Medicaid Managed Care Basics

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Medicaid Managed Care

- 69% of Medicaid population in capitated managed care (54M)
- All states but Alaska & Wyoming
- High enrollment states (>90%): AZ, CO, GA, HI, IA, MO, OK, SC,TN
- About 80% in FL

SOURCE: CMS as of 2011 (www.cms.gov)

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Managed Care Authority

- 42 U.S.C. § 1396u-2 (state plan option)
- 42 U.S.C. § 1396n(b) (managed care waivers)
- 42 U.S.C. § 1315 (demonstrations)
- 42 U.S.C. § 1396b(m) (MCO standards)
- MC regulations: 42 C.F.R. pt 438

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Demonstrations

- 42 U.S.C. § 1315 (Section 1115 of SSA)
  - "experimental, pilot, or demonstration programs"
  - "likely to assist in promoting objectives of Medicaid Act"
- Waivers of Medicaid provisions, e.g.:
  - Free choice of provider
  - Restrictions on copayments

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Problems we see in managed care

- Lack of information re: covered services and enrollment rights
- Inadequate networks
- Problems getting timely reproductive health care
- Application of private coverage standards
- Lack of timely adequate written notice
- Services not continued pending appeal
- Grievance resolution can take months

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Managed Care Terminology

- MCO
- PIHP – Prepaid inpatient health plan
- PAHP – Prepaid ambulatory health plan
- PCCM – Primary Care Case Manager
- In-network (plan) vs. Out-of-network (plan)
- Contracts/RFPs

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Managed Care Terminology

- Capitation
- Risk sharing (full or partial risk)
- Provider incentives: withholds, bonuses
- Grievance/Appeal
- Mandatory vs. Voluntary
- Enrollment, Disenrollment
- Carve out (populations, services)

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Enrollee Rights

- Contracts must prohibit discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and re-enrollment.

42 U.S.C. § 1396b(m)(2)(A)(V); 42 C.F.R. § 438.700(b)(6).

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Enrollee Rights

- Disenrollment rights, 42 C.F.R. § 438.56
  Right to disenroll (voluntary/involuntary)
    - For cause at any time
    - During first 90 days of enrollment
    - At least once every 12 months
    - Must specify methods and procedures

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Disenrollment

CAUSE:
- Enrollee moves
- Plan does not cover services for moral/religious reasons
- Enrollee needs related service that's not covered
- Others reasons, including poor quality of care, lack of access/providers

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Long Term Services and Supports

- More states using managed care delivery systems to provide LTSS to seniors and people with disabilities
- 25 states cover LTSS through capitated managed care, 2 through managed fee-for-service
  - That's up from 8 in 2004

Source: MACPAC

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Adequacy of Services/Networks

- MCOs/PHPs must make covered services available to the same extent as to non-enrolled recipients.
- MCOs/PHPs must assure that they have adequate capacity to serve expected enrollment, including services and providers.
- PCCM contracts must provide for arrangements/referrals to sufficient numbers of providers to ensue prompt service delivery.

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Medicaid Due Process: Legal Authority

- 14th Amd., U.S. Const.
- 42 U.S.C. § 1396a(a)(3)
- 42 C.F.R. pts. 431, 438 pt E (MC)
- Contracts (MC)

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What triggers right to hearing

- Denial of application for benefits/failure to act with reasonable promptness
- Agency has taken an action erroneously
- Reduction, suspension, termination of service
- PASRR, transfer or discharge from NF
    - 42 C.F.R. § 431.220, U.S. Const. 14th Amendment

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Right to Appeal, cont'd

- "Action" of MCO:
    - Denying, reducing, terminating or otherwise limiting services or denying payment for services
    - Failing to timely provide services
    - Denying request for disenrollment or exemption
    - "otherwise adversely affecting the individual"

      42 C.F.R. §§ 438.400(b), 410(f)

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What triggers right to appeal

- BUT NOT: if *sole* issue is federal or state law requiring automatic change
  - 42 C.F.R. § 431.220
- BUT: may have a hearing if there is a valid factual dispute
  - *Washington v. DeBeaugrine* (N.D. Fla.)
  - *Rosen v. Goetz* (6th Cir.)

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Requirements for written notice

- Describe action taken, factual basis for action, legal basis for action
- Notice re: continued benefits
- Info on fair hearing & time frames
- Right to representation
- When expedited hearing is available
- Right to continued benefits

42 C.F.R. §§ 431.210, 438.404.

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Grievance

- An expression of dissatisfaction about any matter other than an action
  42 C.F.R. § 438.400(b)

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Continued Benefits

- Must continue pending final hearing decision if hearing is requested w/in 10 days of action
  - When MCO appeal taken and beneficiary loses, must again request services continue pending fair hearing decision
  - Beneficiary can be required to pay for benefits if he ultimately loses
    42 C.F.R. §§ 431.230, 438.420(d)
  - ISSUE – no continued benefits beyond authorization period. *Id.* § 438.420(b)(4) (Proposed rules try to fix this)

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Exhaustion of MCO Appeal

- May be required by state Medicaid agency
  42 C.F.R. § 438.408(f)
  Proposed rules would make exhaustion mandatory.

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Accountability and Data

- Requirements for making information available:
  - External independent quality reviews
  - Healthcare Effectiveness Data and Information Set (HEDIS)
    - e.g., http://hrsa.dshs.wa.gov/healthyoptions/newho/reports/reports.htm
  - Physician incentives
  - SEC information - http://www.sec.gov/edgar.shtml

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THANK YOU

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