NHeLP
NATIONAL HEALTH LAW PROGRAM

Sunshine & Accountability Project

Report:
The Pursuit of Medicaid Managed Care Quality Information in Six States

Prepared by the NHeLP Sunshine and Accountability Project
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Medicaid managed care is a big and growing business. The federal government and the states pay billions annually to private managed care plans to provide services to Medicaid beneficiaries. And, in the past ten years, the percentage of Medicaid beneficiaries enrolled in managed care has increased from about 55% to more than 70%.[1] At least a quarter of state Medicaid programs contract with commercial plans to deliver services to Medicaid enrollees who, by law, can only obtain needed care through the plans. Significantly, because these private contractors and vendors are publicly traded corporations, they have a fiduciary duty to maximize return on shareholder investments. This can create incentives to reduce coverage of necessary services.

States contract out the provision of Medicaid services to managed care plans based on assumptions that it would save money for the state and improve care to beneficiaries. But, how do we know whether the services are of adequate quality? In order to protect beneficiaries and to ensure that they, along with policy makers and the public, have access to information about the services managed care plans provide, state Medicaid agencies and the plans that contract with them are required by federal statute and regulation to make information about the nature and quality of services publicly available.[2]

The National Health Law Program (NHeLP) has aggressively advocated for transparency and quality in managed care, and for legal and contractual protections to ensure that beneficiaries receive high quality care. In 2008, NHeLP launched its Sunshine and Accountability Project to test adherence with the laws requiring transparency by requesting, analyzing and disseminating information about Medicaid managed care performance. With funding from The Nathan Cummings Foundation and the Public Welfare Foundation, NHeLP, with six state partners, examined the performance and transparency of Medicaid managed care in six states: Connecticut, Virginia, Florida, Missouri, New Mexico, and Washington.[3] The states were chosen to

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[1] U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Services, "National Summary of Medicaid Managed Care Programs and Enrollment," June 30, 2008, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/08Trends508.pdf.

[2] For a detailed description of the legal requirements governing state Medicaid agencies and managed care plans contracting with the agencies, *see* National Health Law Program, *Medicaid Sunshine and Accountability: Listing of Requirements for Information* (January 2010), available at http://www.healthlaw.org/index.php?option=com_content&view=article&id=263&Itemid=200.

[3] The state partners are New Haven Legal Association, Inc.; Florida Legal Services; Legal Services of Eastern Missouri; St. Louis University School of Law; New Mexico Center on Law and Poverty; Virginia Poverty Law Center; and Northwest Health Law Advocates.

reflect a diverse mix of states as well as to take advantage of existing networks with legal services advocates in those states. These states also serve a high proportion of their Medicaid population through risk-based managed care organizations. NHeLP worked closely with the state partners to develop project materials, monitor progress, and offer assistance with analysis and problem-solving.

Development of Data Collection Documents and Requests for Documents

Initially, the Sunshine group identified the legally-required information that would be requested. Next, state partners made requests for information from the state Medicaid agency and managed care plans contracting with the agency. Two template request letters - one for the Medicaid agency and the other for the managed care organizations (MCOs) - were developed for adaptation by each state partner. (Template request letters are attached as Appendices A and B). Partners sent initial letters in December 2008 and January 2009.

The partners requested the following information from the state Medicaid agencies, to the extent applicable:

- A list of the specific Healthcare Effectiveness Data and Information Set (HEDIS) performance measures used by the agency to measure MCO performance in 2006, 2007, 2008, and 2009;
- Specific HEDIS performance results, as reported by each Medicaid-participating MCO for the three most recent years available;
- State Medicaid standards for access to care to ensure that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services available;
- The State strategy for assessing, reviewing and improving the quality of available managed care services, including any reports submitted to CMS discussing the strategy; and
- The current policies and procedures for obtaining prescription drugs that are not on an MCO's drug formulary.

