



Medicaid Managed Care Rule Fact Sheet and Advocacy Guide

The new [Medicaid managed care rules](#) finalized in May 2016 modernize and align the program more closely to the Affordable Care Act (ACA) Marketplaces and Medicare Advantage over the next several years. These regulations mostly set federal standards that give states flexibility in meeting or expanding the final requirements. Overall, the new rules are little changed from the [proposed regulation](#) and add many consumer protections that we support. Yet, there are several ways to make sure that the rule could be stronger for Medicaid managed care enrollees. In this guide, we summarize some key provisions of the rule and identify advocacy opportunities to ensure that Medicaid managed care protects consumer interests going forward.

Network Adequacy (§§ 438.206, 438.68, 440.262, 438.10(h))

- States must propose their own time and distance standards, at minimum, for these provider types: primary care (adult and pediatric); OB/GYN; behavioral health (mental health and substance use disorder, adult and pediatric); specialist (adult and pediatric); hospital; pharmacy; pediatric dental; long-term services and supports (LTSS) providers and additional provider types when necessary.
- Provider directory requirements were expanded to include at least five provider types (physicians, hospitals, pharmacies, behavioral health and LTSS), languages spoken, availability of language assistance services and physical accessibility of the provider's facility. Provider directories must be updated at least monthly.
- States must publish network adequacy standards and provider directories online.

Advocates should participate in the development of time and distance standards, as well as provider directory rules, before they go into effect on July 1, 2018. Advocates can push for stronger state-level standards, such as adding more types of providers to these requirements, developing separate managed long-term services and supports (MLTSS) standards (particularly for home and community-based care), adding enrollee to provider ratios and appointment and office wait times. We recommend adopting a standard of 30 minutes by car or 15 miles for primary care services, a standard of 60 minutes or 30 miles for specialty services, as well as standards for wait times to secure an appointment (see [our comments](#) for more specifics).

As a long-term strategy, advocates can track state Medicaid managed care network adequacy and provider directory standards through consumer surveys and assessing the network adequacy data in states' annual managed care report and quality improvement strategy. Advocates can ask for stronger rules if those standards are not meeting Medicaid managed care enrollees' needs.

Language and Disability Access (§ 438.10)

- Oral interpretation services must be provided for limited English proficient (LEP) individuals in all languages.¹

¹ Department of Justice definition of LEP: Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive

- It is up to states to define which non-English languages are considered “prevalent,” and thus, subject to written translation and taglines. A tagline is a sentence or two in a non-English language or large print that notifies LEP or visually impaired individuals how to request language services.

Before this section goes into effect on July 1, 2017, the advocacy community can urge states to define “prevalent” (using our recommended 5 percent or 500 individuals in a single language group) as a threshold for translating documents. We also recommend taglines in the top 15 languages spoken by Medicaid beneficiaries at a minimum.²

Advocates can also ask their states to include information in provider directories to address whether an office or facility exceeds minimum physical accessibility requirements, has [auxiliary aids and services](#) available or has expertise serving people with disabilities.

Quality Rating System (QRS) (§ 438.334)

- A Medicaid managed care QRS will display standardized quality information for each managed care entity, much like the format and objectives for the [Marketplace QRS](#). States can use the federal system or design their own QRS approved by CMS.
- CMS will release Medicaid managed care QRS guidance in 2018, which will be subject to a public comment process. States must be in compliance with the Medicaid managed care QRS within three years of the release of the guidance. CMS is deferring quality measure selection to the public comment period.

Advocates can use the time until the public comment process begins to educate state stakeholder groups about what [quality measures matter](#) most to consumers. See our comments on the [Marketplace QRS](#) for other recommendations around this issue.

Managed Care State Quality Strategy (§ 438.340)

- States must propose a managed care quality improvement strategy to assess and improve the quality of health care and services provided by the managed care entity. The quality strategy will encompass network adequacy, quality of care and a plan to tackle health disparities around a variety of demographic factors including race, ethnicity, sex, primary language, age and disability status. States must come into compliance with the quality strategy by July 1, 2018.
- States must mandate that managed care plans measure LTSS enrollees’ quality of life and improvement in community integration.

State stakeholder groups and advocates can provide input during the quality improvement strategy public comment process. For instance, advocates could encourage states to collect more

language assistance with respect to the particular service, benefit, or encounter. Retrieved from <http://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-VI/index.html>

² We draw the 5 percent standard from the Department of Justice (DOJ) and HHS’ Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans. The ‘top 15 languages spoken’ standard is currently used by Medicare.

robust demographic data of enrollees that include standards adopted by the [Institute of Medicine](#) and the [American Community Survey](#). Consumer advocates will also have opportunities to provide feedback on various consumer priorities (network adequacy, health disparities reduction, etc.) during state review periods of the state quality strategy, which will happen no less than once every three years.

