
- Structure medical forms to ensure collection of accurate encounter data; and
- Review capitated rates when services are added or deleted from a contract.

[8] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 438.6(c)(2).
[9] American Academy of Actuaries, "Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs" 7 (August 2005), available at http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.
[10] KAISER COMMISSION ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 21 (Sept. 2011).

Access to information

Medicaid applicants, enrollees, and other stakeholders must have ready access to key information about Medicaid managed care programs and the rules that govern them. The law requires that states and plans make a variety of types of information available. This includes the services that are covered and the providers who participate in the plan. States must provide notice describing the right to enroll and disenroll, right to file grievances, and the right to obtain an impartial hearing. In addition:

- States and managed care plans must provide notices about enrollment rules that current and potential enrollees can easily understand.
- Annually, and upon request, states must provide a list of available managed care plans, with information on benefits and cost sharing, service area, and quality measures for each plan.
- Before an individual enrolls in a plan, the state Medicaid agency must inform the individual in writing of any services that are not available through that entity and how the individual may obtain access elsewhere.[12]

Upon request, plans must make the following information – in an understandable format – available to both current and potential enrollees:

- Identity, location, qualifications, and availability of participating providers;
- Enrollee rights and responsibilities;
- Grievance and appeal procedures; and
- Covered items and services.[13]

Advocates should:

- Become familiar with the information disclosure requirements that govern managed care plans and state Medicaid agencies, including state public records laws;
- Request information from the plans and the state Medicaid agencies, including information about available services and network providers;
- Make contacts with the media to publicize egregious instances of failure to provide information;
- Petition elected officials to bring pressure on Medicaid plans to account for their actions; and
- Work with the state's Medical Care Advisory Committee to obtain and publicize information about managed care.

NHeLP has worked on Medicaid Managed Care issues for more than 30 years. Contact us for further information, support, and assistance.

[12] 42 U.S.C. § 1396u-2(a(5)(B); 42 C.F.R. 438.10(f).
[13] *Id.*

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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