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Awaiting New Medicaid Managed Care Rules: Key Issues to Watch

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Introduction

Today, more than half of all Medicaid beneficiaries are enrolled in risk-based managed care organizations (MCOs) through which they receive all or most of their care.[1] In addition, many beneficiaries receive at least some services through prepaid health plans that provide limited benefits, such as dental or mental health care, on an at-risk basis. Not all state Medicaid programs contract with MCOs, but a large and growing number are doing so, and some states mandate that beneficiaries enroll in MCOs to receive Medicaid benefits.[2] Many states are expanding their MCO programs to include larger geographic areas and more medically complex beneficiaries, and integrating additional services, including behavioral health care and long-term services and supports (LTSS), with physical health care.[3] Further, states that have adopted the Affordable Care Act (ACA)'s Medicaid expansion are also relying largely on MCOs to serve the millions of newly eligible adults. In FY 2013, capitation payments to comprehensive MCOs accounted for about 28% of Medicaid spending nationally.[4]

States design, administer, and oversee their own Medicaid managed care programs within minimum federal requirements set forth in federal Medicaid law and further elaborated in regulations.[5] The federal regulations, last updated in 2002, set forth state responsibilities and requirements in areas including enrollee rights and protections, quality assessment and performance improvement (including provider access standards), external quality review, grievances and appeals, program integrity, and sanctions. The Centers for Medicare and Medicaid Services (CMS) is slated to issue a Notice of Proposed Rulemaking (NPRM) this Spring, revising and updating the current regulations. Numerous stakeholders submitted input and recommendations to CMS to consider in drafting the new rules, and the public will have an opportunity to comment on it before CMS finalizes the regulations.

Agency officials have offered some indications about what issues the new rules might address, including rate-setting, stronger beneficiary protections, and easing beneficiary transitions between Medicaid MCOs, Medicare Advantage plans, and Marketplace qualified health plans.[6] The new rules also may address areas that have emerged since the last revision, such as managed LTSS. While this brief focuses on key issues to watch related specifically to states' MCO programs, many of the same issues are implicated for limited-benefit prepaid plans, and parts of the proposed rule may apply, or further extend, MCO requirements and standards to them, too.[7] The issues we have identified reflect assessments of Medicaid managed care over the past decade and the concerns and priorities expressed by a wide range of stakeholders, including states and groups representing beneficiaries, MCOs, and health care providers.

Beneficiary information and protections

Availability and accessibility of plan information. Medicaid managed care plans are required to make a variety of information available to current and potential enrollees, including enrollment notices, provider directories, enrollee rights and responsibilities, information on covered services and cost-sharing requirements, and grievance and appeals procedures. Current regulations also include requirements that such information be accessible for specified populations, such as individuals with limited English proficiency and people with disabilities. For example, states are required to identify the prevalent non-English languages spoken by enrollees, and both states and MCOs are required to make written information available in each such language and to make oral interpretation services available free of charge. States and MCOs are also required to make information accessible to people with disabilities to ensure effective communication, such as providing information in alternative formats, consistent with the Americans with Disabilities Act (ADA).

The usefulness of MCO information can sometimes be limited for a number of different reasons. For example, MCOs may provide required information in inconsistent formats, making plan comparisons and assessments difficult for beneficiaries. Also, current managed care regulations, which were issued before the internet was so pervasive and dominant a source of public access to information, do not require states and MCOs to provide required information online, and many do not. Notably, regulations implementing the ACA Medicaid provisions call for electronic notices, applications, and appeals, modernizing the program.

Current Medicaid rules are intended to ensure that communications about and with managed care plans are effective for all beneficiaries, and other federal laws establish beneficiary protections as well. The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act prohibit discrimination against people with disabilities in all programs, activities, and services of public entities, including requirements to ensure effective communication.[8] However, states' and plans' information for beneficiaries sometimes falls short of the accessibility needs of people with disabilities. For example, plans may fail to provide communications in alternate formats, or may issue materials that are incompatible with screen-reading technology. They may also fail to provide sign language interpreters or other communication aids such as voice recognition systems.[9]

What to watch. The new rule could include additional requirements aimed at improving the clarity and accessibility of MCO information. For example, it could require that plan information be made available electronically or posted online by MCOs and states, as is required for provider directories and certain other types of information provided by plans sold through the health insurance Marketplaces.[10] CMS also could include additional state oversight requirements and require plans to report on accessibility measures for people with disabilities, to strengthen plan and provider compliance with the ADA and Section 504 of the Rehabilitation Act.

