

AHCA/NCAL's

Principles to Ensure Access, Quality and Choice under Managed Care

- 1. Managed care programs must improve quality and efficiency, first.** The core of any policy goal for any managed care program should be improved quality. The current pool of available literature does not provide conclusive findings about the impact of managed care on costs, access or quality. Evidence is needed on how Medicare Advantage (MA) and Medicaid Long Term Services and Supports (MLTSS) plans perform relative to traditional Medicare and Medicaid, particularly for patients with significant medical needs that make them especially vulnerable to unsafe or lower quality care. The Centers for Medicare & Medicaid Service (CMS) and states should ensure that encounter data and other appropriate financial and clinical data is made available to researchers and policymakers to facilitate evaluation of managed care programs and compare costs and outcomes with those in fee-for-service (FFS).
- 2. States and plans should possess demonstrated experience before implementing or expanding managed care.** Managed care programs have typically been developed based on an acute and primary care service delivery model; lack of familiarity with post-acute care/long term care (PAC/LTC) may result in compromised access and quality of care for a large number of beneficiaries. Although CMS and states require plans to undergo a readiness review process to ensure beneficiary needs are met, plans are often unprepared for program implementation as it relates to PAC/LTC, leading to malfunctions that result in significant disruptions to beneficiary care. CMS, states and plans should complete targeted readiness assessments before implementing or expanding managed care and results of these assessments should be publicly available. Readiness assessments should include provider education/training, end-to-end systems testing and readiness to accommodate existing plans of care or existing providers during transition periods to address the unique needs of populations requiring PAC/LTC.
- 3. CMS and states must ensure strong federal and state oversight of managed care program operations and impacts.** Responsibility for oversight of the managed care delivery system must be assigned to the state and federal governmental personnel with the authority necessary to proactively administer the plan in the public interest. These officials should possess experience in addressing the needs of beneficiaries receiving PAC/LTC, seek routine input from providers and other relevant stakeholders, appreciate the importance of establishing an explicit contract with managed care entities and ensure ongoing monitoring of performance against contract requirements. CMS and states should also have mechanisms in place to ensure continuity of care and provider reimbursement in the event managed care plans are not able to meet contractual obligations or become insolvent. As plans are increasingly delegating both administrative and clinical responsibilities to subcontractors, it is also imperative that federal and state personnel pay special attention to subcontracted entities to ensure accountability and contract fulfillment.

- 4. Provider reimbursement should be aligned with managed care program quality and access goals.** Under managed care, plans often seek to reduce reimbursement rates to providers in order to contain costs. In addition, many providers experience lengthy delays in payment from managed care plans. It is well understood that inadequate and/or delayed provider payment significantly compromises providers' ability to deliver quality care. True savings should be derived from care coordination, prevention and wellness and quality initiatives. Rate reductions, excessive payment delays, unnecessary utilization controls or cumbersome prior authorization processes and post-payment audits are not appropriate or meaningful tactics to contain costs. Rate adequacy and timely payment standards should be clearly defined to ensure that plans do not employ these strategies. CMS and states must also take action when plans do not adhere to rate adequacy or timely payment requirements.
- 5. CMS and states should offer individuals meaningful opportunities to make educated health decisions.** Choice is at the core of health care delivery, and managed care programs must seek to enhance individual choice and empower beneficiaries to direct the services/supports they receive. Individuals should have the right and ability to make educated decisions about enrollment. Further, CMS and states should provide beneficiaries with information regarding all enrollment options, including material that describes how to opt-out and into other plans or delivery systems at appropriate times. Beneficiaries also should have the choice of services as well as service setting. Plans should be required to provide resources and tools to individuals so they can make educated decisions about their services and service settings. In addition, plans that incentivize beneficiaries to choose network providers should include clear information about mechanisms to appeal for network rates for out-of-network providers.
- 6. Providers should have meaningful and adequate avenues to raise issues and challenges experienced under managed care programs.** Currently, appeals and/or grievance processes are defined by the health plans in the provider/plan contract, often leaving providers with limited opportunities to voice and/or address concerns when/if plan processes fail. In addition, many providers are fearful that any appeal or grievance action will result in either termination of their contract or loss of their preferred network status. To the extent possible, public programs should preserve existing structures to provide legal due process to providers, including measures to prevent retaliation against providers who bring challenges to plan policies and decisions. CMS and states also should develop independent appeals and grievance processes to ensure that there are sufficient opportunities for providers to raise issues that must be addressed with respect to plan performance and compliance. In addition, CMS and states should maintain provider liaison functions to support participating providers as they encounter hurdles to delivering quality care. Lastly, provider satisfaction surveys should be incorporated into health plan performance measurement processes.
- 7. Managed care arrangements should ensure beneficiaries access to care wherever/whenever it is needed.** Absent adequate provider networks, managed care plans cannot effectively provide beneficiaries with appropriate and timely services. Current network adequacy standards do not adequately account for the complex and varying needs of beneficiaries receiving PAC/LTC. Network requirements for managed care plans providing PAC/LTC services should be established based on the needs, preferences, and existing provider relationships of beneficiaries, and also must maximize choice among providers of a given service area. To the extent the plans use criteria beyond the minimum federal/state standards, these criteria should be made publicly available to prevent provider discrimination. Lastly, managed care programs should offer adequate protections, such as beneficiary access to out-of-network providers to ensure continuity of care without financial penalties.