Stakeholder Engagement (§§ 438.70 and 438.110)

- By July 1, 2017, states and each managed care entity are required to establish stakeholder advisory groups for design, implementation and oversight of LTSS, which are in addition to existing state Medicaid Medical Care Advisory Committees.³
- State and managed care stakeholder groups must be engaged in the development of the quality and performance improvement strategy, performance improvement plans, alternative state-developed QRS and the annual state managed care program assessment reports.
- Representatives of beneficiaries are part of the list of individuals who should be a part of a state stakeholder group and advisory committees to each managed care plan.

Advocates can help states flesh out what the stakeholder engagement process includes beyond the broad rules provided by CMS. For instance, we [recommend](#) that state stakeholder groups meet at least quarterly, represent the diversity of covered individuals, and have at least 50 percent consumer representation. We also recommend that the state provide supports to facilitate consumer participation in these state-level advisory committees, such as providing other methods for those unable to attend meetings (focus groups, in-person or telephonic surveys).

Nondiscrimination (§§ 438.3(d), 438.3(f), 438.104)

- CMS added several protected categories, including: sex, sexual orientation, gender identity, health status and disability – which is a great win because discriminatory plan practices have historically kept these vulnerable populations from accessing medically necessary care.
- States will not need to review marketing materials for meeting the needs of consumers around language, reading level, comprehensibility, cultural sensitivity and diversity – nor will states need to protect consumers from materials that avoid populations based on perceived health status, disability or for other discriminatory reasons. This could potentially lead to problems for vulnerable populations that advocates should monitor.

These requirements must go into effect July 5, 2016. Advocates who have direct connections with vulnerable or LEP communities can monitor the implementation of these nondiscrimination provisions and flag complaints to the state and/or CMS.

Institutions for Mental Disease (IMD) Medicaid Payments (§ 438.6(e))

- Effective July 5, 2016, CMS will allow Medicaid payments for some 15-day stays in IMDs—hospitals, nursing facilities or other institutions of 17 beds or more that care exclusively for people with mental diseases.

³ [Existing regulations](#) require one Medical Care Advisory Committees (MCAC) per state to present stakeholder input to the Medicaid agency.

This is a step in the right direction as it increases access to care for people with mental illness and substance use disorders. However, we believe that capping IMD stays undermines the goal of providing clinically appropriate behavioral health care, including longer-term inpatient care when needed. We encourage advocates to monitor the impact of this policy change. Advocates can also encourage their states to adopt an [1115 waiver](#) that allows for a wider array of substance use disorder treatment services in the context of overall SUD service delivery system transformation (which includes removing limitations on IMD stays).

Beneficiary Support System (§§ 438.2, 438.71, 438.810, 438.816)

- States must provide a beneficiary support system to managed care consumers, including potential enrollees, by July 5, 2016. The system must be available in multiple ways (phone, internet, in-person and via auxiliary aids and services when requested).
- The beneficiary support system will provide support before and after managed care enrollment, including choice counseling for all beneficiaries, assistance to all beneficiaries in understanding managed care and assistance for enrollees who receive or desire to receive LTSS, including help with grievances and appeals, and requiring identification and resolution of systemic problems.

States have flexibility in choosing and expanding the scope and types of services available under the beneficiary support system. Advocates can push states to do more for consumers by ensuring the inclusion of language and cultural competency; assistance around concerns, grievances and enrollment to all enrollees (not just those in LTSS); training about independent living and recovery philosophies for managed care entities and network providers; and providing assistance via an [independent ombudsman](#). We also encourage states to consider the critical importance of caregivers in supporting enrollees as they develop education, outreach and support strategies.

Care Coordination, Continuity and Care Planning for LTSS (§§ 438.56, 438.210, 438.420)

- Managed care plans must develop individualized service and treatment plans for all LTSS consumers.
- Plans must allow LTSS consumers to disenroll if their provider leaves the network and this change disrupts their residence or employment.

Advocates can urge their states to develop more consumer protections, including explicit continuity periods of up to a year, when consumers transfer from fee-for-service into managed care. States can be encouraged to engage community based organizations such as Area Agencies on Aging and Centers for Independent Living in care coordination.

Conclusion

Overall, these rules are a big step forward and will be rolled out gradually. Over the next few years, advocates have a critical opportunity to participate in the development of many key provisions on the state-level to ensure that consumer supports and protections are maximized in Medicaid managed care.