MEDICAID MANAGED CARE

Advocacy Action Guide for AAP Chapters

Overview

- The final Medicaid managed care rule was released by the Centers for Medicare and Medicaid Services (CMS) on April 25, 2016. It is the first major overhaul of Medicaid and Children’s Health Insurance Program (CHIP) managed care regulations in over 10 years.

- The rule focuses on alignment with Medicare and private marketplace plans, delivery system reform, beneficiary protections, modernizing regulatory requirements, and improving the quality of care.

- There are various components of the rule that will impact different types of managed care entities: managed care organizations (MCO), Primary Care Case Management (PCCM), Primary Care Case Management entity (PCCM entity), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP).

Why does this matter to the AAP and AAP chapters?

- Almost 9 out of every 10 children in Medicaid or CHIP are enrolled through managed care arrangements, with 48 states having some form of managed care in place.

- MCOs are the most common Medicaid delivery system, with 39 states using them to cover some or all of their Medicaid populations, including children and their families. Thirty-two (32) of those 39 states covered 75 percent or more children through managed care in 2015.

- Thirty (30) of the 37 states with stand-alone CHIP programs also rely on MCOs, PCCMs, or PCCM entities to deliver care. Eighty percent (80%) of all children in CHIP stand-alone programs are covered through managed care.

- State Medicaid programs and Medicaid managed care plans will have to come into compliance with the standards created by the Medicaid managed care rule. This creates an opportunity for AAP chapters to advocate that changes meet the needs of children and the practice of pediatrics.

- This analysis provides background and guidance on the rule’s major provisions.
Enrollment

- The final rule sets basic standards for enrollment in both voluntary (when beneficiaries have the option to receive benefits through either a managed care or fee-for-service (FFS) program) and mandatory (when beneficiaries are required to enroll in a managed care plan) managed care programs.

- In voluntary Medicaid managed care plans, states are required to provide enrollees the chance to either actively choose to receive benefits through either managed care or FFS. States can either provide a passive enrollment process or a choice period while providing FFS benefits.
  - Enrollment choice period—during this period of time, enrollees would actively choose a delivery system, plan, or provider. If a choice of delivery system is not actively made, benefits would continue to be provided through the FFS plan.
  - Passive enrollment system—states would enroll beneficiaries into a specific plan or provider while also providing an enrollment choice period. During this choice period, enrollees can either accept the plan to which they were assigned or choose a different plan or provider, or choose to receive benefits through the FFS plan.

- In mandatory Medicaid managed care plans, beneficiaries do not have the choice to receive benefits through an FFS delivery system. However, there will still be either an enrollment choice period before an enrollee is auto assigned to a plan or a passive enrollment system in which enrollees are assigned to a plan and they can either accept that assignment or choose a different plan.

- The final rule does not require a set time period that states must allow for enrollees to make these decisions.

- Enrollees may disenroll from a plan with cause at any time, due to things such as moving out of a plan’s service area or lack of access to services covered under the plan. To disenroll from a plan without cause, beneficiaries must do so in the first 90 days of their initial enrollment or at least once every 12 months.

- The final rule also contains provisions around consumer information, such as content, timeliness standards and delivery methods for consumer notices. The rule includes requirements that information for enrollees and potential enrollees be provided in a manner that is easily understood and readily accessible, and available in the prevalent non-English languages in the state.

ADVOCACY ACTIONS

☑️ AAP chapters can advocate for an enrollment choice time frame that is reasonable for enrollees to understand their choices and make decisions. A 14-day time frame would provide enrollees with sufficient time to choose a plan.

☑️ The final rule sets a floor for rules around disenrollment. Chapters can advocate for a comprehensive list of causes for disenrollment, such as poor quality of care or lack of providers experienced in an enrollee’s needs.
Beneficiary Support System

- Under the final Medicaid managed care rule, each state must develop a beneficiary support system (BSS), which will serve to help consumers choose their managed care plan beginning July 1, 2018.

- The BSS is required to perform beneficiary outreach and must be accessible in-person, by phone, and online. The role of the BSS is to ensure enrollees understand the managed care system and assist enrollees in choosing a managed care plan that works best for them.

- Conflict of interest standards that are required of enrollment brokers are also required of BSS choice counseling.

