NAMD
National Association of Medicaid Directors

October 17, 2014

Daniel R. Levinson, Inspector General
Office of the Inspector General
Department of Health and Human Services

330 Independence Avenue, SW
Washington, DC 20201

Cindy Mann, Director
Center for Medicaid & CHIP Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Levinson and Ms. Mann,

On behalf of the nation's Medicaid Directors, we are writing you in response to the recent report issued by the Office of Inspector General of the U.S. Department of Health & Human Services (HHS), "State Standards for Access to Care in Medicaid Managed Care."

NAMD is a bipartisan, professional, nonprofit organization representing the nation's 56 state and territorial Medicaid agencies, including the District of Colombia, whose mission is to represent and serve state Medicaid Directors. NAMD works closely with our members to provide a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of our member states now and in the future.

NAMD appreciates that Members of Congress, the Centers for Medicare and Medicaid Services and the Office of Inspector General (OIG) wish to contribute to the overall body of knowledge regarding Medicaid managed care practices and the oversight role played by the Centers for Medicare & Medicaid Services (CMS). This report comes during a period of significant growth and transformation in the Medicaid program, including within state Medicaid managed care programs. It also is well-timed with CMS's effort to modernize federal managed care rules, an effort for which NAMD has sought to provide the states' perspective.

For Medicaid Directors, access is one of several fundamental components of the program. Without a doubt, the growth in enrollment and limitation in the supply of providers in some locals and in some specialties have challenged states and health plans. In response, states and their health plan partners have had to design innovative service delivery systems, payment models, provider enrollment strategies and many other aspects of their programs to ensure enrollees can access appropriate, high quality services.

Overall, OIG's top-level policy review reflects that states employ a range of approaches when doing so, including in their approach to establish access standards for managed care entities. CMS and the OIG should not consider the lack of uniformity among the state Medicaid programs as states failing to fulfill their obligations to ensure Medicaid beneficiaries are able to access medically necessary health care. As with most aspects of state Medicaid programs, there is more to the story.

First, NAMD believes that OIG's survey instrument is narrowly focused on access standards and fails to place these standards in their appropriate context, which in turn paints a misleading picture of the overall state of Medicaid managed care programs. States develop their standards in accordance with the needs and characteristics of their beneficiary populations, providers, and policy priorities.

State network standards are one of many elements in the overall framework and ongoing process of Medicaid managed care plan procurement, service delivery and oversight. A state's network standards may inform its approach towards these issues, but it is important to place the standards in their proper context as one of many tools states utilize to ensure the provision of high-quality care to their Medicaid beneficiaries.

States also have dedicated staff that regularly communicate with health plan partners to discuss trends in service utilization such as out-of-network providers and emergency room utilization, monitor compliance through direct calling, closely track trends in the enrollee grievances and appeals process and evaluate the information contained in consumer satisfaction surveys. These are in addition to tools the managed care entities may use, such as member surveys, member and provider grievances, and network software.

States have found that these processes can effectively prevent, identify and expeditiously resolve enrollee challenges with access to appropriate care. Thus, policymakers should not interpret network standards as the state's primary means of assessing beneficiary access to care, and it is inappropriate to infer beneficiary access issues based on the degree of a state's enforcement of its network standards.

Further, access must be considered in the broader context of the health care marketplace and the state Medicaid program's goals. State Medicaid agencies design their programs in ways that balance access requirements along with assurances of economy, efficiency and appropriate utilization.

As their managed care programs continue to mature, states are working with managed care entities to implement provider network requirements and models that maximize the efficiency and effectiveness of individual physicians, practitioners and others who are part of a client's care team. States want to provide greater flexibility for plans to build networks and care teams that include not just physicians, but also access to care managers, community health workers, and other practitioners and supports that will address the continuum of a client's needs. Many states are planning or implementing reforms to encourage these types of arrangements, such as patient-centered medical homes or other team-based care approaches. It is vital to place the conversation around network standards within this broader context of innovations in state delivery system reform.

