NHeLP
NATIONAL HEALTH LAW PROGRAM

Medicaid Managed Care: 20 Questions to Ask Your State

April 2012 update

This memo lists 20 questions to ask as your state develops Medicaid managed care.

1. **Is the state seeking a waiver that requires beneficiaries to enroll in managed care?**

The trend is definitely toward mandatory enrollment. If enrollment is going to be mandatory, has the state submitted a waiver request to the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)? If so, what federal Medicaid laws does the state plan to waive? Does the waiver require approval by the state legislature?

2. **What type of managed care waiver is the state seeking?**

If the state is seeking a section 1915(b) waiver, what specific provisions of the Medicaid Act does the state seek to waive and why? If the state is seeking a 1115 waiver, what sorts of beneficiary cost sharing will be required - deductibles, co-insurance or copayments?

3. **How do I find out about the state's plans**?

- Call the state Medicaid agency for information.
- Contact local providers to find out what they know.
- Contact the CMS Regional Office and speak with the person who has been assigned responsibility for your state's waiver.
- Attend public meetings about Medicaid managed care.
- Obtain a copy of the waiver and other public documents dealing with managed care, including the state's model health plan/provider contracts and requests for proposal.
- Ask the state Medicaid agency to provide you with drafts of these documents.

NOTE: if there is a problem obtaining these materials, file a public records act/Freedom of Information Act request. For instructions on how to file this request, see Jane Perkins, Obtaining Information from HHS, 22 CLEARINGHOUSE REV. 1401 (April 1989). Contact Jane Perkins or Sarah Somers at (919) 968-6308 at NHeLP. We can provide you with names of state and federal contact persons and help you review and comment on developments.

4. **What population groups will be included in the system?**

Medicaid waivers traditionally have been used to enroll women and children in managed care. Other populations have been "carved out," that is, exempted from mandatory enrollment. The most common grounds for exemption have been: participation in the program children with special health care needs, medically needy spend-down status, nursing home residency, dual-eligibles (Medicare/Medicaid), children in foster care

placement, who have developmental disabilities, behavioral health needs, and psychiatric hospitalizations. Recently, states have begun to include many of these groups in managed care for primary care services, particularly persons with disabilities, children in foster care, and persons with behavioral health needs. Some states are developing separate managed care programs for behavioral health.

What is the impact of the system on Native Americans who receive services through the IHS and Medicaid beneficiaries (such as SSI recipients) who will not be required to enroll in the program? If the state is seeking an 1115 waiver, how will the state distinguish between populations eligible only because of the 1115 expansion versus populations eligible without the waiver?

5. **What types of providers are being included?**

Is the plan limited to prepaid health plans that meet the requirements of 42 U.S.C. 1396b(m)?

Are there special provisions/protections for safety-net providers, such as community health clinics, public health departments, and school-based health clinics? Are there protocols for referral and treatment between the managed care providers and these "safety net" sites?

Will participating plans use the same panel of providers and provider sites for Medicaid as they do for their privately insured customers?

Will there be competitive bidding? Will there be a request for proposal (RFP) process for potential managed care contractors to submit bids? Has the state addressed the possibility that plans will engage in predatory pricing, bidding under cost, in order to win a contract? (NHeLP has additional memoranda on predatory pricing).

6. **How will providers be paid?**

Is the state going to use fee-for-service reimbursement with a case management fee (such as $3.00 per month per enrollee) or will providers receive pre-set, capitated payments? The trend is decidedly toward the latter. If the state is using capitated payments, will the system be "fully capitated" - include all services in the capitation rate (including in-patient) - or "partially capitated" - include a set of services in the capitation rate? If plans are partially capitated, what services are excluded from the rate? Will the state continue to provide transportation and appointment scheduling assistance to children needing services not included within the capitation rate? What sort of data has the state developed to establish that the capitation rates are adequate?

7. **What type of solvency/financial risk arrangements are being used?**

Do health plans have to meet the licensing requirements of the state department of insurance? Do they have to meet licensing requirements of the state department of corporations?

Will the state monitor the plans' physician incentive plans? If physicians are going to be placed at substantial financial risk, will the state require plans to conduct periodic surveys of enrollees to determine the degree of access and satisfaction with the quality of services?

Are there limits on administrative costs (which include profits)? This is also known as the "medical loss ratio" (MLR).