- There are additional BSS requirements for beneficiaries who wish to use long-term services and supports (LTSS), which are not required for other beneficiaries. LTSS provide assistance with activities of daily living and can include both institutional and community based services such as home health aide or personal care services. LTSS can apply to children with special health care needs. For these beneficiaries, the BSS also:
  - Serves as a place to report complaints and coverage issues;
  - Educates and provides assistance on grievance and appeal procedures and rights;
  - Can offer referrals for legal representation for appeals;
  - Reviews the LTSS program and complaint data to help with solving widespread issues.

ADVOCACY ACTIONS

- AAP chapters can work with the state and stakeholders in the development of beneficiary support systems to ensure they are developed in a manner that supports children and their families.
- Chapters can also advocate that the requirements for LTSS beneficiary support systems are in place for all beneficiaries.
Network Adequacy

- The final rule works to improve access to care by implementing network adequacy requirements for Medicaid and CHIP managed care plans.

- Under these requirements, managed care plans must have a sufficient network of providers in order to serve all enrollees, including those with limited English proficiency and physical or mental disabilities.

- States are required to establish and make publically available time and distance standards for the following providers, if services they provide are covered under a Medicaid or CHIP managed care plan:
  - pediatric and adult primary and specialty care;
  - pediatric and adult behavioral health (including mental health and substance use disorder);
  - OB/GYN;
  - pediatric dental;
  - hospital;
  - pharmacy; and
  - Long-term services and supports (LTSS)

- Plans are required to provide out-of-network care for emergency services if the existing network cannot provide timely emergency care.

- The final rule also requires states to determine if plans are complying with network adequacy and access standards.

ADVOCACY ACTIONS

✓ These network adequacy provisions represent a floor for compliance, but chapters can advocate for additional rules on time and distance standards, provider to patient ratios, and other objective measures.

✓ The AAP Network Adequacy Advocacy Action Guide offers specific policy guidance that could be implemented in Medicaid and CHIP managed care plans.
Access to Out-of-Network Care

- The final rule requires capitated plans (plans with fixed per-member-per-month (PMPM) payments to providers) to provide access to all covered services in a timely manner, which also includes access to out-of-network physicians and nonphysician practitioners if none are available to provide a given service in a plan’s network.

- States are required to ensure that plans provide out-of-network emergency care with no prior authorization.

- Plans must ensure that, in instances when authorized out-of-network care is provided, patients are not required to pay higher cost-sharing than if the service was provided in network.

- The rule requires that states ensure enrollees be allowed to continue seeing their existing physician or nonphysician practitioner during specific transition periods:
  - When patients move from a Medicaid fee-for-service plan to a managed care plan;
  - When a patient changes plans; or
  - If there is a risk of hospitalization or institutionalization due to a lack of continuity of care.

- States are given flexibility to determine how long enrollees can see their current physician or nonphysician practitioner who are out-of-network.

ADVOCACY ACTIONS

☑ Chapters can advocate that patients have access to their current pediatrician or pediatric subspecialist for ongoing or scheduled treatments or procedures, even when they become out-of-network.

☑ States can also be urged to expand the list of events that qualify for a transition period, such as when a patient moves from a marketplace to a Medicaid managed care plan.
Provider Directories

- Managed care plans are required to make provider directories available in both electronic and print formats. Electronic directories are required to be updated no later than 30 days after a plan received updated provider information, while paper directories must be updated monthly.

- Physician information that must be included in a provider directory includes:
  - Physician’s name and any group affiliation;
  - Street address(es);
  - Telephone number(s);
  - Web site (if available);
  - Specialty (if applicable);
  - If the provider is accepting new patients;
  - The cultural and linguistic capabilities offered by the physician’s office or a skilled medical interpreter at the office, and whether cultural competence training has been completed; and
  - If the office has accommodations for individuals with physical disabilities.

- In instances when an enrollee relies on an incorrect directory, the final rule “encourages”—but does not require—that patients be held harmless for additional expenses that may result, and treat visits as if the provider was in network.

ADVOCACY ACTIONS

- Chapters can work with other stakeholders to identify additional information to be included in directories that may be needed for children and families, and advocate for this inclusion with the state.