We must also be cognizant that states develop contract standards consistent with their marketplace. The realities of a state's geography, geographic location of providers and members, and provider workforce levels are all key elements for states as they determine appropriate network standards. New or tighter standards will not solve underlying challenges associated with an insufficient supply of physicians and providers that exist in some regions and certain situations –affecting not only Medicaid enrollees, but also individuals with other public and private coverage.

Access standards should also be viewed in light of the many reform efforts states are currently undertaking to address these provider workforce capacity issues. These efforts include a greater emphasis on telemedicine and e-visits, especially - but not exclusively - in rural or frontier states which pursue these creative policy solutions to

maximize their often-sparse provider base. These states are particularly cognizant of the challenges for beneficiary access and are working diligently to address them.

All of these factors make overly prescriptive federal standards and processes a potentially burdensome, ineffective approach. A uniform approach to access or network adequacy standards will not necessarily ensure Medicaid enrollees receive timely access to appropriate services and could do more to drive up costs, impede state reform initiatives, and fail to improve service access or quality.

Instead, states – and their managed care partner organizations -- would benefit from a continuing discussion with CMS regarding effective state policies and practices in this area. As states continually engage with their managed care entities to improve plan performance and high-quality, high-value service delivery, CMS and state Medicaid agencies can and should be doing more to elevate such approaches, namely by providing forums for states to learn from their peers. Clear expectations from CMS in regards to the standard-setting process -- a process which should provide states the leeway to create standards most suited to their populations and policy goals -- could facilitate CMS, state Medicaid programs, and their managed care partners in developing and sharing best practices on access for particular populations and geographic challenges.

Regarding plan compliance, several states have made significant strides in plan oversight and monitoring and more can be done to strengthen these efforts in emerging state managed care programs. NAMD supports the OIG's recommendation that CMS facilitate the dissemination of effective approaches between the states.

We believe a strong federal-state partnership – and ongoing collaboration with health plans – is necessary to ensure federal policies both strengthen the Medicaid program and accommodate the realities for the states as they administer the program. NAMD is ready to serve as a resource for CMS to facilitate this partnership via our existing Managed Care Workgroup, including calls to provide more in depth insight into state practices, or other means, particularly as it pertains to disseminating effective state practices. In addition, NAMD has already issued several recommendations to CMS regarding network adequacy, oversight and other managed care issues. These provide an operations-based perspective for policymakers.

We appreciate your consideration of Medicaid Directors' perspectives on this important issue, and are happy to provide further information.

Sincerely,

Darin J. Gordon
TennCare Director
Department of Finance and Administration
State of Tennessee
President, NAMD

Thomas J. Betlach
Arizona Health Care Cost Containment System Director
State of Arizona
Vice-President, NAMD

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Letter to CMCS Director Cynthia Mann (September 25, 2014)
Medicaid Managed Care Modernization: Strengthening Program Efficiency and Consumer Protections

NAMD
National Association of Medicaid Directors

October 17, 2014

Cindy Mann, Director
Center for Medicaid and CHIP Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20001

Dear Ms. Mann:

NAMD is pleased to submit the third in our series of recommendations to you to inform CMCS's ongoing work modernizing the Medicaid managed care regulations and sub-regulatory guidance and tools for states. This set of recommendations addresses consumer protections in managed care programs.

We share CMS' commitment to ensuring consumers receive appropriate information to assist them with plan selection and access to appropriate services in a timely fashion. States have also made notable progress in recent years to safeguard the rights of Medicaid beneficiaries and ensure the provision of high-quality care. Medicaid agencies are utilizing the technical assistance opportunities offered by CMS and its contractors as well as forums provided by our Association to continue to strengthen managed care contracts, including provisions for oversight and monitoring of plans.

