

Addressing Challenges in Accessing Medicaid Managed Care

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About the National Health Law Program

- National non-profit law firm committed to improving health care access, equity, and quality for underserved individuals and families
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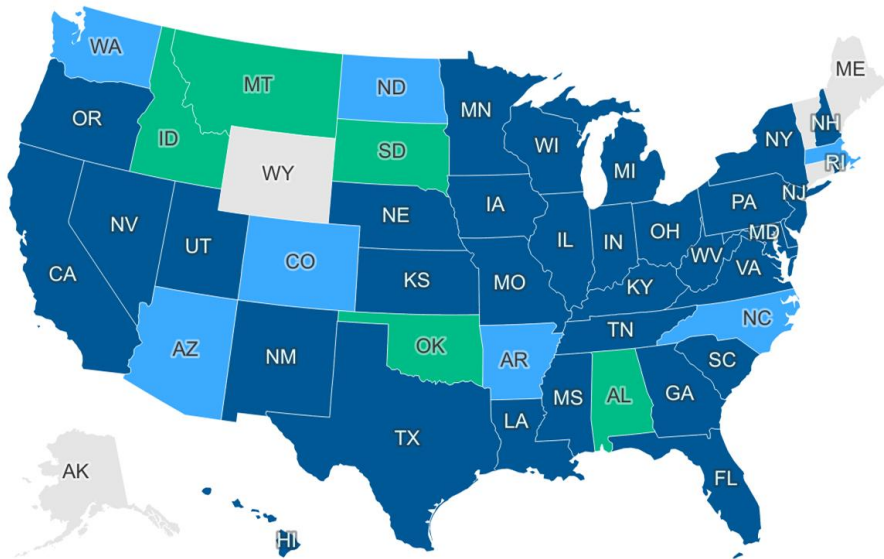
Today's Agenda

- Managed Care Overview
- Addressing Common Managed Care Problems
- Accountability

Managed Care Overview

Managed Care Overview

■ MCO only (34 states including DC) ■ MCO and PCCM (7 states) ■ PCCM only (5 states)
■ No comprehensive MMC (5 states)



NOTE: ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare. Publicly available data used to verify status of states that did not respond to the 2022 survey (AR and GA). DC is included in count of states with MCO only. CT and SC use PCCMs but are not counted here as such.

SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022

KFF

Managed Care Overview

- 82% of Medicaid beneficiaries are enrolled in managed care plans
 - 72% in comprehensive, risk based (capitated)
- Payments to MCOs accounted for 52% of all Medicaid spending

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

Network Adequacy

- States must ensure that there are adequate providers to make covered services available to serve the expected enrollment
 - Time and distance standards for certain providers, including LTSS
- To enroll tribal members, must ensure there are sufficient Indian Health Care Programs (e.g., IHS, other program operated by the tribe)
- Common barriers

Network Adequacy - Plan Info

- Plans must provide potential enrollees:
 - Names, locations, qualifications
 - Languages spoken by providers
 - Interpretation and translation services
 - Whether provider is accepting new patients
- NC managed care transition experience

Addressing Common Managed Care Problems

Challenging Compliance Issues

Common Advocacy Areas:

- Due Process
 - Notices
 - Prior authorization procedures
 - Assessment tools
 - Secretive guidelines
- Reasonable Promptness
- EPSDT

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

- Required internal appeal

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

Due Process

Goldberg v. Kelly, 42 C.F.R. 438.400

- Note: Continued benefits prior auth wrinkle

Notices Issues:

- Failure to provide adequate explanation
- Timing, including mailing issues
- Failure to provide appeal rights

Due Process Decisions of Interest

- *Bellin v. Zucker*, 6 F.4th 463 (2nd Cir. 2021)
 - Potential enrollee did not have right to appeal initial hours determination
 - NY design and subsequent litigation
- *Cassidy v. Zucker*, 2021 WL 4472592 (2021)
 - Distinguishes Bellin for plan to plan transfer reductions