Enrollment and disenrollment processes. Under federal Medicaid law, states have the option to require that most beneficiaries receive Medicaid benefits through an MCO so long as they are offered a choice of two plans (except in specified situations), and other federal statutory and regulatory requirements are met.[11] However, states must obtain federal waiver authority to mandate managed care enrollment for certain beneficiaries.[12] Federal regulations lay out the general requirements that states must meet in establishing MCO enrollment and disenrollment processes, including a requirement that Medicaid beneficiaries must be allowed to change MCOs during the initial 90-day period following their enrollment in a plan. After that, they may be

locked into the MCO until the next annual opportunity to change plans, unless they have "cause" to disenroll from the plan.[13]

If beneficiaries do not have sufficient time or information to choose among their managed care plan options, particularly when they first gain Medicaid coverage or are first making the transition from fee-for-service to managed care, they cannot make an informed choice. If beneficiaries do not select an MCO on their own, they are assigned to a plan through a default enrollment process based on a state-defined algorithm. These algorithms may not adequately take into account existing beneficiary-provider relationships or other factors that may optimize beneficiary access to care. Delays in the processing of beneficiary disenrollment requests can also jeopardize beneficiaries. Finally, beneficiaries do not have the right to disenroll from an MCO if a provider from whom they have been receiving ongoing treatment or services leaves the MCO's network, potentially disrupting their care and thereby causing harm.

What to watch. New Medicaid managed care rules could incorporate stronger beneficiary protections in the areas of enrollment and disenrollment. For example, the new rule could require states to offer independent options counseling to assist beneficiaries making enrollment decisions with this often complex and unfamiliar process. It could also require them to develop and use "intelligent assignment" algorithms that, to the extent possible, preserve continuity of providers and services for beneficiaries subject to default enrollment in plans. The regulation also could establish specific requirements for state agencies and plans regarding expedited disenrollment requests. For example, CMS could further the define the requirement that states permit beneficiaries to disenroll from an MCO for cause at any time by specifying "for cause" criteria that address the types of problems that beneficiaries in plans have encountered.[14] The rule could also require states to provide beneficiaries who are disenrolling and must enroll in a different plan with the information necessary to make an informed choice when doing so, such as current provider directories.

Enrollee appeal rights. The Medicaid program includes a basic set of beneficiary protections, such as the right to adequate notice and a state fair hearing, which are grounded in the Due Process Clause of the U.S. Constitution.[15] In addition to the state fair hearing process, Medicaid MCOs must establish internal appeal procedures for enrollees to challenge the denial or termination of Medicaid covered services.[16] MCOs are required to notify beneficiaries when they take an action subject to appeal and provide beneficiaries with the reasons for service denials, terminations, or reductions. The notice must describe the right to and process for an appeal, how to request an expedited appeal, and how to request that services continue while an appeal is pending. The notice must be easily understandable and accessible to those with limited English proficiency and those with disabilities. MCOs must offer beneficiaries access to an internal plan hearing, during which beneficiaries can present their case and have their appeal decided by a person who was not involved in the initial decision and who has appropriate expertise if medical necessity or clinical issues are involved.

Notwithstanding these protections for Medicaid beneficiaries, problems with the MCO internal appeals processes and the required notices sometimes occur. Among these problems are impermissible delays in issuing written plan appeal decisions, despite prescribed timeframes in current regulations; notices that do not contain all required elements; insufficient state oversight of MCO appeals processes; and lack of training for MCOs regarding state and federal requirements.[17] Weaknesses in the current regulations have also been cited as a factor contributing to inappropriate disruptions in enrollees' access to services. Specifically, the regulations

now provide that, when a beneficiary appeals a termination of a service, the Medicaid MCO is required to continue services until the end of the "authorization period" for the service – a formulation that conflicts with the general Medicaid appeals rule, which entitles beneficiaries to continued benefits for as long as the appeal is still pending.[18] The right to continued benefits pending appeal is grounded in Constitutional due process, based on Supreme Court decisions holding that individuals cannot be deprived of public benefits such as Medicaid services without a pre-termination appeal hearing. This issue has become more pronounced with the expansion of managed LTSS programs, which involve beneficiaries who have ongoing needs for services to ensure their ability to live independently in the community. Terminating services such as personal care assistance while an appeal is pending can disrupt existing arrangements and threaten the beneficiary's ability to remain in the community safely, even if the appeal is ultimately resolved in the beneficiary's favor.

