Medicaid Managed Care 101

NHeLP Summer Internship Workshop

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NATIONAL HEALTH LAW PROGRAM

Roadmap

- What is managed care?
- Enrollment and enrollee protections
- Accessing Care
- Due process
- Accountability
- Equity Impacts

Managed Care Types

Capitated

- Limited provider network
- Capitated payment (per member/per month) for ALL covered services
- Comprehensive or limited service plans

Primary Care Case Management

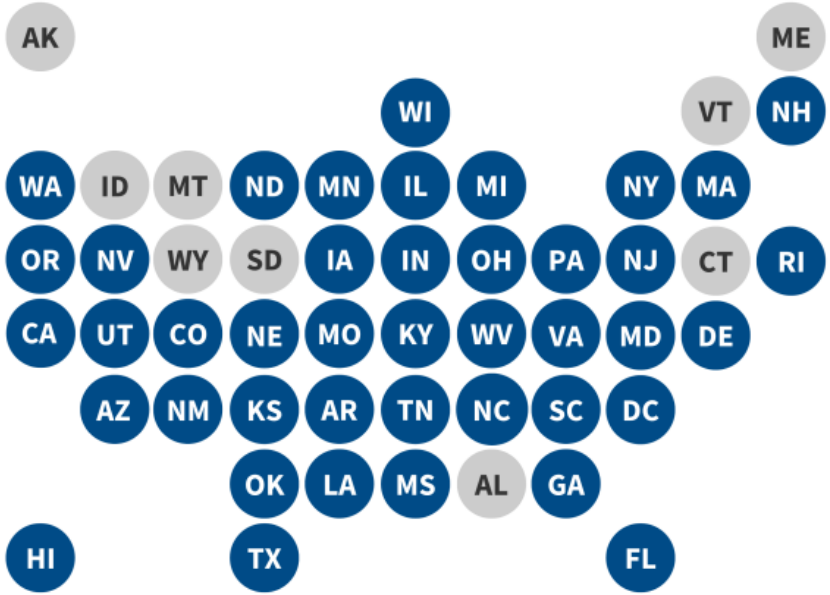
- No limited provider network
- Capitated payment for care coordination only

Managed Care by State and Type

Most States Contract with Comprehensive Medicaid Managed Care Plans

- Contracts with comprehensive managed care plans (42 states, including DC)
- Other managed care (primary care case management) or no managed care (9 states)

Source: Annual KFF survey of state Medicaid officials, Nov. 2023.



Managed Care Overview

- 82% of Medicaid beneficiaries are enrolled in managed care plans
  - 74% in comprehensive, risk based

- In 24 states/districts/territories, more than 85% are enrolled in managed care plans
  - TN, HI, NE, KS, NH, NJ, PR, VA
  - Only five states have none

Managed Care Overview

Managed Care is dominated by large insurance companies

- 14 parent firms operate MCOs in multiple states
- 5 parent firms operate MCOs in 12+ states

Managed Long Term Supports and Services (MLTSS)

