FIELD REPORT

FamiliesUSA
The Voice for Health Care Consumers

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Medicaid Managed Care Regulations Issued: What Do They Do? Will They Be Implemented?

The Balanced Budget Act of 1997 (BBA) included the most sweeping changes to Medicaid since the program was created more than 30 years ago. Under the BBA, states gained the ability to require Medicaid beneficiaries to enroll in managed care plans without seeking federal approval through a waiver. In exchange, consumer concerns about how mandatory managed care might affect access to, and quality of care, were addressed through the enactment of substantial new beneficiary protections and quality assurance standards.

In 1998, the Health Care Financing Administration (HCFA) issued a proposed rule laying out the specific details needed to implement the BBA. Families USA and numerous other consumer groups—along with states, managed care industry groups, accreditation organizations, and others—submitted comments in December 1998. After spending two years considering all of the comments received, HCFA published a final rule in the *Federal Register* on January 19, 2001, to take effect April 19, 2001. (Provisions that are implemented through contracts between states and managed care organizations (MCOs) would not take effect until existing contracts are renewed, but not later than April 19, 2002.)

Now, the fate of this final rule is in question. On January 20, 2001, Andrew Card, Chief of Staff to President Bush, issued a memorandum delaying the effective date of any published regulations by 60 days, pending review by the Administration. Subsequently, on February 26, HCFA published a notice in the *Federal Register* stating that, pursuant to the Card memorandum, the agency was delaying the effective date of the final rule until June 18, 2001.

Medicaid advocates must mobilize to build support for the full and timely implementation of the final rule. Congress struck a careful balance in the BBA by giving states new flexibility and giving beneficiaries new protections. It is important that Medicaid beneficiaries gain the protection afforded by the reasonable and workable provisions of the final rule.

The following summarizes key provisions of the final rule:*

Mandatory Managed Care

Before the BBA, states complained vigorously that the waiver process was too protracted and contentious. The BBA lets states bypass the waiver process in order to mandate enrollment in managed care. This change lets states create mandatory managed care programs through the simpler process of submitting a State Plan Amendment to HCFA.

> ***BUT** : states cannot use the State Plan Amendment process to mandate enrollment for dual eligibles (persons who receive both Medicaid and Medicare), children under 19 with special health care needs, and, in most circumstances, Indians who are members of federally recognized tribes.*

States that choose to use the State Plan Amendment process to mandate managed care must operate an enrollment system that 1) gives priority to individuals already enrolled in the participating MCO, and 2) in the case of default enrollment, seeks to preserve existing provider-recipient relationships. Additionally, states must give beneficiaries a choice of at least two health plans, unless individuals reside in rural areas or receive care from certain county-run entities. Rural beneficiaries must be given a choice of at least two providers, and they must be permitted to go out-of-network when the MCO is unable to provide a needed, covered Medicaid service. Persons in specific county-run entities must be given a choice from at least two primary care providers.

Information

The final rule contains several new information requirements.

Language and format: States are required to establish a method for determining which non-English languages are spoken by Medicaid beneficiaries in their state and then provide written information in those languages spoken by a significant number or percentage of enrollees or potential enrollees. MCOs are required to make written information available in languages prevalent in their service areas. States are also required to make oral interpretation services available free-of-charge and to inform enrollees and potential enrollees how to obtain these services. State and MCO materials must be in a format and language that is easily understood and be available in alternative formats that take into consideration special needs, such as persons who are visually impaired or who have limited reading proficiency.

Potential enrollees: States (or their representatives) must provide potential enrollees with the following information: the basic features of managed care; which populations are excluded from enrollment; and MCO responsibilities for care coordination. Each MCO must also provide information about its specific plan, including: benefits covered; any cost-sharing; the MCO's service area; names, location, and non-English language spoken by network providers (including specialists); and where and how to obtain Medicaid benefits that are not provided by the MCO.

Enrollees: MCOs must provide enrollees, on enrollment and once a year thereafter, the following types of information: the kinds, amount, and duration of benefits provided under the MCO's contract with the state; information about enrollee rights; procedures for obtaining benefits; names, location, and non-English language spoken by network providers (including specialists); any restrictions on freedom of choice of network providers; how to obtain family planning services and other benefits from out-of-network providers; coverage for after-hours care and emergency services, including how to obtain such services; MCO policies on referrals to specialists; any cost-sharing; grievance and appeal rights; where and how to obtain Medicaid benefits that are not provided by the MCO; and information on how to receive continued services during a transition from the MCO to another MCO or into the fee-for-service system.