The second set of requests went to each MCO, to the extent applicable, that contracts with the state to provide services to Medicaid beneficiaries:

- Descriptions of any physician incentive plans which the MCO uses;[4]
- Lists of specific types of providers included in the MCO network. For each provider listed, MCO were asked to include the name, location, qualifications and availability, non-English language spoken, information

[4] 42 C.F.R. §§ 422.208, 422.210, and 438.6(h).

on whether the provider is accepting new Medicaid patients, and any other information legally required to be provided to Medicaid beneficiaries. In addition, MCOs were asked to provide any additional information that the MCO in the course of business provides enrollees or potential enrollees about physicians with which it contracts:[5]

- Pediatricians,
- Dentists,[6]
- Orthopedists,
- Dermatologists,
- Endocrinologists,
- Psychiatrists,[7] and
- Neurologists.

- For July 1, 2007 through June 30, 2008:

  (a) the total number of requests for payment for a prescription drug covered under the state contract for which the MCO electronically approved payment at the pharmacy point of service for the prescription as written; broken down into numbers of approved requests for each therapeutic class of drug

  (b) the total number of requests for payment for a prescription drug covered under the state contract for which the MCO electronically rejected payment at the pharmacy point of service because the drug is not on the MCO's restricted drug list (also referred to as a "formulary" or "preferred drug list" or similar term), broken down into numbers of rejected requests for each therapeutic class of drug; and

  (c) of the total number of electronically rejected requests described in section (b), the percentage for which payment of the original prescription, or of a substitute drug in the same therapeutic class approved by the prescribing physician, was approved by the MCO for payment within 24 hours after the initial payment rejection was rejected.[8]

States' Responses to the Requests

All of the states except Connecticut ultimately provided most of the information requested. Response times ranged from a speedy 14 days for Virginia to 160 days for Connecticut's incomplete response. Two of the slow-responding states, Washington

[5] 42 U.S.C. §§ 1396u-2(a)(5)(B), (c); 42 C.F.R. §§ 438.10(e)(2)(ii)(D), (f)(6)(i).
[6] Request regarding dentists was only made in Florida, Missouri, and New Mexico where Medicaid dentistry is contracted to MCOs.
[7] This information was not requested for Connecticut.
[8] This information was not requested for Connecticut.

and New Mexico, provided an initial response within a month stating that they needed more time to comply with the request. Four states (Virginia, Washington, New Mexico, and Missouri) requested payment for copying. In order to avoid copy costs, local partners requested that information be made available in a electronic format. The copy costs requested generally were not very high, but they would likely pose a barrier to a Medicaid beneficiary who might want to review the information.

States generally provided the HEDIS data requested. Washington and New Mexico provided web links where the reports detailing HEDIS information were available on the state's website. Virginia and Missouri provided the data in a format that readily enabled comparisons of plan performance.

Florida's initial response contained links to its website, where a number of reports about Medicaid managed care could be found. None of the reports contained HEDIS data from before 2007. After a second request, the state provided a voluminous spread sheet listing HEDIS scores from 2005 and 2006.

Connecticut's response which was provided in paper format, was disorganized, confusing, and incomplete. The state agency sent a number of older quality review reports, but were missing many pages. HEDIS measures from only one of three plans were provided. That state's data were provided by individual plan, rather than by measure and across plans, and performance comparisons between plans were impossible. The state did not provide a list of the HEDIS measures it used. Outside research indicated that Connecticut uses non-HEDIS measures.[9]

The states' responses to the other requests were mixed. While most of the states attempted to answer the third and fourth questions on the template request, the responses often did not reveal clear policies regarding continuity of care, assessing adequacy of networks and promptness of care, or strategies to improve care over time.

MCOs' Responses to the Requests

Responses were less forthcoming from the thirty-eight MCOs to whom the state partners sent requests.

- **Connecticut** The MCOs took at least two months to respond, and generally three months to do so. One managed care plan, AmeriChoice (United Heathcare) told the state partner that the state Medicaid agency had instructed the plan not to respond until it received further instructions. Eventually, however, it and the other two plans (Aetna Better Health and Community Health Network of CT) did provide complete responses regarding physician incentives and provider networks. No pharmacy data was requested or provided because pharmacy benefits, along with dental and mental health benefits, are carved out from the MCOs in Connecticut.