As states continue to expand and enhance their Medicaid managed care programs, each one encounters unique challenges posed by their particular populations and state-specific circumstances. The solutions and approaches states employ to work through challenges are tailored to their contexts to ensure effective and efficient service delivery, to safeguard rights of consumers and to safeguard the integrity of the Medicaid program.

The states' approaches and experiences inform the recommendations we make to you today. The recommendations fall into four broad categories: network adequacy, enrollment processes, managed long-term services and supports (MLTSS) and communications to and with consumers.

As CMS revisits its Medicaid managed care regulations around consumer protections, we ask our federal partners to adhere to three main principles:

- First, the diversity of the Medicaid population and the states' unique characteristics should be kept at the forefront of CMS thinking. A uniform approach to consumer protections will likely prove counterproductive; instead CMS should promote and support existing state models which have proven effective.
- Second, CMS policy should encourage states to leverage existing state programs and infrastructure. These structures are often built to maximize expertise and resources and to tailor engagements to specific subpopulations when at all possible.
- Third, CMS should modernize its beneficiary communications standards with timeless policies which allow states the flexibility to adapt to new methods and technologies, while preserving state flexibility to engage with their Medicaid beneficiaries in the manner best suited to state and beneficiary needs.

The enclosed set of consumer protection recommendations will provide further details regarding the above issue areas and principles. As CMCS progresses with its managed care efforts, NAMD requests that you continue to consult with Medicaid Directors through our national association to ensure continued, optimal support for ongoing program operations.

We appreciate your consideration of our requests and look forward to ongoing dialogue with you on these and other issues.

Sincerely,

Darin J. Gordon
TennCare Director
Department of Finance and Administration
State of Tennessee
President, NAMD

Thomas J. Betlach
Arizona Health Care Cost
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State of Arizona
Vice-President, NAMD

Enclosure: Medicaid Managed Care Modernization: Strengthening Program Efficicency and Consumer Protections

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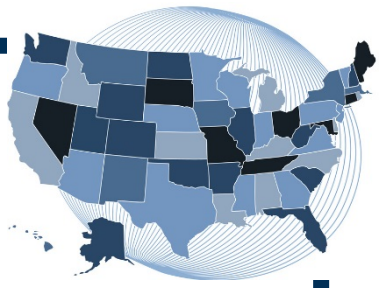

Medicaid Managed Care Modernization:

Strengthening Program Efficiency and Consumer Protections

September 2014

Network adequacy

1. CMS should support additional state-to-state learning and capacity building for Medicaid managed care contract development and oversight. Federal Medicaid statute already requires that each Medicaid managed care plan ensure that all services covered under the state plan are available and accessible to managed care enrollees. The existing federal regulations also require Medicaid managed care plans to assure and document to the state their capacity to serve the health care needs of their enrollees. Documentation must demonstrate that the participating plans offer a range of primary, preventive and specialty services. In addition, plans must maintain a provider network sufficient in number, type and geographic distribution.

   CMS could promote model practices, standards and tools currently in use to ensure access to high-quality, high-value providers. In particular, model practices for measuring geographic access, especially in rural areas and by specialty type, would be helpful for states. CMS also could focus resources on building capacity in state agencies to support design and implementation of policies to strengthen quality in provider networks.

2. CMS should not apply prescriptive national network adequacy standards to state managed care programs due to: (1) the complex and varied needs of Medicaid enrollees; (2) the variation and nuances in state health care marketplaces; and (3) the adverse impact they would have on state initiatives to drive appropriate utilization of services and outcomes. Medicaid managed care programs are designed to improve access and better coordinate and manage services for enrollees with a broad range of medical, behavioral and supportive service needs. States may offer plans for those with behavioral health conditions, children with special health care needs, or for long-term services and supports for older people and people with disabilities. Prescriptive federal network adequacy standards for managed care would not capture the critical differences within a state's managed care products, which are necessary to meet the complex and varied needs of Medicaid enrollees. States are best equipped to understand these differences and ensure access to care for populations served in Medicaid managed care.