What to watch. In the revised rules, CMS could clarify that services must be continued pending a final appeal decision, regardless of whether an authorization period has expired. The agency could also strengthen enforcement of timeframes for MCO resolution of complaints and reviews. The rule could also provide for state oversight and review of service plan reductions and appeals as part of ongoing monitoring and during beneficiary transitions to managed care, to identify systemic issues and ensure that MCOs are providing all medically necessary covered services. The rule could also establish requirements for states to educate managed care contractors about the grievance and appeals requirements.[19]

Grievance systems. MCOs also must establish an internal grievance process for beneficiaries. The grievance process allows beneficiaries to raise issues that are not subject to appeals, such as concerns about care quality or a plan's or provider's failure to respect enrollee rights. States have flexibility to determine the method that MCOs will use to notify enrollees of the disposition of their grievances.

There is both a lack of uniformity and variation in quality between different plans' grievance systems. In addition, as noted above, sometimes enrollees with disabilities and limited English proficiency struggle to access the grievance and appeal system, contrary to the requirements of Section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act.

What to watch. CMS could propose uniform requirements governing grievance processes and seek to ensure that states actively enforce those requirements by, for example, requiring states to certify their compliance.

Provider network adequacy

States are required by federal Medicaid law to ensure that MCO provider networks are adequate and appropriate to meet the needs of their Medicaid enrollees and that enrollees have timely access to covered services. MCOs, in turn, are required to ensure that they meet state standards.[20] The federal rules do not establish specific standards for network adequacy or timeliness of access; rather, states define their own standards based on the general factors set out for consideration in the federal regulation.

Two recent studies by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) identified important gaps in state and federal oversight of Medicaid MCO access standards and network adequacy. One study found that, while all 33 states identified as having MCO programs have quantitative access standards in place (e.g., maximum time or distance to a provider, required provider-to-enrollee ratios)

and employ various strategies for assessing MCO compliance, few states actually test access directly, using "secret shopper" methods that involve calling provider offices to determine whether they accept new Medicaid patients or what the wait time for the next available appointment is. The study also cited limited CMS oversight of state access standards.[21] In a companion study, the OIG found evidence of widespread inaccuracies in plans' provider directories and determined that wait times for appointments exceeded one month for more than one-quarter of the providers who could offer appointments to Medicaid enrollees.[22]

What to watch. The new Medicaid managed care rule could seek to address some of the problems identified in the OIG reports. For example, it could require states and MCOs to ensure that provider directories are corrected and updated in a timely manner as providers' participation status changes (under the current regulation, this information must be provided annually or at an enrollee's request). The new rule could also require states to conduct direct tests of access relative to state standards, such as through "secret shopper" studies as described above. Some stakeholder groups representing beneficiaries have weighed in with suggested strategies to more effectively ensure that Medicaid beneficiaries enrolled in MCOs have adequate access to providers.[23] For example, the rule could require states to report to CMS on the results of their monitoring and oversight activities and the corrective actions they take. It could establish specific requirements for state and plan monitoring of provider availability, such as quarterly reporting by MCOs to states and the public, online and in written form, on the number, type, location, and current capacity of the providers in their networks providers.[24] Timeliness standards could be established for state action when access problems are identified, and a system of recourse for beneficiaries who cannot gain needed access to providers could be required of states.

Quality of care

Federal rules require states that contract with MCOs to have in place a strategy for assessing and improving the quality of care provided to MCO enrollees. States must also have arrangements for annual external review of managed care quality. States have a great deal of flexibility in designing their quality strategies and standards, specifying the procedures for assessing the quality of care provided by MCOs, monitoring plan compliance, and establishing specific performance improvement and reporting requirements in plan contracts.[25] Although HHS has developed core quality measure sets for children and adults in Medicaid and a standardized reporting system for states, federal regulations do not specify which quality measures states must use in their MCO quality programs;[26] in addition, there are recognized gaps in the availability of quality measures for LTSS.[27] Some stakeholders have noted that standardized reporting on a limited set of quality measures would allow for meaningful comparisons of quality performance across both MCOs and states.[28]