[9] Lewin Group, "Assessment of HUSKY, Connecticut's Medicaid Managed Care Program," p. 28 (Jan. 22, 2007), http://www.lewin.com/content/publications/CTMedicaidMCFinalRpt.pdf (last visited Dec. 4, 2009).

- **Florida The** state partner sent requests to 15 managed care plans. Five plans provided minimal partial responses: One plan, **Universal HealthCare**, had not responded two months after the response was sent. Eventually, however the plan was responsive and attempted to cooperate. It answered the questions about physician incentives and provider networks. It also indicated a willingness to provide the pharmacy data. After several emails and calls, it provided data which appeared to be unresponsive and incomprehensible. The plan underwent some major personnel changes and indicated a willingness to cooperate in the future.

  Two plans, **Sunshine** and **Healthease** called but did not send information to the state partner. Sunshine explained that they had just opened and did not have all the information requested**.**

  Prestige, **Jackson Health Plan, Preferred Medical Plan, and Amerigroup,** provided minimal, partial responses (such as provider handbooks which did not indicate whether providers were accepting new patients or whether networks included specialists). **Preferred Medical Plan provided** some statistics in response to the question about pharmacy denials but stated that providing the requested data would cost upwards of $10,000 in programming costs.. .

  Molina Healthcare of Florida directed the local partner to the state for the information sought on pharmacy denials and noted that most of the information requested "is only available by court order or subpoena…." They also suggested that the pharmacy information be obtained from the state Medicaid agency.

  UnitedHealthcare refused to provide responses to the requests for information about physician incentive programs and the provider network unless the state partner provided the name and contact information of a beneficiary enrolled in the plan. It would not answer the question about pharmacy requests without a subpoena "or citation of legal authority."

  None of the other plans contacted: **Humana, Total Health Choice, Freedom Health, Personal Health Plan, Vista/Buena Vista,** and **Citrus Health Care** responded.

  One plan, the Health Care District of Palm Beach County, sent a letter referring the state partner to their website. This was surprising, because no request had been sent to that plan.[10]

[10] Notably, Florida is at a critical stage in its five year 1115 Waiver referred to as "Medicaid Reform." The current pilot project is operating in several counties and the 2010 Legislature must determine whether it intends to terminate the project or seek re-authorization. A

- **Missouri Health Care USA,** and **Children's Mercy** (**Family Health Partners**) provided nearly complete and prompt responses. Other plans' responses were spotty. The pharmacy information for **Health Care USA** was missing some information, but they made an attempt to provide the requested information. Both **Blue Advantage Plus** and **Harmony** both indicated that they were unaware of any obligation to provide a response, but referred to their website for provider listings. No information was found for physician incentive plans for either plan. **Blue Cross BlueShield of Kansas City** provided some information but also asserted that it had no obligation to provide the information. **Missouri Care Health Plan (Aetna)** sent its member handbook and provider directory, but the directory did not indicate providers' qualifications or whether a provider was accepting new patients. After a follow up request, the plan stated that it did not have a physician incentive plan. It deflected the request for pharmacy information, indicating that the information "should be released by the MO HealthNet Division as they receive encounter information." **Molina Healthcare of Missouri** provided some of the information requested, indicating that there was no physician incentive plans, referring to its website for information about participating providers, and referring to the state Medicaid agency for information about prescription drug claims. At the same time, the letter stated that it "considers much of the information you requested, confidential and protected and we are unable to provide you with that information. The information is only available by court order or subpoena and most likely not in the specific format you have requested."[11] The state partner sent a follow up letter, to which Molina did not respond.