Information available on request: The final rule also includes specified sets of information that must be provided to enrollees and potential enrollees on request.

Marketing materials: The final rule places new parameters on permissible and impermissible marketing activities. MCOs are required to receive state approval before distributing marketing materials; any marketing materials that they distribute must be distributed to their entire service area; and MCOs are prohibited from distributing materials that are false or misleading (such as telling a potential enrollee that they must enroll to avoid losing benefits). MCOs are also prohibited from engaging in door-to-door or other cold-call marketing.

Access to Services

The final rule also contains various provisions designed to improve access to services.

Disenrollment requirements: MCOs are prohibited from disenrolling enrollees on the basis of various factors including the enrollee's health status or use of medical services. Enrollees are given a right to change plans for any reason in the first 90 days after enrollment and at least once every 12 months thereafter. Enrollees can also disenroll at any time for cause. Cause is defined in the final rule to include: people who need covered Medicaid services that are not provided by their MCO on moral or religious grounds; poor quality care; lack of access to covered services; and lack of access to experienced providers.

Continuity of care: For enrollees who are disenrolled from an MCO for any reason other than ineligibility for Medicaid, states must have in place a mechanism to ensure continued access to services for enrollees with ongoing health care needs.

Emergency services: MCOs must pay for emergency services based on the "prudent layperson" standard. This defines an emergency as a condition of sufficient severity that a person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of any organ or body part. Also, the final rule requires MCOs to pay for emergency services even when the services were provided at an out-of-network facility.

Network capacity: States must receive assurances that MCOs maintain an appropriate network and in developing this network must consider "the anticipated Medicaid enrollment, with particular attention to pregnant women, children, and persons with special health care needs." MCOs must also consider the geographic location of providers and Medicaid enrollees, whether the location provides physical access for Medicaid enrollees with disabilities, and the training and experience of providers required to provide the contracted services.

Initial screenings: States are required to identify all beneficiaries at risk of having special health care needs. MCOs must make a best effort attempt to perform an initial screening within 30 days for all enrollees identified by the state. For all persons who are determined to have special health care needs, the screening must be followed by a comprehensive health assessment within an additional 30 days. For all other enrollees, MCOs must perform an initial screening within 90 days of enrollment.

Confidentiality

States must ensure that MCOs develop procedures to: maintain medical records in a timely and accurate manner; abide by all federal and state laws (including recently issued privacy regulations resulting from the Health Insurance

Portability and Accountability Act of 1996); specify the purposes for which MCOs use personally identifiable health information; specify to whom and for what purposes the MCO discloses personally identifiable health information; enable the enrollee to request a copy of his or her own medical records and request that corrections or amendments be made; and enable the enrollee to request and receive information on how the MCO uses and discloses information that identifies the enrollee.

Enrollee Rights

States must ensure that MCO enrollees are guaranteed specific rights. These include an enrollee's right: to be treated with respect, and shown consideration for one's dignity and privacy; to receive information on available treatment options and alternatives; to participate in decisions regarding one's own health care, including the right to refuse treatment; to be free from restraints and seclusion as a means of coercion, discipline, convenience, or retaliation; and to obtain a second opinion from an appropriate qualified health care professional. Provider gag clauses are prohibited, and MCO enrollees cannot be held liable for MCO debts for covered services in instances where the state fails to pay the MCO, or for excess charges if referral services are more costly than if the services were provided directly by the MCO.

Cost-Sharing

States are permitted to charge beneficiaries the same cost-sharing that is allowed in Medicaid fee-for-service programs.

Grievance Systems

The final rule establishes a grievance system that mirrors, in most respects, the grievance system for Medicare+Choice enrollees.

Appeal rights: MCOs must have in place a system that enables enrollees to appeal denials or limited authorization of services; reduction, suspension, or termination of previously authorized services; or denials of payment for services. Enrollees must be permitted to initiate an appeal orally (which must be followed up with a written appeal). For a standard (non-expedited) appeal, the MCO must generally decide the appeal within 30 days. Individuals maintain a right to request a state fair hearing, and the Medicaid law says that the state must reach a final decision within 90 days. The 90-day clock begins when the state receives an enrollee's request for a fair hearing. The final rule permits states to require enrollees to go through an appeal before requesting a fair hearing; this is called an exhaustion requirement. If the state requires exhaustion of an appeal, then the number of days that the MCO took to reach an appeal decision must be subtracted from the 90 days.