   In addition, national Medicaid network adequacy standards cannot sufficiently account for the differences between state health care marketplaces, including the

unique geographic challenges that are present in many rural regions of states. This is demonstrated by the fact that existing federal network adequacy approaches, such as in Medicare Advantage, are not appropriate for Medicaid managed care networks. The metropolitan statistical areas (MSAs) used by Medicare do not accurately reflect the characteristics of many regions within states. For example, certain MSAs have an extremely low population density, which fails to support the number of providers anticipated for a region with an MSA designation. As a result of these marketplace differences, applying federal standards will result in perverse incentives that drive up the cost of services simply to meet the standards.

Finally, prescriptive national standards could also undermine delivery models that are designed to improve care coordination, efficiency and outcomes and stifle innovation in the future. In particular, Medicaid populations often have complex health needs, including multiple chronic conditions which require unique coordination and management. States are working to optimize provider networks in ways that utilize high performing providers and meet the complex needs of Medicaid beneficiaries. They are also using different and more cost-effective providers (i.e. community health workers, personal care workers and peer support specialists) to deliver services and supports in ways that cannot be captured in national network adequacy standards.

3. <u>If CMS revises existing federal network adequacy regulations and guidance, a state-specific network adequacy plan offers the best pathway to ensure enrollees have access to high quality, medically necessary services.</u> States are ideally equipped to understand the dynamics of their health care marketplace and how best to ensure access for the diverse population of beneficiaries they serve. As a result, a state-specific network adequacy plan would ensure that states plan for and address the key issues in network adequacy, such as how the state is securing access in all geographic regions of the state.

   The state network adequacy plan should address two components. The state would submit its plan to CMS as part of the contract review process. The components are the following:

   a. Network adequacy standards developed by the state. The standards would apply to specified populations and specialty plans. In addition, the standards could build upon existing state approaches and structures rather than create

new ones.

b. A monitoring plan would describe the processes by which the state will monitor the standards.

Enrollment Processes

1. CMS should promote model enrollment practices and offer technical assistance as other states work to incorporate information about value-based choices for consumers. States share CMS' belief that informed member choice is an important component of the enrollment process, but believe there should be flexibility in the specific model that is used to make this information available to consumers.

   Further, many states have already invested extensive resources to incorporate informed choice in their Medicaid enrollment processes. These experiences offer many learnings that can be adapted by other states as they work towards improving their engagement with consumers and the information they provide about value-based choices. States would benefit from a library of resources which highlight effective policies and practices, including for specific subpopulations.

2. CMS should support state approaches to enrollment that balance consumer choice and obligations of the state Medicaid agency and health plans ability to demonstrate quality. Increasingly states are using the enrollment process as a means of driving quality improvement and value among participating plans and networks.

   Several states utilize beneficiary auto-enrollment as a means to incentivize managed care entities to invest in quality improvement and drive delivery system reforms. States develop auto-assignment algorithms that use a variety of criteria and are designed to select the best health plan for enrollees who fail to choose their own. For example, a state may choose, based on reported plan quality measures, to increase or decrease the number of beneficiaries passively or mandatorily enrolled into the plan in order to drive plan performance. A state may also suspend enrollment as a way to address plan performance. These types of approaches should be supported by CMS as important levers to ensure quality in managed care.

3. CMS should modify the federal definition of "choice" to reflect geographically driven aspects of managed care marketplaces. The current policy, which requires regions

with an MSA designation to offer plan choice, does not account for geographic differences and the low population and provider density within different MSAs. In certain regions of the country, MSAs simply do not have the population density to support multiple plans. Further, the current application of this policy has also led to disruption in state delivery system improvement initiatives.