- **New Mexico** Shortly after the state partner sent out requests, representatives from several MCOs called to ask why the information was being requested. Two plans subsequently sent links to information on their websites. Lawyers representing two other plans called the state partner and asked why the state partner was requesting the information. A little more than a month after the response was mailed, **BlueCross BlueShield** sent a provider list and physician incentive plan. They reported that they did not have pharmacy data because they had only been participating in Medicaid since October 2008. **Amerigroup** provided a nearly complete response; however, they cautioned that they had only been providing services in NM for a little over a year so they did not have the pharmacy data requested, and they were not warranting that their provider directory was complete. **Evercare** did not respond to two letter requests, one sent in December and a follow-up in March. **Molina**

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fundamental difference between the Reform and Non-reform counties is that virtually everyone in a Reform counties is required to be in a managed care plan and there is no fee-for-service option, as in the Non-reform counties.

[11] Letter from Joann Volovar, Molina Healthcare, to Joel Ferber (Feb. 11, 2009) (on file with NHeLP).

Healthcare of New Mexico directed the local partner to the state for the information sought on pharmacy denials and noted that most of the information requested "is only available by court order or subpoena…."

Lovelace provided an incomplete response, which it supplemented on request. **Molina** responded quickly that it had no physician incentive plans and referred to the website for its contracted providers. It suggested that the state partner should try to get the information about prescription drugs from the state. **Presbyterian Salud Health Plan** responded after about four months. It noted that it was not required to provide the information, but provided a copy of the quality incentive program aimed at encouraging physicians not to have prescriptions denied (because of prescribing off formulary or failing to get prior authorization) and a link to the website where the provider directory could be found. It denied having the requested pharmacy information, but offered to discuss whether it could provide other information that might be useful.

- **Virginia** All five plans contacted, **Anthem, Amerigroup, Optima, CareNet**, and **Premier**, eventually responded to the requests and provided information in response to the first two requests, but none provided information in response to the question about pharmacy refusals. **Amerigroup's** provider list included the physician specialties requested, but not the providers' qualifications.

- **Washington** None of the plans provided the requested information; they either responded that they would only comply with a request made by a particular beneficiary or did not respond at all. Two plans, **Columbia United Providers** and **Community Health Plan of Washington** responded promptly that they would not provide the requested information unless made by an individual beneficiary. After being reminded by letter, about two months after the original request**, Group Health Cooperative** wrote to the state partner to indicate that they would not respond to the requests unless it was made on behalf of a particular enrollee. Also after a reminder, **Regence Blue Shield** responded to the request made to **Asuris Northwest Health,** giving a similar response. **Molina Healthcare of Washington**, the largest Medicaid managed care plan in Washington state by number of members, did not respond.[12]

One of the greatest challenges for the project was reviewing and tracking the responses from the states and the MCOs. Some information was in a user-friendly format, and it directly answered the questions posed. Most states appeared to take care to send information or pages from documents which answered the particular questions in the requests. MCOs generally answered less carefully. Some responses

[12] It is interesting that Asuris responded and Regence did not, because Asuris is a wholly owned subsidiary of Regence.

were one or two sentences in a response letter. Other questions were ignored or an answer was refused.

Conclusion

After several months, seven law firms were able to obtain a portion of the purportedly publicly available information they requested about Medicaid managed care. State agency response was fair, but nearly half of the Medicaid managed care plans never responded to the requests. If a Medicaid beneficiary encountered these obstacles when seeking information – non responsiveness, requests for payment, information provided in incomprehensible formats – it is likely that they would give up. In addition, the agencies pay MCOs hundreds of millions of dollars to provide Medicaid services to vulnerable populations. The fact that so many of these MCOs failed to respond to requests for information is disappointing. Not only does it reveal the difficulty that stakeholders would have obtaining information. It also raises questions about how seriously some MCOs take their other legal responsibilities.