Prior Authorization

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

Source: Kaiser Family Foundation, [Claims Denials and Appeals in ACA Marketplace Plans in 2021](#)

Prior Authorization

Assessments, mystery standards, and ascertainability

- *K.W. v. Armstrong*
 - Not managed care, but helpful on these issues
 - Also, *Waldrop v. New Mexico*; *L.S. v. Wos*
 - Watch: *JR v. Horizon* (NJ Appeal)
- Must explain the decision/rationale

EPSDT

Requires that children receive all medically necessary services to correct or ameliorate their conditions

- Few exceptions

Common Issues:

- Failure to apply EPSDT in PA denials
- Medical necessity criteria
- Restrictive criteria
- Reliance on parents

Other Cases of Interest

- *St. Anthony Hospital v. Eagleson* (7th Cir.)
- *Graham v. BCBS of NM*
 - *But see Park v. Hawaii*
- *Waskul v. Washtenaw County Cmty Mental Health* (6th Cir.)
 - *Wiesner v. Washtenaw*, Mich. App., 968 N.W.2d 629 (2022) (budget must meet IPOS; PHP could not appeal)
- *Fitzmorris v. Weaver* (NH)

Administrative Interest

- [OIG report prior auth denials](#)
 - Attention on Medicare Advantage too
- Pallone & Wyden letters of investigation
- [OIG report on MLR](#) (2022)
- Forthcoming MACPAC report and recommendations
- Proposed rules

Making Managed Care Work

- Identification of common problems
- Collaborative advocacy

Also...

- Beneficiary Support Systems→Ombudsman
 - NC & NY; CA

Accountability

Accountability

Effective oversight – a PATH to enforcement:

Probing

Accessible

Timely

Heterogeneous

Probing

Trust...but verify

- Direct testing of compliance
 - Secret shopper
 - Test samples of prior authorizations, encounter data, etc.
 - Site visits in addition to desk reviews
- Quality measures – process and outcome

Accessible

- Post results publicly, but also...
- Available AND understandable
- Train enrollee groups to read results
- Test systems for accessibility

Timely

- Quality measure lag time
- Consistent, public reporting
- Recommendations and progress on prior recommendations
- Quality over short and long term

Heterogeneous

Mixed methods of oversight:

- Qualitative and quantitative
- Quality measures
- Stakeholder feedback loops

Oversight that accounts for everyone

- Stratified reporting
- LTSS
- Filling gaps in measures

Accountability – State of Play

- Quality Strategy every 3 yrs
- Quality and Performance Improvement
- External Quality Review
 - Annual technical report
 - Core Measure reporting
- Managed Care Program Annual Report

Accountability – Info Reporting

Managed Care Program Annual Report (MCPAR)

- State level
 - Enrollment and state systems data
 - Contracts
- Program information
 - Enrollment, contract, state standards
- Plan information
 - Measures reported
 - Beneficiary Support System
 - Grievances, appeals, sanctions

Accountability – What's new?

- Required measure reporting
 - Child and behavioral health core sets by 2024
 - Stratifying measures by race/ethnicity
 - HCBS measures (proposed)
 - Experience of care surveys
- Proposed Quality Rating System (QRS)
- Independent secret shopper surveys
 - Standards for max wait time to appointment
- Prior authorization reporting

Does Managed Care Improve Equity?

Hypotheses:

Better care coordination = Fewer disparities?

Managed care = better care coordination?

Some states implementing requirements related to health equity in MCO contracts

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

Sanctions

Types of Sanctions

- Corrective Action Plans
- Monetary Penalties
- Restrictions
 - Enrollment, Payment, Marketing
- Temporary Management of a Contractor
- Contract Termination or Refusal to Renew

Sanctions

Are Sanctions Effective?

- Publicly available information is hard to find
- Fines and other liquidated damages are relatively small
- Only a few of states are imposing sanctions for network adequacy problems

NHeLP's EQR and 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)

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