- The provision regarding incorrect or inaccurate directories does not preclude a state from requiring that Medicaid enrollees be held harmless in such instances when care is provided by an out of network provider inaccurately described as in network.

- Chapters can encourage states and/or regulators to allow families to be held harmless for potentially unaffordable medical bills incurred through no fault of their own.
Grievances and Appeals

- All MCOs, PIHPs, and PAHPs are required to have grievance procedures in place for all enrollees. The process allows patients or their families to express issues—such as being treated poorly or disputes over how long it takes the plan to make an authorization determination—but grievances do not address adverse benefit determinations.

- Grievances can be filed either verbally or in writing, and reported at any time. States will determine if grievances will be filed with either the plan or the state.

- Every MCO, PIHP, and PAHP must also have an appeals process in place for enrollees to challenge an adverse benefit decision. Under the final rule there can only be 1 level of appeal. After that appeal is exhausted, a state fair hearing may be requested by the enrollee.

- All appeals must be filed within 60 days of the adverse decision notice from the managed care plan. The appeal may be filed either verbally or in writing, including an online filing. All appeals filed orally must be followed by a written appeal, unless an expedited appeal is requested.

- All Medicaid managed care enrollees are required to receive “timely and adequate” notice of an adverse benefit determination. The notice must explain things such as:
  - The reason for the determination and how to obtain, upon request, reasonable access to all documents and records relevant to the determination;
  - The right to request an appeal and the process for exercising that appeal;
  - The circumstances under which an expedited appeal may be requested; and
  - The right of the enrollee to continue receiving benefits while an appeal is pending and the circumstances under which the enrollee may be required to pay the cost of those services.

ADVOCACY ACTIONS

☑ Chapters can work to ensure that families in Medicaid managed care plans know their rights to file grievances and appeals, and educate them as to what information may be needed during those processes.

☑ Chapters can also advocate that appeals be reviewed by a pediatrician, pediatric medical subspecialist, or surgical specialist in cases involving children.
Quality Rating System

- The final rule also creates a Quality Rating System (QRS) for each capitated Medicaid managed care plan contracted by the state. This system will be modeled on existing rating systems for marketplace and Medicare Advantage plans.

- The QRS will provide performance information on all capitated managed care plans and help states to contract with plans that provide higher-value care.

- As the QRS will be based on both the marketplace and Medicare Advantage quality rating systems, it will be important that they be adjusted to accommodate Medicaid specific populations, especially children.

- CMS will use a public engagement process, including multiple stakeholder sessions while developing the Medicaid QRS.

- States can also develop their own Medicaid QRS, which would need to be “substantially comparable” to the CMS developed QRS and require CMS approval.

ADVOCACY ACTIONS

☑️ Development of the QRS will largely be driven at the federal level—the AAP will be advocating that this QRS appropriately reflect the needs of children and pediatrics. However, there will be opportunities for chapters to provide feedback at the federal level on the QRS and work to ensure that there are sufficient quality measures for pediatrics.

☑️ In states that choose to develop their own QRS, chapters will have opportunities to comment and provide feedback on those proposed systems.
Medical Loss Ratio

- The Medicaid managed care final rule requires that Medicaid and Children’s Health Insurance Program (CHIP) managed care plans calculate and report a Medical Loss Ratio (MLR) of at least 85% beginning on July 1, 2017.

- Unlike Affordable Care Act (ACA) requirements for private plans, there is no requirement for Medicaid and CHIP managed care plans to provide rebates to enrollees if the standard is not met. However, if a managed care plan fails to meet the MLR target, a state Medicaid program must take that into account in setting subsequent capitation rates.

ADVOCACY ACTIONS

✔ Chapters can encourage the state to require plans to provide rebates, as is required for private plans under the ACA, if the MLR requirements are not met. States could put those funds back into the program and perhaps increase payment rates.

✔ Chapters can also monitor plan’s required state filings to ensure that MLR requirements are being met and encourage states to bring plans not meeting the standard into compliance.

Additional Resources

- Medicaid.gov: Medicaid Managed Care
- Kaiser Family Foundation: Medicaid Managed Care Market Tracker
- AAP Department of Federal Affairs: Medicaid Managed Care Final Rule Summary
- AAP Division of State Government Affairs