COMMUNITY CATALYST

Shaping Medicaid Managed Care Expansions to Better Serve Consumers

Half of all Americans covered by Medicaid are in managed care plans run by companies paid a per member fee to provide most medical services.[1] State governments are increasingly mandating this approach for seniors in long-term care and for people with disabilities, rather than serving them through traditional fee-for-service arrangements. In many states, these changes are motivated by efforts to control growth in Medicaid costs. The increasing number of people covered by managed care has attracted more for-profit insurance companies to bid for this business.

At its best, Medicaid managed care provides opportunities for improved coordination, quality and efficiency of services. But it comes with risks for consumers, such as restricted access to needed care, that require vigilance and advocacy from organizations representing consumer interests. The following principles can help guide consumer advocates as they work for managed care that best serves seniors and people with disabilities. Many of these goals also represent preferred practices for all Medicaid managed care.

Consumer Engagement at All Levels

- **Involvement in the design, governance and monitoring of managed care programs**
  Managed care is more likely to provide quality services that meet consumer needs if consumers or advocates are involved in the planning and implementation. States should consult with a broad range of stakeholders, including consumers, before moving ahead with plans for mandatory managed care. They should establish consumer advisory committees that include both advocates and actual consumers who represent the diversity of races, ethnicities, ages and disabilities of the population to be served. State officials should attend all advisory committee meetings and provide copies of all monitoring reports; the committees should meet in the community and be run by consumer advocates. States should also conduct regular focus groups and surveys of consumers, including ones that focus on subpopulations such as people with physical or mental disabilities, children with special needs or seniors in long-term care.

- **Choice for consumers**
  One size doesn't fit all in health care. Ideally, enrollment in managed care should be voluntary for seniors and people with disabilities. If states do mandate participation, consumers should have: a choice of managed care plans; enough information and time to make an informed selection; and the ability to enroll in and change plans easily. Consumers should also be able to choose their providers, including those who speak their language and understand their cultural beliefs. If their existing provider is not part of a managed care plan, they should be able to continue with their existing provider until they can make a smooth transition, or should be allowed a special exemption to continue seeing that provider. Finally, consumers should be able to choose whether they get their care at institutions or in a community setting.

- **Robust consumer education and assistance**
  Consumers newly joining managed care plans need information about how plans work and assistance navigating the system, as well as means of resolving disputes with the plans. States should work with consumer and community organizations to develop materials that explain the plans. This process should be independent of the plans themselves. Federally supported Aging and Disability Resources Centers are used in some states to help consumers understand their Medicaid choices. States should also engage consumer advocates in the design of simple and accessible means of registering and addressing complaints. States should establish independent ombudsmen to run hotlines with experienced staff empowered to address consumer problems. These ombudsmen should feed information about systemic problems to state and plan officials and consumer advisory committees. States should also provide patient advocates to those who need help navigating the health system.

- **Consumer-directed care**
  Consumers with complex care needs should be equipped to play a leading role in their own care. They should be integrally involved with providers in developing an individualized care plan. They should be provided with, and educated in the use of, shared decision-making tools. Also, providers should educate consumers about their illnesses, and use a self-help model like the Stanford Chronic Disease Self-Management Program to train them in helping themselves.

Comprehensive, Coordinated Services

- **Full range of services to treat the whole person**
  In designing managed care programs, states should go beyond the federally required services for prevention, primary care, specialty and acute care. Whenever possible, they should also include prescription drugs and medication management, long-term care including home and community-based services, behavioral health care, social services and supports, and transportation in a comprehensive plan. If specific services are carved out of the managed care plan, states should publish resources on how patients can access those services as required by federal law, and also directly connect patients with those services.

- **Coordinated and integrated care**
  The expansion of managed care to chronically ill patients with complex needs makes care coordination essential. Patients should be served by multidisciplinary teams based in medical or health homes and using electronic medical records to deliver care according to an individualized care plan. A member of the care team should be available 24/7 by phone and email. Transitions between providers or care sites should be planned and managed. Patients should be connected with appropriate community-based support services and with any services that the state excludes from the managed care plan.

- **Robust provider network**
  All patients, but particularly those with complex conditions, need access to a broad network of qualified providers. This should include community providers with: experience working with seniors and people with disabilities as well as cultural and linguistic competency matched to the population. It should also include peer specialists – people who are recovering from mental illness or addiction and are trained to help others – and personal care assistants, who provide daily support

services to people with disabilities. Providers' facilities must be physically accessible to those with disabilities.