What to watch. The new Medicaid managed care rules could include more specific requirements regarding MCO quality measurement and reporting. For example, CMS could propose that MCOs and states report on a standardized set of measures, such as those common to both HHS's pediatric and adult core quality measures and the Medicaid Healthcare Effectiveness Data and Information Set (HEDIS) measures that many states currently require MCOs to report. In light of the expansion of Medicaid managed care to include more special-needs populations, including individuals with disabilities, beneficiaries with LTSS needs, and people with behavioral health conditions, the proposed rule could also require that, in developing quality measurement and

reporting strategies, states consider the needs of these populations and specify the factors that states must take into account.[29]

Managed long-term services and supports

A growing number of states are expanding their Medicaid managed care programs to people with LTSS needs, including seniors and people with disabilities, some of whom are dually eligible for Medicaid and Medicare. These initiatives involve the coverage and delivery of LTSS – institutional and/or home and community-based services, increasingly with the inclusion of physical and behavioral health services – through MCO contracts, or managed LTSS (MLTSS).[30] States have indicated that they are moving LTSS into managed care plans in an effort to improve care quality and health outcomes through increased coordination and MCO accountability across the full spectrum of services that beneficiaries need. However, MCOs may lack experience serving beneficiary groups with more complex needs and those who self-direct their services, and their existing networks may not include providers who are important to their care, such as those who provide HCBS.[31] In addition, a shift to MLTSS risks disrupting beneficiaries' existing care arrangements.[32] Therefore, some additional beneficiary protections specifically related to MLTSS may be appropriate.

Recognizing a growing need for federal policy on MLTSS in light of widening use of these arrangements, CMS issued guidance in 2013 that identified best practices among states and laid out CMS' expectations for MLTSS programs.[33] CMS identified a number of elements that characterize a high-quality MLTSS program. These elements include: support for beneficiaries in enrolling in and disenrolling from MLTSS programs, including choice counseling to help potential participants and caregivers understand their MLTSS options; independent advocacy or ombudsman services free-of-charge to participants; processing of enrollment by an independent, disinterested entity; and enhanced disenrollment opportunities, particularly when the termination or exit of a provider from an MCO's network could cause a disruption in a beneficiaries' residential placement or employment. Additional elements of high-quality MLTSS programs include qualified provider networks to ensure adequate access, beneficiary protections, and a comprehensive quality improvement strategy.

What to watch. Given that the current managed care rules pre-date most MLTSS programs, the proposed new rule could formally incorporate some of the elements of the 2013 MLTSS guidance. For example, per the guidance, the rule could require states or MCOs to allow enrollees to disenroll or change MCOs if their LTSS providers leave the MCO network, if there is jeopardy to the beneficiary's living arrangements or employment. It could also require states and plans to provide for a transition period during which new MCO enrollees can continue with their existing LTSS providers and/or previously authorized services. To help beneficiaries understand their options and rights, choose among MCOs, enroll and disenroll, access services, and navigate grievance and appeals processes, and also to identify systemic problems in MLTSS programs, the rule could require states to provide for the services of independent ombudsman.[34] Some states already have managed care ombudsman programs, and the capitated financial alignment demonstrations for beneficiaries dually eligible for Medicare and Medicaid include them.

States could be held to more specific oversight standards to ensure that MCO provider networks include an appropriate range of MLTSS providers and that MCO quality improvement strategies take into account the special circumstances of populations needing LTSS. For example, CMS could require states to routinely

monitor the availability of MLTSS providers, to certify to CMS that all MLTSS plans comply with standards for service availability, and/or to develop systems in their MLTSS programs for identifying, tracking, and eliminating disparities in access to health care services for enrollees. In addition, the rule could strengthen state oversight requirements regarding physical accessibility of health care services and sites (including accessibility of exam tables, x-ray equipment, etc.) and accessibility of plan information and communications for people with disabilities. Some possible approaches to strengthening enforcement could be to require states to develop and report quality measures related to accessibility for people with disabilities, or to require MLTSS providers to submit compliance plans that describe how they will ensure accessibility for all enrollees.

Capitation rates

Actuarial soundness. Federal law requires that capitation rates for MCOs be "actuarially sound," and federal regulations define actuarially sound rates as those developed in accordance with generally accepted actuarial principles and practices, appropriate for the populations covered and services furnished, and certified by qualified actuaries.[35] States are required to demonstrate their compliance by documenting the methodologies and data they use to set rates.