Figure 1. MLTSS Programs in 2010

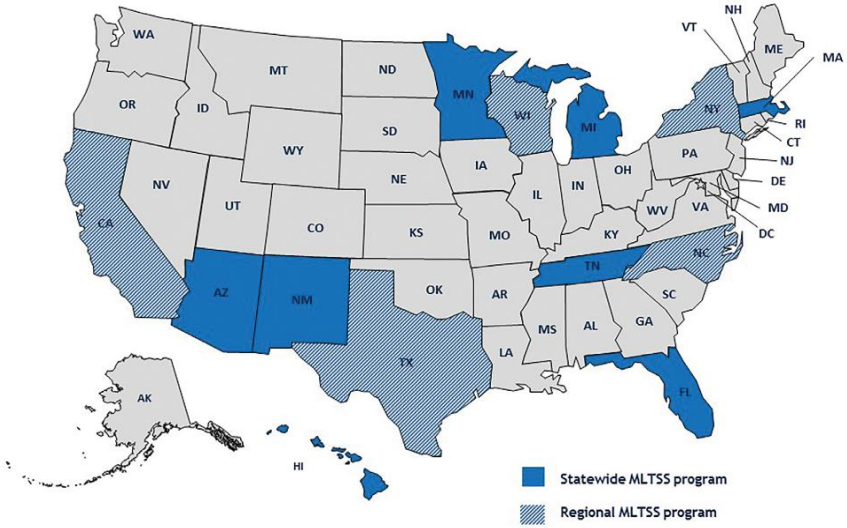
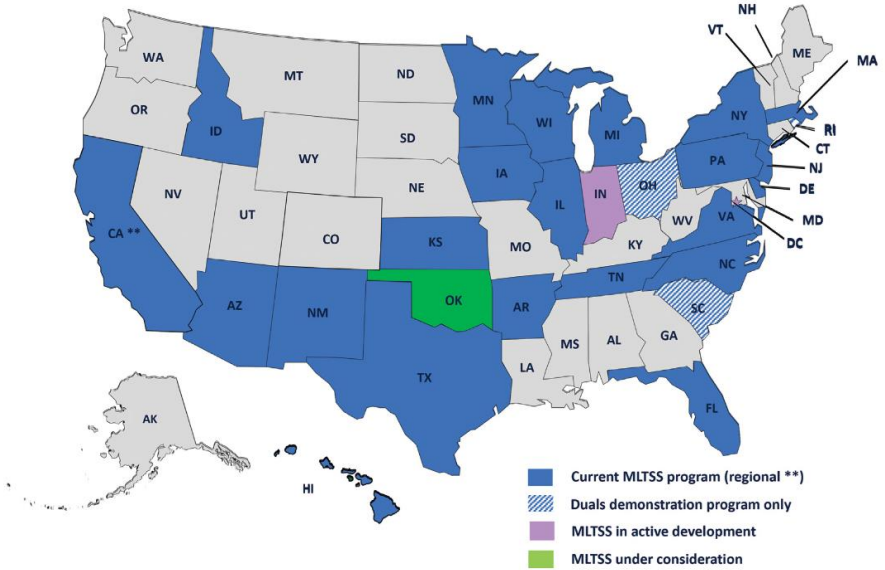


Figure 2. MLTSS Programs in 2021



Source: Advancing States: [Demonstrating the Value of Medicaid MLTSS Programs: 2021 Edition]

MLTSS (cont.)

- Managed care regulations offer added beneficiary protections for MLTSS
  - More robust Beneficiary Support System
  - Required performance measure categories
  - Enhanced care coordination
  - Required stakeholder advisory group

- Plans often have less experience with these populations
  - Can disrupt community-based provider networks

Managed Care Legal Authorities

- State plan amendment (§ 1932)
- Section 1915(b)
- Section 1115 demonstrations
  - Detailed notice and comment for approval
  - Evaluation requirements apply
- Typically more information and reporting requirements than in FFS

Enrollment and Enrollee Protections

Enrollment

- Voluntary / Mandatory / Hybrid
- When can the state enforce mandatory enrollment?
- Member supports/ recourse there are enrollment problems

Enrollee Rights and Protections

Right to:

- Adequate provider networks
- Timely access to services, including specialists
- Participate in health care decisions
- Receive information on available treatment alternatives
- Disenroll due to poor quality or lack of access
- Be treated with respect and dignity
- Be free from discrimination

Nondiscrimination

- Contracts must prohibit discrimination in enrollment, disenrollment, and re-enrollment on the basis of health status or need for health services.
- Plans must comply with the ADA, Section 504, and other civil rights laws.
- States must take into consideration the extent to which locations and equipment are physically accessible.

Information for Consumers

- Consumers have the right to receive plan information that may help them select a plan (network, cost sharing, plan benefits, quality info).
- States must share information on disenrollment options, how to obtain services, and how to file appeals and grievances.
- States must provide a beneficiary support system to do choice counseling and other assistance.