8. **How does the state assure adequate access to primary and specialty care providers?**

What is the actual source of the data supporting the state's claims of adequate provider participation? Does the state have letters of intent from physicians? How do the data measure the actual (and ongoing) availability of providers to accept patients? What information or standards are there regarding the location of providers, the ability of participating providers to care for "special needs" patients, and the manner in which medically indicated existing care arrangements will be maintained? Will pediatricians, gynecologists, and obstetricians be available as primary care providers?

What are the exact plans for ensuring that specialty services will be available? Are there adequate numbers of pediatric specialists? Are provider specialists chosen and listed according to board certification as opposed to their own self-designation?

What sorts of patient-to-provider ratios are being used for primary care doctors, physician extenders, and specialists? Will the state allow managed care plans to place quotas on the numbers of Medicaid beneficiaries they will enroll? If so, has the state described how it will assure that access will not become impaired if certain plans reach their quotas early on, thus reducing the choices available to the remaining beneficiaries?

What arrangements will the state, plans, and providers have to make to assure that information and services are accessible to persons with limited English proficiency? Are there any indications that minority providers will be included as contractors? Will managed care plans be prohibited from engaging in red-lining?

How will participating primary care doctors be trained to recognize referral needs?

9. **Are there standards for accessibility, coverage and appointment scheduling?**

Are there quantitative time/distance travel standards? Are there time standards for scheduling emergency, urgent, and routine visits? Are there time standards for waiting on-site to see the provider? Are these standards broken out by primary care, specialty, inpatient, dental, mental health, and pharmaceutical provider?

Are there guidelines for satisfactory phone-response systems, minimum office hours, prohibitions against practices such as "batch" or "block" appointment scheduling?

Who will make prior authorization decisions? What will their medical training be? Will there be time frames for making prior authorization decisions? Will these frames vary, depending on whether there is an urgent or routine health care need?

10. **How will beneficiaries' choice of providers be limited?**

How many plans will beneficiaries have to choose from? Will beneficiaries be locked into a plan for a set period of time (for example, six months)?

What is the process for disenrollment? How is "good cause" for disenrolling defined? Are there time frames for re-enrolling beneficiaries with another provider? Will the state guarantee enrollment for six months regardless of change in income/eligibility?

11. **How does the state define an "emergency"?**

Has the state used the federal Medicare anti-dumping provision definition of an emergency (42 U.S.C. § 1395dd) or is the definition more restrictive? [The Medicare definition includes the onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain and pregnancy-related conditions, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the mental or physical health of the individual or impairment of bodily functions.]

12. **What is the process for marketing and education about the program?**

Who will have responsibility for marketing and education - as the plan is implemented and on an ongoing basis?

Will applicants and enrollees receive written information about managed care and health plan choices? Will this material be subject o pre-testing and/or pre-clearance by the state?

Will there be an impartial enrollment manager? How will this manager be chosen? Will this manager work on enrollment quotas?

Will door-to-door marketing by health plans be allowed? Will financial incentives (i.e. cash gifts, food, gift certificates, diapers) be allowed? Will marketers be paid on commission?

Will toll-free enrollment assistance lines be established? What is the time frame for making an enrollment choice? Will marketing and enrollment be included in consumer satisfaction surveys? Will marketing materials and personnel be available in other languages?

Will the state use automatic assignment ("auto-assignment" or "default enrollment") to enroll people who do not choose a plan? How does auto-assignment work? Will auto-assignment direct enrollees to the low-bid plan? Will auto-assignment account for the enrollees' location, special health needs, language needs, prior relationships with providers, and provider capacity? What percentage of enrollees does the state plan to auto-assign (a high number indicates inadequate beneficiary education)?

Are marketing and enrollment sites and methods accessible to persons with chronic disabilities or conditions? Do enrollment materials include names/locations of primary care providers and specialists? Do enrollment materials discuss transportation to/from plans?

Will it be clear to the beneficiary when they are enrolled and what enrollment in a managed care plan means about seeking health care?

13. **Is the scope of benefits clearly defined?**

Do the waiver and contracts spell out the scope of benefits? IS case management included and defined? Is Early and Periodic Screening Diagnosis and Treatment (EPSDT) included and defined? Are transportation services covered? Will benefits include services covered under a home and community based waiver, and if so, will these services be available in the same amount, duration, and scope as under the home and community based waiver?

Does the state define standards for "medical necessity" and "usual and customary" that will apply to all plans? For children will the EPSDT definition of medical necessity apply to all plans? Is there discussion of use of drug formularies (individual plan formularies versus Medicaid coverage requirements)?