8. **Managed care programs should ensure administrative efficiency and consistency across plans.** Managed care plans typically develop unique processes for functions such as eligibility/enrollment verification, prior authorization, care coordination, grievances and appeals, quality improvement and claims payment. Often, managed care plans may delegate certain roles and responsibilities to subcontracted entities, which may also develop their own unique processes for these functions. Such variation creates significant confusion and administrative burden for providers, negatively impacting overall efficiency and timely access to care. This confusion and burden is amplified in integrated Medicare-Medicaid plans, as these plans may have differing processes for Medicare and Medicaid services and benefits. Administrative simplification and inter-plan consistency should be core components of any managed care arrangement, particularly given the possibility for opting in and out of plans.
9. **Care coordination should enhance healthcare delivery, not impede it.** Care coordination is the foundation of managed care. When done properly, it holds the potential to yield better outcomes and lower costs. Employing these practices is critical for beneficiaries who receive care across a wide array of settings. However, unclear delineation of care coordination roles and responsibilities will only create confusion and could impact quality and efficiency. Such roles and responsibilities should be clearly defined, particularly for managed care plans that have limited experience serving the PAC/LTC populations or that delegate these roles and responsibilities to subcontractors. Managed care plans should clearly identify contact names and information of employees responsible for resolving issues around utilization review, audits, and payment to avoid disruptions in care. In addition, CMS and states must ensure that plan care coordination practices are integrated into other existing care coordination programs that CMS, states and providers already have underway to reduce duplication or inconsistency across efforts. CMS and states must also ensure that care coordination protocols do not prevent a provider from discussing beneficiary treatment options or advocating for the beneficiary within the utilization review or other relevant processes.
10. **Stakeholder engagement should play an integral role in all aspects of managed care program planning, implementation, refinement and expansion.** Managed care plans typically develop unique processes for functions such as eligibility/enrollment verification, prior authorization, care coordination, grievances and appeals, quality improvement and claims payment. Often, managed care plans may delegate certain roles and responsibilities to subcontracted entities, which may also develop their own unique processes for these functions. Such variation creates significant confusion and administrative burden for providers, negatively impacting overall efficiency and timely access to care. This confusion and burden is amplified in integrated Medicare-Medicaid plans, as these plans may have differing processes for Medicare and Medicaid services and benefits. Administrative simplification and inter-plan consistency should be core components of any managed care arrangement, particularly given the possibility for opting in and out of plans.