An alternative approach, which would address these concerns, is to tie population density to the members being served to the application of plan choice requirements. Using this method, an area designated as an MSA must also meet a specified population density (determined through federal consultation with state Medicaid programs) in order for plan choice requirements to apply. If an MSA does not meet this de minimus threshold, mandatory federal plan choice requirements would *not* apply. In this situation, states would have the option to request that single plan service that area. States would still submit to CMS documentation that the risk-based entity meets applicable network adequacy standards.

Managed Long-term Services and Supports

1. In the managed long-term services and supports (MLTSS) arena, states can build on existing consumer protection and oversight structures and utilize multiple entities and resources to strengthen education for consumers, where needed. In conjunction with recent comprehensive 1115 and 1915(c) waivers, CMS has included certain elements in the state's special terms and conditions (STCs), in particular Ombuds programs for beneficiaries.

   If CMS seeks to apply the Ombuds requirement more broadly in Medicaid, states must have the flexibility to leverage and coordinate across structures that already exist. In fact, many states and communities already have some form of an Ombuds program, though it may not reside within the Medicaid agency. Duplication of existing functions to comply with a new federal requirement could potentially divert valuable state resources from other plan functions and create confusion for the beneficiary.

   In addition, with regard to Ombuds programs and consumer protections more broadly, a one-size-fits-all federal approach will not work for the Medicaid program. For example, the needs of enrollees in MLTSS can be so highly specialized and individualized from beneficiary to beneficiary that the task of properly educating the consumer about plan features may be too nuanced for a single consumer education

entity to accomplish. State experiences with MLTSS and the Duals Demonstration Projects show this often to be the case. CMS should afford states the flexibility to draw upon the expertise and resources of multiple state agencies and other knowledge bases to best accommodate beneficiary questions and needs

Further, states want to ensure any new federal rules do not undermine the ability to direct enrollee concerns to the contracted health care entity. States include requirements and certain consumer protections as part of their contracts with plans and networks. Any new federal requirement for Ombuds or other consumer protections should be designed considering the state's contracting tools.

2. CMS should work with states to identify and disseminate effective plan contracting and structuring approaches, with a focus on specific Medicaid subpopulations. Medicaid managed care has grown substantially over the past decade, but it is important to acknowledge that states possess varying levels of expertise in this arena. This is especially true for subpopulations, such as the MLTSS population or states utilizing managed care to provide behavioral health services. CMS should work with states to identify plan contracting practices, structures and approaches that appear especially effective for these challenging subpopulations. For example, one state utilizes specialized contractors and highly trained agency staff to conduct targeted counseling and consumer education for its special populations. These effective practices should be widely disseminated by CMS to the states.

Communications

1. CMS should modernize its policies to allow states and plans to communicate with their beneficiaries in the methods the beneficiary prefers and that is feasible to the states and plans. The technological environment in which modern health services operate has changed substantially since CMS promulgated its initial Medicaid managed care regulations. Many consumers now regularly utilize electronic communications as their primary means of interacting with modern businesses and government entities. However, elderly beneficiaries may still prefer to receive communications from states and plans via paper mail and telephone. States support CMS modernizing its communications policies, so long as this modernization does not unduly burden the states and ensures beneficiaries receive timely communications in the form they find most useful.

2. CMS's rules and guidance must be "timeless." The health care data, technology and social media climate is constantly changing, but CMS' current rules do not work well in this environment. States need to continually adapt to these technological advances and trends, while maintaining policies that protect the rights and reasonable preferences of enrollees. We believe CMS should focus on articulating how states will notify CMS of its communications processes and mechanisms, as opposed to implementing federal policies to address specific technologies.

3. Member choice packets should include the option for enrollees to request hard copies of provider directories. States believe it is important for consumers to make an informed selection between available health plans. However, consumers may be less likely to actively select a health plan when they face information overload, which can result from receiving multiple, sizable hard copies of provider directories in the member choice packet. Giving consumers the option to receive hard copies of provider directories, rather than including the information by default, would mitigate this concern and help ensure consumers receive the most appropriate, useful information to make an informed choice. This is also a more efficient use of taxpayer resources.