



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES



Managed Care Rules: Improving Consumer Information

Kelly Whitener

Tricia Brooks

Sarah Somers

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Children in Managed Care

- CMS finalized sweeping changes to Medicaid and CHIP managed care regulations in May, 2016
- Regulations set minimum standards; states have flexibility to do more
- Many opportunities for legal and health advocates to take action



Flag potential actions for legal and health advocates

Why are these rules so important?

11% of
children in
Medicaid/
CHIP are
enrolled in
FFS

22% of
children in
Medicaid/
CHIP are
enrolled in
PCCMs

66% of children in
Medicaid/CHIP are
enrolled in MCOs



Managed Care Project

- Series of six explainer briefs and webinars
 - ① Looking at the Rule through a Children's Lens (released)
 - ② *Improving Consumer Information* (6/23)
 - ③ Enhancing the Beneficiary Experience (7/11)
 - ④ Assuring Network Adequacy and Access to Services (8/4)
 - ⑤ Advancing Quality (9/8)
 - ⑥ Ensuring Accountability and Transparency (9/29)
- Fall meeting in D.C. with child health and legal advocates to strategize over implementation
- Thanks to Robert Wood Johnson Foundation

Our Topic Today: Consumer Information

- Basic Rules and Applicability
- Consistency in Information
- Electronic Information Requirements
- Language and Format Provisions
- State and Plan Requirements

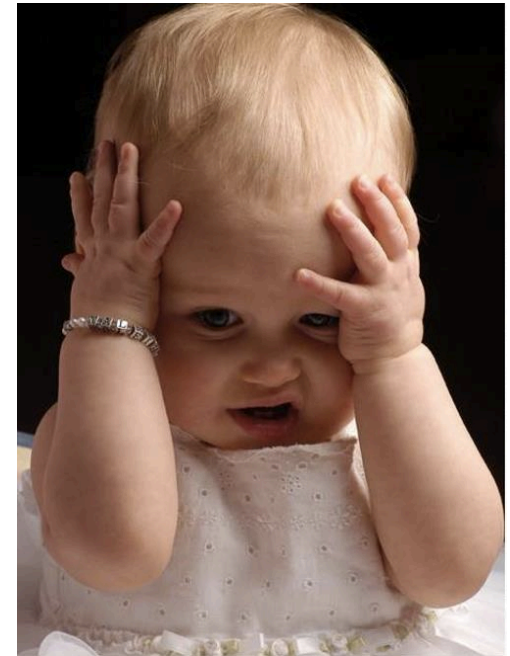


Flag potential actions for legal and health advocates

Background

- Prior rules not sufficiently clear or direct
- Did not reflect use of current technology
- Often inadequate or lack of timely information to make an informed plan selection and understand benefits and rights
- Information varies from plan to plan, lacks consistency

Getting Help
Network
Benefits
Accessing Services
Drugs
Appeals



Applicability

- All Medicaid managed care plans regardless of authority (state plan option, § 1115 demonstration, or § 1915(b) waiver) and CHIP
- Basic rules – information must be easily understood and in a readily accessible manner and format – apply to states, enrollment brokers, and all types of plans
- Some differences for PCCM entities depending on scope of responsibilities, while PCCMs only need to meet basic requirements

Timeline



- Provisions at § 438.10 are effective, starting with rating periods beginning on or after July 1, 2017.
- Rating period = the 12-month period selected by the State.
- States may contract for multiple years but must set rates for approval to CMS to 12 month periods.



Find out when your state's next rating period starts.

Basic Rules

- All required consumer information must be provided in a manner that is easily understood and is readily accessible.



Applies to the state, enrollment brokers, and ALL types of managed care entities, including MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities.



States have flexibility to define “easily understood” – such as a grade reading level. Encourage your state to engage stakeholders in defining easily understood.



A best practice is to have all information consumer tested!

State Requirements

- Use beneficiary support system (§ 438.71) to provide education and choice counseling.
- Ensure through contracts that each MCO, PIHP, PAHP, and PCCM entity complies with this section.
- Operate a website.



Encourage your state to provide opportunities for website testing/feedback, and to explore the advantages of having all prevalent consumer materials posted on state's website (rather than linked to plan's website).

Consistency in Information

Key Managed Care Terms –

- States must define and require plans to use.



States have flexibility to expand the list of standardized terms.

Encourage your state to seek stakeholder input on terms and definitions.

- Appeal
- Copayment
- Durable medical equipment
- Emergency medical condition
- Emergency medical transportation
- Emergency room care
- Emergency services
- Excluded services
- Grievance
- Habilitation services and devices
- Health insurance
- Home health care
- Hospice services
- Hospitalization
- Hospital outpatient care
- Medically necessary
- Network
- Non-participating provider
- Physician services
- Plan
- Preauthorization
- Participating provider
- Premium
- Prescription drug coverage,
- Prescription drugs
- Primary care physician
- Primary care provider
- Provider
- Rehabilitation services and devices
- Skilled nursing care
- Specialist
- Urgent care

Electronic Information Requirements

- Information may NOT be posted electronically unless it meets all standards
- Rule updates definition of readily accessible
- Information must be provided in paper form upon request



Applies to states, enrollment brokers, MCOs, PIHPs, PAHPs, PCCMs,* and PCCM Entities

- **Readily accessible:** info must comply with modern accessibility standards such as section 508 guidelines § 438.10(a).
- Information:
 - must be posted in a prominent and readily accessible place on the state's, MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's website.
 - can be electronically retained and printed.
 - is consistent with content and language requirements.
- The enrollee is notified that the information is available at no cost upon request in paper form, which must be provided within 5 business days.