Accessible Information

- Right to written information in alternative formats
  - take into consideration special needs, e.g., visual impairment
- Right to oral interpretation in any language
- Must be informed that they can get the information in accessible formats

Accessing Care

Network Adequacy

- States and plans must ensure that there are adequate providers to make covered services available to serve the expected enrollment
  - Must develop time and distance standards
  - Phasing in maximum wait time standards for certain routine care
- Common barriers
- New final rule requires independent secret shopper analysis

Network Adequacy - Information about the Plan

- Plans must provide potential enrollees:
  - Names, locations, qualifications
  - Whether provider is accepting new patients
  - Accessibilty, languages spoken, & translation
- Notoriously poor accuracy of provider directories is focus of new final rule

Access to Care – Prior Authorization and Service Denials

In 2021, Marketplace plans denied 48.3 million claims (17%), but fewer than 91,000 (<0.2%) were challenged. Medicaid is likely similar.

- Systematic denials?
- Problems with length of authorization
- Timeliness of access
- Use of additional clinical criteria

Source: Kaiser Family Foundation, Claims Denials and Appeals in ACA Marketplace Plans in 2021

Due Process

Due Process in Managed Care

Adverse Benefit Determination includes:

- Denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit.
- Failure to adhere to timeliness standards

Appeal – review by plan or by fair hearing of an adverse benefit determination

Grievance – expression of dissatisfaction not related to an adverse benefit determination

Due Process in Managed Care

Managed care decisions require internal appeal exhaustion prior to seeking state fair hearing.

- One level only
- 30 day timeline (72 hrs if expedited)
- Written decision
- Continuation of services pending appeal available

State decisions, such as eligibility determinations, go direct to state fair hearing.

Grievances

- Filed anytime orally or in writing
- Up to 90 day timeline for resolution, unless extension granted
- Notice requirements for beneficiary
- Some grievance date reported in MC annual report

Accountability

Accountability – Goals

- Multi-method accountability systems
  - "Direct testing" vs. attestation
  - Quantitative, qualitative, feedback loops
- Prioritizing beneficiary perspectives
  - Beneficiary Advisory Council
  - Experience of care surveys
- Transparent and consistent
- Measuring health equity

Accountability – State of Play

- Quality Strategy
- Annual External Quality Review
- Managed Care Program Annual Report
- Beneficiary Advisory Groups
- Quality Rating System and website (in process)

Quality Strategy

A detailed description of state quality objectives, requirements, and activities, including:

- Details on required quality metrics and performance improvement projects
- Arrangements for EQR
- The states plan to improve health equity
- Subject to public comment, at least every 3 yrs.

External Quality Review

Independent analysis of information on quality, timeliness, and access to covered health care services for each managed care entity. Includes:

- Quality measure and PIP validation
- Network adequacy validation
- Compliance review and recommendations for improvement
- Other optional activities
- Annual publicly posted report

Managed Care Program Annual Report (MCPAR)

A one-stop shop for state, program, and plan level information on managed care, including:

- Enrollment, state standards, contracts
- Quality measures reported
- Beneficiary support system
- Info on grievances, appeals, and sanctions
- New rule requires posting within 30 days of submission

Beneficiary Advisory Groups

Various required advisory groups at the plan and state level, including:

- Medicaid Advisory Committee
- Beneficiary Advisory Council
- MLTSS Plan advisory group
- Stakeholder input on core measure sets

What's Next for Accountability?

- Required measure reporting under new rule
  - Quality Rating System
  - Experience of care surveys
  - HCBS core measures
  - Stratified reporting by race/ethnicity
- State managed care website
  - Compare performance across plans
  - Compare plan networks, cost sharing, formulary, and other plan info
  - Info on beneficiary support system

Does managed care improve equity?

Some states implementing requirements related to health equity in MCO contracts

- Screening for health related social needs
- Reporting on disparities
- Performance improvement initiatives

Research shows mixed results.

NHeLP's EQR/Accountability Resources

NHeLP's 2015 Advocates' Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care. Companion papers include:

- Medicaid External Quality Review: An Updated Overview (Nov. 2020)
- Finding and Analyzing Medicaid Quality Measures (Jan. 2021)
- Addressing Health Equity in Medicaid Managed Care Quality Oversight (May 2021)
- State quality fact sheets: Florida, Ohio
- Managed Care Sanctions: An Important Tool for Accountability (Dec. 2022)
- Secret Shopper Surveys: A Powerful Tool for Directly Testing Medicaid Managed Care Enrollees' Access to Care (Apr. 2024)

Questions?