APPENDIX A

[Letterhead]

VIA FAX AND REGULAR MAIL

[Health plan officer
Name of Health Plan
Address of Health Plan]

RE: Request for Information on Your Company's Medicaid Plan

Dear :

I am writing on behalf of clients who are enrolled members and potential enrollees of your Medicaid health plan. On behalf of our clients, we are requesting the following information:

1. Descriptions of any physician incentive plans which your MCO uses. This request is made pursuant to the requirements of Title 42, Code of Federal Regulations §§ 422.208, 422.210, and 438.6(h);

2. Lists of the following types of contracting providers. Please include for each provider listed, the name, location, qualifications and availability in the specific MCO, including Non-English language spoken, information on whether the provider is accepting new Medicaid patients, and any other information legally required to be provided to Medicaid beneficiaries. In addition, please provide any additional information that your company in the course of business provides enrollees or potential enrollees about physicians with which you contract. This request is made on behalf of Medicaid beneficiaries pursuant to Title 42, United States Code §§ 1396u-2(a)(5)(B), (c); Title 42, Code of Federal Regulations §§ 438.10(e)(2)(ii)(D), (f)(6)(i):

   - Pediatricians;
   - Dentists; [MO, FL, NM only]
   - Orthopedists;
   - Dermatologists;
   - Endocrinologists;
   - Psychiatrists; and
   - Neurologists.

3. For July 1, 2007 through June 30, 2008, please provide:

   (a) the total number of requests for payment for a prescription drug covered under your state contract for which you electronically approved payment at the pharmacy point of service for the prescription as written; and this total number broken down into numbers of approved requests for each therapeutic class of drug

   (b) the total number of requests for payment for a prescription drug covered under your state contract for which you electronically rejected payment at the pharmacy point of

service because the drug is not on your restricted drug list (also referred to as a "formulary" or "preferred drug list" or similar term.) Please break down this total number into numbers of rejected requests for each therapeutic class of drug

(c) of the total number of electronically rejected requests described in section (b), the percentage for which payment of the original prescription, or of a substitute drug in the same therapeutic class approved by the prescribing physician, was approved by you for payment within 24 hours after the initial payment rejection as described in section (b).

This request applies to all documents within your company's or its contractors' possession, whether in writing or in electronic form.

Thank you for your prompt attention to this request. If you have any questions about this request, you may contact me at [phone number].

Sincerely,

[your name, title, and organization]

APPENDIX B

[Letterhead]

VIA FAX AND REGULAR MAIL

[Address of State Medicaid Agency]

RE: Request for Information on MCO Performance

Dear :

I am writing to obtain information about Medicaid managed care. This request is submitted pursuant to the state public records act, [insert citation]. Please provide the following information:

1. A list of the specific Healthcare Effectiveness Data and Information Set (HEDIS) performance measures used by the state Medicaid agency to measure managed care organization (MCO) performance in 2006, 2007, 2008 and 2009.

2. Specific HEDIS performance results, as reported by each Medicaid-participating MCO for the three most recent years available.

3. The State Medicaid standards for access to care to ensure 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. This request is made pursuant to Title 42, United States Code § 1396u-2(c).

4. The current written state strategy for assessing, reviewing, and improving the quality of managed care services offered by MCOs. This includes the current state strategy related to the quality assessment and improvement procedures in place for Medicaid managed care providers and any regular reports on the implementation and effectiveness of the strategy, which must be submitted to the Centers for Medicare and Medicaid Services under Title 42, Code of Federal Regulation § 438.202.

5. The current policies, procedures and standards for obtaining prescription drugs that are not included on participating MCOs' formularies or preferred drug lists. This request is made pursuant to Title 42, Code of Federal Regulations § 438.10(e).

This request applies to all documents within your possession or control, whether in writing or in electronic form. According to the state statute, this request should be fulfilled by/within [insert time frame from your PRA]. If access to the records I am requesting is expected to take longer, please contact me so we can work out a reasonable date.

I request a waiver of all fees for this request. Disclosure of the requested information to [insert your organization's name] is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in my program's commercial interest. I am seeking to use this information to assist the public in understanding the MCO

system and the resources available to them under the federal and state regulations pertaining to the MCOs.

Thank you for your prompt attention to this request. If you have any questions about this request, you may contact me at [phone number].

Sincerely,

[your name, title, and organization]