NHeLP
NATIONAL HEALTH LAW PROGRAM

Sunshine & Accountability Project

Medicaid Sunshine and Accountability:
Listing of Requirements for Information

Prepared by the NHeLP Sunshine & Accountability Project
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State Medicaid programs and managed care organizations (MCO) must collect and report information in accessible formats:

- Each State, enrollment broker, and MCO must provide "all informational materials … relating to enrollees and potential enrollees in a manner and in a format that may be **easily understood**." 42 C.F.R. § 438.10(b)(1).

- Written materials must be available in **alternative formats** and in a manner that accounts for the needs of persons who are, e.g., visually limited or have limited reading proficiency. 42 C.F.R. § 438.10(d)(1).

- "All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats." 42 C.F.R. § 438.10(d)(2).

Requirements for service area information:

1. MCOs must make available to enrollees and potential enrollees in the MCO's service area information concerning:

- The **names, locations, qualifications, and availability of health care providers** that participate in the specific MCO, including **non-English language spoken** by current contracted providers and information on providers who are not accepting **new Medicaid patients**;
- The responsibilities of the MCO for **coordination of care**;
- **Services and items available** through the MCO and any **cost sharing**;
- Medicaid **benefits that are not covered by the MCO**, including how and where the enrollee can obtain those benefits, any cost sharing, and how transportation is provided,
- **Quality and performance**, and
- **Procedures available to challenge problems** with enrollment and services in the MCO.

42 U.S.C. §§ 1396u-2(5)(B), (C); 42 C.F.R. §§ 438.10(e), (f). This information must be provided to enrollees annually and upon request and to potential enrollees in a time frame that allows them to use the information as they make enrollment decisions. 42 C.F.R. § 438.10(e). The information can be provided in summary form but "the State must provide more detailed information upon request." 42 C.F.R. § 438.10(e).

2. Each MCO must provide the State and U.S. Department of Health and Human Services (DHHS) with assurances that the MCO has **adequate capacity**, including assurances that the MCO

> (A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and (B) maintains a **sufficient number, mix, and geographic distribution of providers of services**.

42 U.S.C.§ 1396u-2(b)(5); 42 C.F.R. § 438.207.

Requirements for information about performance:

1. Each state that contracts with MCOs must develop and implement **standards for "access to care** so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity." 42 U.S.C. § 1396u-2(c)(1)(A).

2. Each state that contracts with MCOs is required to have a **written strategy for assessing, reviewing, and improving the quality** of managed care services. 42 C.F.R. §§ 438.202, .204, .240(e). Each MCO must conduct "performance improvement projects" that focus on clinical and non-clinical areas and that measure performance objectively. 42 C.F.R. §§ 438.240(b), (d).

3. **Annual external independent quality reviews** must assess "the quality outcomes and timeliness of and access to the items and services for which the [managed care] organization is responsible under the contract." 42 U.S.C. § 1396u-2(c)(2)(A); 42 C.F.R. §§ 438.310-.364. A detailed report must describe how the review was conducted, including an assessment of each MCOs "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" and recommendations for improving quality in each MCO. 42 C.F.R. § 438.364. The report must be provided, upon request, to enrollees, potential enrollees, participating health care providers, recipient advocacy groups, and other interested parties. 42 U.S.C. § 1396u-2(c)(2)(A); 42 C.F.R. § 438.364(b). "The State must make this information available in alternative formats for persons with sensory impairments, when requested." 42 C.F.R. § 438.364(b).

4. Each state must submit **Early and Periodic Screening Diagnostic and Treatment (EPSDT) performance reports** on low-income children and youth to CMS by April 1st of each year. The CMS Form 416 is used to collect this information. In 2009, Congress amended the Social Security Act to require states to report additional information. Currently, states must report, by age groups, information including:

- the number of children provided child health screening services,
- the number of children who received a lead blood test (required at 12 and 24 months of age),
- the number of children referred for corrective treatment,
- the number of children who receive any, preventive, or restorative dental care;
- the number of children in the 8-year-old age grouping who have received a protective sealant on at least one permanent molar tooth,
- results in attaining the EPSDT participation goals set for the State by DHHS

(currently 80 percent of children should be screened).