Can participating providers subcontract with other providers for services? If so, are subcontractors held to the same quality, accessibility, and reporting standards as contracting providers?

14. **Will the program be coordinated with other programs that serve Medicaid beneficiaries?**

How is the inter-relationship with the WIC, Head Start, Food Stamp, and Part B and Part H of the Individuals with Disabilities Act Programs handled? Does the program continue to allow beneficiaries a free choice of family planning services (required in 1915(b) waivers)?

15**. How will grievances and fair hearings be handled?**

Is the in-plan and out-of-plan grievance process explained clearly? Does the state want to require in-plan grievances to be exhausted prior to appeal to the state agency? Do informal and formal in-plan grievance processes occur promptly so that the federal rules for hearing decisions are met (42 C.F.R. §§ 431.200-250)?

Must all grievances and complaints be logged, including those informally resolved? Will the state agency regularly collect and review grievance data? Are these data to be public record?

Are there time frames for resolving grievances, especially those relating to service denials? Is there a process for expedited review of emergency/urgent care disputes?

Does the state prohibit plans from using the filing of a grievance as a basis for "good cause" disenrollment?

Will the grievance and appeal systems be well-publicized? Are there written materials that will explain the grievance process? Do these materials notify enrollees who they can contact for help (e.g. legal services)? Do these materials notify the enrollees that they have a right to notice, fair hearing, and aid paid pending the resolution of the appeal?

Does the program include a provision for second opinions at the plan's expense (as in the Medicare program for surgery)?

Will an independent ombudsprogram be used?

16. **What types of quality measures will be used?**

Are federal quality-assurance requirements addressed, that is: internal quality-assurance plans at the plan level; annual state audits; annual independent external reviews; periodic surveys of enrollees in plans where physicians are placed at substantial financial risk (see 42 U.S.C. 1396b(m); 42 C.F.R. pt. 438)?

Will health plans providing or arranging comprehensive services be required to meet the standards for accreditation of the National Committee for Quality Assurance?

Given the on-again, off-again nature of Medicaid eligibility, what steps will the state take to assure Medicaid quality? What sorts of input measures will plans be required to report (e.g. immunizations, ambulatory-sensitive hospital admissions, travel distance and time; race-based utilization data)? Will the state use performance outcome measures, such the Healthcare Effectiveness Data and Information Set (HEDIS)?

What are the credentialing and screening requirements for participating providers (contractors and subcontractors)? Will anyone at the health plan be responsible for quality assurance and monitoring?

Is it clear to participating plans and providers that information about quality assurance and plan performance will not be subject to privilege, such as a trade secret privilege?

Will there be toll-free liens that beneficiaries can use to register complaints with the state agency?

17. **What types of monitoring and enforcement are envisioned by the program?**

What sorts of data will plans be required to report? Will plans be required to collect and report encounter data? Will plans be required specifically to gather data regarding EPSDT compliance?

Will monitoring be multifaceted, include internal and external monitoring of access and provider panel standards and uniform quality-assurance measures?

Will there be consumer satisfaction surveys? Will there be provider satisfaction surveys? Will enrolled providers be surveyed? How often will these surveys occur? Will these surveys be of public record?

Will plans be required to develop corrective action plans when there is a problem? Will plans be sanctioned for repeated bad audits?

18. **Is consumer involvement anticipated?**

Is there a consumer advisory committee? If so, who is on it? Does the committee represent only the interests of consumers?

Are consumer comments on drafts of documents being solicited? Will in-person meetings with advocates be held?

Are education and outreach materials and enrollment handbooks being developed for use prior to first enrollment? Are these materials being pre-tested on consumer users?

Will there be public hearings moderated by a neutral third party?

19. **Is the state ready for this program?**

What is the state's past track record with managed care? How quickly is actual enrollment to begin? How has the state projected growth rates for the beneficiary population?

How many full-time employees (FTEs) will be devoted to monitoring and enforcement? Has the state developed, tested, and affirmed the computer capability to handle a mandatory, capitated managed care program?

Has the state complied with requirements of its administrative procedure act for notice and public comment on rules of general applicability?

20. **Does the program address cultural and linguistic needs?**

Has there been an assessment of the community's language/cultural needs?

Are marketing materials and information available in languages other than English? Are bilingual personnel available to answer questions and help resolve problems? Will contracting plans have to meet language accessibility requirements in membership services, health care personnel, appointment and health advice lines, grievance procedures? Do contractors have plans to recruit qualified, culturally appropriate providers?

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