Grievance rights: MCOs must also have in place a system that enables enrollees to express dissatisfaction with aspects of their care that is not eligible for appeal. This may include cases where enrollees are dissatisfied with the quality of care they receive. Grievances must be decided by individuals who were not previously involved in any level of review or decision-making. In cases where a grievance involves a denial of expedited resolution of an appeal or clinical issues, the decision-maker must be a health care professional with appropriate clinical expertise in treating the enrollee's condition. Grievances are not appealable or subject to a state fair hearing.

Expedited resolution: Enrollees have a right to have grievances and appeals resolved as quickly as their medical conditions require. Enrollees (or their provider) also must be given an op-

portunity to request an expedited resolution of grievances and appeals when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. In most cases, expedited grievances and appeals must be decided within 72 hours.

Continued benefits during appeal: If an enrollee or provider files a timely appeal and the issue in dispute involves the termination, suspension, or reduction of previously authorized services, then the MCO must continue providing the services if the enrollee requests it. As with fee-for-service Medicaid, if the appeal is ultimately decided against the enrollee, he or she can be held liable for the cost of those services in dispute during the appeal period.

Quality Assurance

The final rule seeks to assure quality care through a range of provisions.

Monitoring: States are required to monitor MCO activities, including at a minimum: enrollment and disenrollment operations, processing of grievances and appeals, and violations of the law.

State quality strategy: States are required to develop procedures for educating MCOs on the clinical and other needs of enrollees with special health care needs. States are also required to have a written quality assessment and performance improvement strategy that was developed with input from beneficiaries and stakeholders and that is published for public comment before being finalized. HCFA does not mandate a particular strategy, but sets minimum required elements of a state strategy. States must ensure compliance with state standards, conduct periodic reviews of the effectiveness of the strategy, and provide HCFA with a copy of the initial strategy and regular reports on the implementation and effectiveness at least every three years. Requirements of the strategy also include procedures for identifying and assessing the quality of care provided to enrollees with special health care needs and procedures for identifying the race, ethnicity, and primary language spoken by each enrollee. The state must provide this information to the MCO at the time of enrollment. The state strategy must also arrange for annual independent, external reviews of the quality outcomes, timeliness of services, and access to services covered under each MCO contract. The state is also required to have an information system that supports the implementation and ongoing operation of the state plan.

MCO quality assessment and performance improvement program: MCOs are required to achieve minimum performance levels on standardized quality assessment measures; have mechanisms to detect both under-utilization and over-utilization of services; and initiate one or more performance improvement projects each year related to specific clinical and non-clinical areas. Clinical areas include prevention and care of acute and chronic conditions, high volume conditions, high-risk services, and continuity and coordination of care. Non-clinical areas include grievances and appeals, access to and availability of services, and cultural competence. To ensure that projects cover the entire spectrum of clinical and non-clinical areas, the state must specify the distribution of projects. The state must also review, at least annually, the impact and effectiveness of the MCO's quality assessment and performance improvement program.

Practice guidelines: MCOs must adopt practice guidelines such as the *Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents*. Practice guidelines must: be based

on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of MCO enrollees; be adopted in consultation with contracting health care professionals; and be reviewed and updated periodically, as appropriate.

Adequate Payments

The final rule contains new provisions that are open for public comment. These provisions relate to actuarial soundness of payments. Members of the public were able to submit comments to HCFA—only on Section 438.6 (c)—by March 20, 2001.

In commenting on the proposed rule, states and MCOs asserted that it is impossible to ensure the full range of medically necessary services and supports are provided for especially vulnerable populations if states are constrained in making capitation payments to MCOs by existing upper payment limits that are tied to fee-for-service reimbursement rates. HCFA addressed this in the final rule by eliminating the upper payment limit restriction and adding proposed new requirements that MCO payments must be actuarially sound and appropriate for the populations covered and the services to be furnished under the MCO's contract.

Sanctions

The final rule establishes new sanctions that states may use if MCOs are not meeting the terms of their contracts.

Intermediate sanctions: States are required to establish in their contracts with MCOs the ability to impose intermediate sanctions in several circumstances, including when an MCO: fails to provide medically necessary services; imposes premiums or charges on enrollees that are in excess of those permitted under the Medicaid program; discriminates among enrollees on the basis of health status or need for health care services; or misrepresents or falsifies information. States may impose the following types of penalties: civil money penalties; appointment of temporary management of the MCO; granting to enrollees the right to terminate enrollment; suspension of new enrollment; and suspension of payment.

Contract termination: The final rule also empowers states to terminate MCO contracts if an MCO has failed to substantively meet the terms of its contract.

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* Provisions described apply to MCOs. Some, but not all, also apply to prepaid health plans (PHPs) and primary care case management systems (PCCMs).

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