The purpose of the actuarial soundness requirement is to ensure that Medicaid MCO capitation rates are adequate to cover the costs of care needed by their enrollees and counteract inherent incentives to plans at financial risk to avoid higher-need beneficiaries or deny services. Appropriate rate-setting concerns MCOs and their contracted providers, Medicaid beneficiaries, and states, which are responsible for ensuring both beneficiary access to care and sound fiscal management.

In 2010, the GAO issued a report assessing CMS oversight of states' compliance with the actuarial soundness requirements. The GAO study found weak and inconsistent CMS oversight of states' rate-setting as well as inadequate CMS efforts to ensure the quality of the data used to set rates.[36] Data quality is a particular problem in setting rates for people with complex health care needs since states have less experience providing capitated services to people with disabilities or chronic conditions, or who need LTSS or behavioral health care. In the years since the GAO report, CMS has issued "consultation guides" that provide additional guidance to states about the information they must take into account in setting actuarially sound rates for Medicaid enrollees."[37] Some stakeholders representing Medicaid MCOs and providers have expressed support for measures to increase transparency and accountability in state rate-setting processes.

What to watch. The new managed care rule could codify standards and requirements that are described in the consultation guides or strengthen those requirements by, for example, establishing standards regarding the transparency of the rate-setting process. It could also seek to increase state accountability in this area, for example, by requiring states to conduct routine examinations of the effect of capitation payment rates on beneficiary access to care or establishing a process by which MCOs, providers, and beneficiaries can raise concerns about states' capitation rates, which might trigger CMS review and possible adjustments.[38]

Medical loss ratio. A medical loss ratio (MLR) is the share of premium revenues that an insurer or managed care plan spends on patient care and quality improvement activities, as opposed to administration, marketing, and profits. The ACA established a minimum MLR of 80% for most insurers in the individual and small group markets, and set the threshold at 85% for large group plans. The health reform law also established a minimum

MLR of 85% for Medicare Advantage and Medicare prescription drug plans. The federal minimum MLR requirements do not apply to Medicaid plans, although some states have minimum MLRs for their Medicaid MCOs in state law or contract provisions, and some states include minimum MLR requirements for plans providing care under the dual eligible financial alignment demonstrations.[39]

What to watch. CMS could propose a federal minimum MLR requirement for Medicaid MCOs to ensure that plans serving Medicaid beneficiaries meet the standard that plans serving other Americans must meet and that an appropriate portion of the federal and state dollars that fund capitated rates are spent on services to beneficiaries rather than plan administration and profits.

Encounter data

Federal legislation enacted in 1997 required all states to report managed care encounter data to CMS as part of their Medicaid Statistical Information System (MSIS) submissions, and federal regulations require MCOs to collect encounter data, ensure their accuracy and completeness, and make them available to the state.[40] A 2009 HHS Office of Inspector General report found that all states with MCOs require their plans to collect and report encounter data, and that the majority use the data to manage their programs, but that CMS has not enforced the requirement that states submit their managed care encounter data to the federal government. The OIG recommended that CMS clarify and enforce the federal requirements for encounter data submission and seek authority to sanction states that fail to comply.[41] The ACA strengthened the requirement for Medicaid MCOs to provide encounter data to states and permits federal Medicaid matching funds to be withheld from states that fail to report accurate enrollee encounter data to CMS "at a frequency and level of detail to be specified by the Secretary."[42] Notably, CMS is requiring encounter data from states that are participating in the financial alignment demonstrations for dually eligible beneficiaries.[43]

Encounter data give state and federal governments an important monitoring tool to make sure that beneficiaries are getting needed care, and can be used to assess plan performance on measures of utilization, access, and quality. These data can be used to track rates of use of high-value or high-interest services, such as preventive screening, immunizations, or hospitalizations, including readmissions, and to identify disparities in utilization of services across populations or geographic areas within communities.[44] Encounter data are also important input for calculating payments under risk stabilization programs – for example, for purposes of making retrospective reinsurance payments based on the use of high-cost services or the number of high-cost beneficiaries. Encounter data are also necessary for targeted studies of high-need or other populations of key policy interest. To illustrate, they could be used to determine whether HIV+ beneficiaries are receiving needed drugs, or whether beneficiaries with mental illness are receiving appropriate preventive care.

What to watch. In the new regulations, CMS could propose specific standards for encounter data reporting by plans and states, regarding required timeframes, elements, format, validation, etc. The rule could also include provisions to strengthen state oversight responsibilities and accountability.