Prevalent Language Requirements

- States must establish a methodology for identifying prevalent non-English languages spoken throughout the state and in each plan service area



States have flexibility to determine what is a significant # or % of LEP consumers.

Encourage your state to consult with stakeholders in establishing these parameters.

New definition of prevalent: *“a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient (LEP).”*

Definition of LEP: *“potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read write, speak, or understand English.*

Oral Interpretation and Written Translation

General Requirements:



Apply to States and Plans

- Oral interpretation
 - Applies to all languages, not just prevalent
 - Includes auxiliary aids (TTY/TDY and American Sign Language)
- Written translation
 - 12 point font
 - Prevalent languages (area varies)
 - Large print taglines (18 point font)

States and enrollment brokers

- Applies generally to *potential enrollees*
- Translations and taglines in prevalent languages in the state

MCOs, PIHPs, PAHPs, and PCCM entities

- Applies generally to *enrollees*
- Translations for prevalent languages in service area
- Taglines for prevalent languages in state

Applicability of Language and Format Requirements to “Critical Materials”

- Rule defines critical materials minimally as:
 - Enrollee handbooks
 - Provider directories
 - Appeal and grievance notices
 - Denial and termination notices



States have flexibility to expand list of critical written materials.

Encourage your state to involve stakeholders in assessing additional materials that should be subject to language and format requirements.

Other Opportunities for Stakeholder Engagement on Language & Format



Wording and placement of taglines on notices is important to getting the message across.

Encourage your state to seek stakeholder input/feedback on development of tagline language.



While plans are required to provide information in alternative formats, the rule does not require specific formats.

Encourage your state to involve stakeholders in determining the alternative formats that must be available to enrollees.



Plans must have mechanisms to help enrollees and potential enrollees understand the requirements of the plan.

Encourage your state to engage stakeholders in assessing what mechanisms are needed to help consumers understand the plan.

Information for Potential Enrollees

Information must be provided to potential enrollees within a timeframe that enables use of the information to choose a plan.



Applies to states or contracted representative(s) (e.g., enrollment brokers, choice counseling entity)



Encourage your state to engage stakeholders in determining what is a sufficient timeframe.

- Clear information about the right to disenroll.
- The basic features of managed care.
- Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily.
- The service area covered by each plan.
- Which benefits are covered by the plan or provided directly by the state.
- Where and how enrollees can obtain counseling or referral services not provided by the plan for moral or religious objections.
- Provider directory and prescription drug formulary information.
- Any cost-sharing requirements.
- Requirements of each plan to provide adequate access to covered services, including the state's network adequacy standards.
- The plans' responsibilities for coordination of enrollee care.
- Quality and performance indicator data for each plan, including enrollee satisfaction.



Information for Enrollees



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).



Encourage your state to engage stakeholders in determining what defines regular use of a provider that considers provider type. For example, regular use of an OB/GYN might be once annually.

- Plans must provide:
 - Enrollee handbooks
 - Provider directories
 - Drug formularies
 - Physician incentive plans (upon request)
- Make a good faith effort to provide written notice within 15 days to enrollees if PCP or regular provider leaves the network

Enrollee Handbooks

Information must be provided to potential enrollees within a reasonable time following enrollment.



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).



Encourage your state to engage stakeholders in determining what is a reasonable time.


ABBREVIATED LIST OF ENROLLEE HANDBOOK REQUIREMENTS

- Detailed benefit information and how to access.
- Procedures for obtaining benefits.
- Cost sharing.
- How transportation is provided.
- Details about after-hours and emergency services.
- Restrictions on enrollee's freedom of choice among network providers.
- Specific information about accessing family planning services.
- How and where to access counseling or referral services that the plan does not cover based on moral or religious objections.
- How and where to access benefits provided by the state.
- Enrollee rights and responsibilities.
- The process of selecting or changing the enrollee's primary care provider.
- Detailed information on grievance, appeal, and fair hearing procedures and timeframes.
- How to exercise an advance directive.
- How to access auxiliary aids and services, including additional information in alternative formats and languages.
- The toll-free telephone number for member services, medical management, and any other unit providing services.
- Information on how to report suspected fraud or abuse.
- Other content required by the state.



Flexibility in Providing Enrollee Handbook

- Mail a printed copy
- Provide electronically after enrollee agrees to receive the information electronically
- Inform enrollees by mail or email that information is posted on website and include Internet address
- Provide content through auxiliary aids and services



Give enrollees a 30-day notice of significant change



States may require other content, or define what is a significant change.

Encourage your state to engage stakeholders in development of the enrollee handbook to ensure it is useful, thorough, and easy to understand; and in defining what is a significant change.

Provider Directories

- Specific information must include...
- Available in electronic or paper form
 - Paper updated monthly
 - Electronic updated within 30-days



- Provider's name, as well as any group affiliation.
- Street address(es).
- Telephone number(s).
- Web site URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider is accepting new enrollees.
- The provider's cultural and linguistic capabilities, including spoken and American Sign languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- Whether the provider's office has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.



Encourage your state to engage stakeholders in determining additional content or standardized formats for provider directories.

Drug Formularies

- Required information is limited to:
 - Medications covered (both generic and brand name)
 - Drugs' tier
- Must be posted on plan's website (and available in paper form upon request)
- No requirements for timeliness of updates.



Encourage your state to engage stakeholders in identifying additional content, standardizing the format, or setting timeliness standards for updates to drug formularies.

For More Information

- Kelly Whitener
 - kdw29@georgetown.edu
- Tricia Brooks
 - pab62@georgetown.edu
- Sarah Somers
 - somers@healthlaw.org