42 U.S.C. § 1396a(a)(43)(D); 42 U.S.C. § 1397hh(e)(1). DHHS Center for Medicare & Medicaid Services (CMS) Form 416. Reports must include information on children enrolled in managed care. 42 U.S.C. § 1397hh(e)(2).

5. CMS encourages States to report using performance measures contained in the **Healthcare Effectiveness Data and Information Set** (HEDIS), published by the National Committee for Quality Assurance (NCQA). According to NCQA, the following 20 states legally require the use of at least some HEDIS measures: AK, CA, CO, DC, FL, MD, MA, MN, MO, NE, NV, NJ, NM, NY, OH, PA, RI, TN, UT, VA.[1] And, even though they are not legally required to do so, other states use them as well. The 2010 Medicaid HEDIS includes childhood immunization status, childhood lead screening, adult body mass index assessment, breast cancer screening, cervical cancer screening, chlamydia screening, and comprehensive diabetes care. NCQA, HEDIS 2010 Summary Table of Measures, Product Lines and Changes, http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010_Measures.pdf.

NOTE: HEDIS measures do not necessarily comply with the Medicaid requirements. For example, Medicaid requires two lead blood tests (at 12 and 24 months of age), the HEDIS measure asks only whether a child had one or more lead screening by his second birthday. Morever, HEDIS did not even include this measure until 2008.

6. State Medicaid agencies and MCOs must develop and implement grievance and appeal processes that assure the timely and fair resolution of disputes. 42 U.S.C. §§ 1396a(a)(3), 1396u-2(b)(3); 42 C.F.R. §§ 431.200-.250, 438.400-.424. MCOs must maintain **records of grievances and appeals**. 42 C.F.R. § 438.416. The State must have procedures for monitoring MCOs' processing of grievances and appeals. 42 C.F.R. § 438.66(b). State fair hearing decisions must be publicly available. 42 C.F.R. § 431.))).

Requirements for information about financial Incentives:

A physician incentive plan is "any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to any plan enrollee." 42 U.S.C. § 1396b(m)(2)(A)(x); 42 C.F.R. § 438.6(h). MCOs must **disclose whether their contracts include physician incentive plans** that affect use of referral services, the type of incentive being used (e.g. capitation, withhold, bonus), whether stop-loss coverage is provided,[2] and a summary of survey results, if surveys are used. 42 C.F.R. § 438.6(h). MCOs must disclose the information to any Medicaid beneficiary who requests it. 42 C.F.R. § 438.6(h).

Information about the publicly traded MCOs:

Some states contract with publicly traded MCOs. Commercial, publicly-traded plans must **file reports with the Securities and Exchange Commission**, available at www.sec.gov/edgar/searchedgar/companysearch.html, that include:

[1] www.ncqa.org/LinkClick.aspx?fileticket=ClkKqM0a%2Bfk%3D *(accessed Dec. 30, 2009).*

[2] Stop loss is insurance coverage designed to limit the amount of financial loss experienced by a health care provider. An MCO or physician group will buy this insurance to cover liabilities that exceed what is expected.

- Form 10-K. This report provides a comprehensive analysis of the company's financial position. It includes the medical cost ratio (the amounts spent on medical care or administrative expenses) and Medicaid, Medicare, and military enrollment.[3] The "selected financial data" portion of the report is particularly descriptive. Attachments may include the agreement between the company and the state Medicaid agency.

- Form 10-Q. This form is filed with the SEC each quarter. It includes unaudited financial statements and provides a picture of the company's ongoing financial situation.

- Form 8-K. This form is filed with the SEC each quarter and is used to report information that was not previously contained in the Form 10-K or Form 10-Q. For example, the information could describe a recent acquisition or major litigation involving the company.

- Form DEF 14a. This form includes company proxy statements which should show executive compensation and board of director membership.

[3] The medical cost ratio, is also called the medical loss ratio, medical care ratio, or benefit ratio.