Federal law requires managed care organizations to provide assurances that they offer an "adequate" network to provide access to covered services in a reasonable amount of time. States should set standards for patient access ensuring patients do not have to wait long or travel far for necessary care. For primary care, the states with the strictest requirements mandate one physician for every 200 patients or one physician within 8 miles, and urgent care appointments within 24 hours.[2] Low payments to providers are a major obstacle to maintaining robust networks. To address this problem, payment to providers should be as close to Medicare rates as possible, and adjusted for age and health status of the patient.

Better Value for the Money

- **Minimize plan spending on administration, marketing and profits**
  States should establish medical loss ratios (MLR) of at least 85 percent, requiring plans to spend at least that percent of premium dollars on patient services as opposed to administration and profits. This would match the MLR requirement for large-group plans in the private sector, required by the Affordable Care Act. Currently 11 states set MLR requirements for Medicaid managed care, from 80 percent in Illinois to 93 percent for Hawaii's aged and disabled program.[3] States should also impose penalties on plans that skimp on services.

- **Continually improve quality and reduce health disparities**
  States should promote innovations and use financial incentives to reduce harmful or unnecessary care, such as avoidable complications or hospitalizations. They should include penalties for stinting on recommended services. These tactics can be part of state compliance with federal law requiring each state to develop a strategy for assessing and improving quality of managed care. States should incorporate strategies to reduce health disparities. Where possible, these strategies should focus on patient outcomes. States should also be transparent about the quality of plans. Federal laws require states to commission and publish an annual review of Medicaid managed care quality conducted by an outside agency, as well as to collect patient data by race, ethnicity, gender, primary language and disability to monitor health disparities. States should make all this information public in a format easily understood by consumers.

- **Cost containment must not impede access to necessary care**
  To help contain health costs, states should implement smart, consumer-friendly cost containment strategies that do not cut eligibility, benefits or provider fees. Options include reducing payment for preventable complications and readmissions, and expanding use of generic drugs. If managed care plans pay providers incentives that could cause them to reduce care, such as bonuses for making fewer referrals to specialists, federal law requires them to disclose these payments. States should ensure that per patient payment rates to health plans adequately reflect the cost of providing comprehensive care to the population served, which will be higher for people with disabilities and chronic diseases.

Strong Accountability

- **Hold plans accountable**
  To ensure that patients get easy access to quality care, states need to exercise rigorous oversight using mechanisms authorized under federal and state law, including annual assessments of quality and reports on grievances and appeals. Since plans get public funds, they should be subject to federal and state sunshine laws about disclosure of documents. In addition, to facilitate scrutiny by consumers and the media, states should make public all contracts, and require plans to publicly report on their finances, reserves, provider rates, patient outcomes and financial reports, as Minnesota[4] has recently required.

- **Adhere to federal law on the rights of people with disabilities**
  At a minimum, states should follow federal laws. There are three key laws that are especially important. The Americans with Disabilities Act (ADA) requires public services to be equally available to people with and without disabilities. Section 504 of the Rehabilitation Act of 1973 prohibits organizations receiving federal funding from denying services to people with disabilities. The Olmstead decision of the U.S. Supreme Court interpreted the ADA to require that care be provided in the least restrictive environment possible, which includes the home or community. Managed care should provide consumer-directed care and robust home and community-based services.

Resources:

Center for American Progress and Community Catalyst
- The Dual Eligible Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid,

National Health Law Program
- Making the Consumers' Voice Heard in Medicaid Managed Care
- Assuring Accountability and Stewardship in Medicaid Managed Care: Public Reporting Requirements for States and MCOs

Kaiser Commission on Medicaid and the Uninsured
- A Profile of Medicaid Managed Care Programs in 2010: Findings From a 50-State Survey

California Foundation for Independent Living Centers
- Principles Protecting Medi-Cal Beneficiaries with Disabilities

Campaign for Better Care
- A Yardstick for Better Care

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[1] A Profile of Medicaid Managed Care Programs in 2010: Findings From a 50-State Survey, Kaiser Commission on Medicaid and the Uninsured, 2011
[2] Ibid.
[3] Ibid.
[4] Executive Order 11-06: Creating Public Disclosure for Minnesota's Managed Care Health Care Programs, Minnesota Governor's Office, 2011