Program integrity

Under federal law, CMS and the states are responsible for the proper and efficient operation of the Medicaid program and must ensure Medicaid program integrity by preventing, detecting and recovering improper

payments.[45] CMS conducts comprehensive state program integrity reviews, which include an assessment of states' managed care program integrity activities. CMS also contracts with Audit Medicaid Integrity Contractors to conduct post-payment audits of Medicaid providers, including MCOs. Through its Medicaid Integrity Institute, CMS offers training to state program integrity officials, including courses on managed care issues, and it provides guidance and technical assistance to states as well. In addition, MCOs are required by law to have in place a compliance plan designed to guard against fraud, waste, and abuse.

Recently, however, the Government Accountability Office (GAO) issued a report that identified gaps in state and federal efforts to ensure Medicaid managed care program integrity.[46] The GAO found that CMS has largely delegated managed care program integrity oversight activities to the states but has given them little specific guidance. The study also found that CMS does not require states to audit their payments to MCOs, and that states were not closely examining the activities of MCOs. The GAO recommended that CMS require states to audit payments to and by MCOs to better ensure program integrity. In addition, it recommended that CMS increase its oversight and support for states and update its guidance on Medicaid managed care program integrity.

What to watch. CMS could incorporate requirements in the proposed rule that reflect the GAO's recommendations. For example, it could require states to audit MCO payments and specify required elements of, or set standards for, state managed care audit systems.

Conclusion

In the more than 10 years that have elapsed since the federal Medicaid managed care regulations were last revised, states have continued to expand their reliance on managed care plans to serve Medicaid beneficiaries. States are increasingly enrolling populations with more complex medical and LTSS needs in MCOs, as well as millions of Americans who are newly gaining Medicaid under the ACA. Accordingly, state and federal Medicaid spending on managed care also continue to grow in both total dollars and as a proportion of overall Medicaid spending. Given the growing role of Medicaid managed care and the beneficiary, plan, provider, and budgetary issues at stake, the need for sound operation of managed care programs, timely and accurate data on plan and program performance, strong beneficiary protections, and robust state and CMS oversight is great.

In crafting new managed care regulations, CMS will likely seek to strike a balance between strengthening federal standards and avoiding rules that are too prescriptive to account for diverse Medicaid programs and markets or that pose barriers to desirable state innovation. The new regulations present CMS with an opportunity to address managed care developments over the last decade, such as the expansion of managed LTSS, the inclusion of populations with special health care needs, and the increased use of the internet and demand for electronic information. With the benefit of recent assessments of key aspects of Medicaid managed care, federal policy recommendations for strengthening the existing regulations, and broad stakeholder input, the new rule has the potential to enhance the framework for Medicaid managed care programs, increasing the prospects for high performance in terms of access, quality, and costs in this vital sector of Medicaid. Rigorous state and federal oversight and enforcement of Medicaid managed care will be essential to ensure that those prospects can be realized and that beneficiaries can receive the necessary services to which they are entitled.

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Endnotes

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[2] Vernon Smith et al. *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, Kaiser Family Foundation, October 2014, http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/

[3] MaryBeth Musumeci, *Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers,* Kaiser Commission on Medicaid and the Uninsured (November 2014), http://kff.org/medicaid/issue-brief/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers/

[4] *Ibid.* Table at http://kff.org/other/state-indicator/total-medicaid-mco-spending/

[5] Mostly in Sections 1903(m) and 1932 of the Social Security Act (42 U.S.C. § § 1396b(m), 1396u-2) and 42 CFR Part 438.

[6] Virgil Dickson, "Coming Medicaid plan rules will set new access standards," *Modern Healthcare*, "October 28, 2014, http://www.modernhealthcare.com/article/20141028/NEWS/310289915

[7] Comprehensive Medicaid managed care organizations (MCOs) provide comprehensive acute care, and in some cases, long-term services and supports as well, to Medicaid enrollees. States pay MCOs a fixed monthly premium or "capitation rate" on behalf of each enrollee. Limited-benefit prepaid health plans (PHPs) provide a limited set of inpatient or outpatient Medicaid benefits, such as mental health services, usually on a capitation basis.

[8] See*, e.g.,* 28 C.F.R. § 35.104 (defining auxiliary aids and services under ADA Title II, which applies to state and local governmental entities).

[9] Mara Youdelman and Elizabeth Edwards, *Medicaid Managed Care Model Provisions: Accessibility & Language Access, Issue 4*, National Health Law Program, http://www.healthlaw.org/issues/medicaid/managed-care/medicaid-managed-care-model-provisions-issue-4#.VONaWPnF-So

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[11] Section 1932(a)(3) of the Social Security Act (42 U.S.C. § 1396u-2)

[12] States are prohibited from mandating enrollment in MCOs for children with special health care needs, beneficiaries dually eligible for Medicaid and Medicare, and Native Americans unless they obtain a federal waiver to do so. 42 U.S.C. § 1396u-2(a)(2)

[13] Social Security Act, § 1932(a)(4) [42 U.S.C. § 1396u-2(a)(4)]

[14] *Ibid.*

[15] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, Kaiser Commission on Medicaid and the Uninsured (March 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf

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[18] Compare 42 C.F.R. § 438.420 with 42 C.F.R. § 431.230; *see also Medicaid Managed Care: Grievances and Appeals,* Fact Sheet #4, National Health Law Program (April 2012), http://www.healthlaw.org/issues/medicaid/managed-care/MMC-Fact-4#.VOtkm_nF98E

[19] *Medicaid Managed Care Model Provisions: Grievances and Appeals, op. cit.*

[20] 42 CFR § § 438.206, 438.207

[21] *State Standards for Access to Care in Medicaid Managed Care*, Department of Health and Human Services, Office of the Inspector General (September 2014), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

[22] *Access to Care: Provider Availability in Medicaid Managed Care,* Department of Health and Human Services, Office of the Inspector General (December 2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

[23] *See, e.g.,* Abbi Coursolle, *Medicaid Managed Care Model Provisions: Network Adequacy, Issue 3,* National Health Law Program (September 16, 2014), http://www.healthlaw.org/issues/medicaid/managed-care/medicaid-managed-Care-model-provisions-issue-3#.VRFkevnF98E and *Medicaid Managed Care for People with Disabilities: Policy and Implementation Considerations for State and Federal Policymakers*, National Council on Disability (March 18, 2013), http://www.ncd.gov/publications/2013/20130315/

[24] *Medicaid Managed Care Model Provisions: Network Adequacy, op. cit.*

[25] 42 CFR §§ 438.202, 438.204

[26] Section 402(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires identification of children's core quality measures and Section 2701 of the Affordable Care Act requires identification of adult core quality measures. For more information, *see* the CMS Technical Assistance Center at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html

[27] MaryBeth Musumeci, *Measuring Long-Term Services and Supports Rebalancing*, Kaiser Commission on Medicaid and the Uninsured (February 2, 2015), http://kff.org/medicaid/fact-sheet/measuring-long-term-services-and-supports-rebalancing/ (See endnotes 11 and 12)

[28] MaryBeth Musumeci, *Rebalancing in Capitated Medicaid Managed Long-Term Services and Supports Programs: Key Issues from a Roundtable Discussion on Measuring Performance*, Kaiser Commission on Medicaid and the Uninsured (February 2, 2015), http://kff.org/medicaid/issue-brief/rebalancing-in-capitated-medicaid-managed-long-term-services-and-supports-programs-key-issues-from-a-roundtable-discussion-on-measuring-performance/

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[30] Julia Paradise, *Medicaid Moving Forward*, Kaiser Commission on Medicaid and the Uninsured (March 9, 2015), http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/

[31] *Rebalancing, op. cit.*

[32] *Key Themes, op. cit.*

[33] *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs,* Centers for Medicare and Medicaid Services (May 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

[34] *Ibid.*

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[39] MaryBeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS, Kaiser Commission on Medicaid and the Uninsured (July 24, 2014),* http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/

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[41] *Medicaid Managed Care Encounter Data: Collection and Use,* U.S. Department of Health and Human Services, Office of Inspector General (May 2009), http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf

[42] 42 U.S.C. § § 1396(I)(25), 1396b(r)(1)(F), 1396b(m)(2)(A)(xi)

[43] MaryBeth Musumeci, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries: A Look at CMS's Evaluation Plan*, Kaiser Commission on Medicaid and the Uninsured (July 18, 2014), http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-a-look-at-cmss-evaluation-plan/

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[45] 42 USC § 1396a(a)(37)(B) and 42 USC § 1396b(m)(2)(A)(iv); § 1396u-6

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