

**American Society of Internal Medicine
Policy Statement on Medicaid Managed Care
April 1996**

Standards for Medicaid Managed Care

By the end of this century, all state Medicaid programs are expected to be engaged in some type of managed care delivery system. As Medicaid patients increasingly receive care from managed care organizations, important safeguards must be adopted to protect patients and to preserve the program's integrity. ASIM recommends a number of steps states should take to avoid some of the problems that have arisen in certain existing Medicaid managed care programs.

1. State governments should demonstrate to the federal government the organizational capacity and structure sufficient to operate a Medicaid managed care program. Running a fee-for-service Medicaid program in which a state's major responsibility is to process claims is vastly different from a managed care Medicaid program in which a state must evaluate health plans, oversee enrollment of beneficiaries in those plans and monitor the health plans' performance during a contract period. States must have clearly delineated lines of accountability and must make sure that health plans have the ability to ensure access to all Medicaid benefits and have in place solid quality assurance processes to maintain and improve the care delivered to beneficiaries.
2. States should conduct appropriate education and outreach programs to their Medicaid populations to familiarize them with the rules of managed care. Many Medicaid recipients are unfamiliar with the rules and requirements of managed care and this lack of knowledge, often coupled with procedures in which some states have simply assigned patients to a particular health plan, has led to problems when patients didn't realize they had to use network providers or did not know that they had to seek care from a primary care physician. To avoid confusion on the part of recipients and providers created by automatic enrollment policies, states should be required to notify enrollees concerning any health plans to which they may be assigned and the need to use a health plan's network of providers.
3. States should establish a statewide grievance system for their Medicaid managed care program for use by enrollees and providers to report instances of fraud and abuse or unreasonable denials of care. Under Medicaid managed care, health plans are the recipients of public funds and taxpayers have a right to have their money spent for the purposes intended. Furthermore, patients and providers must have some avenue of redress when health plans appear to be abusing their responsibilities to them and to the Medicaid program.
4. States should have the authority to impose fines, terminate enrollment and cut off payments to health care plans violating the standards of the Medicaid managed care program. To "put teeth" in any grievance system, states must be able to take actions against health plans that fail to live up to the standards set for Medicaid managed care.
5. States should be encouraged to adopt independent enrollment brokers for their Medicaid managed care plans and to develop processes that lessen incentives for marketing abuses.
Rules on marketing by Medicaid managed care plans should be strengthened, including, but not restricted to, prohibitions on door-to-door canvassing in low-income areas,

marketing at food stamp offices and offering gifts as incentives to join a plan.

To alleviate problems associated with rotating enrollment, beneficiaries who join a managed care plan should be required to remain in the plan for the remainder of the plan year, after an initial 60 day trial period.

The experience to date with several state Medicaid managed care plans suggests that some managed care organizations engaged in numerous instances of deceptive and aggressive marketing tactics aimed at enticing patients to enroll in their company. A number of states have sought to avoid these sales abuses by designating independent entities that collect information about all health plans, disseminate that information to Medicaid recipients and then serve as the avenue through which patients enroll in a health plan.

Many managed care organizations complain that some Medicaid programs automatically sign patients up with a plan with little, if any, notice to the beneficiary, but the beneficiaries are not required to remain with a plan for any length of time. After a few months, the beneficiaries may drop out of the plan when they discover that they cannot go to their regular health care provider. Under these circumstances, health plans cannot anticipate their costs and usage of services per enrollee making participation in Medicaid less appealing. In addition, perverse incentives can be created in which some health plans may contract with Medicaid and receive monthly payments on behalf of beneficiaries who never use the plan's services before they drop out after a short period of time.

6. State contracts with Medicaid managed care plans should include standards for accountability and management of the health plan. This should include review of a health plan's medical necessity standards and preauthorization rules, with input from physicians in the community, to ensure that the health plan's standards of care are consistent with those in the medical community. States must ensure that the utilization and quality review requirements that health plans use reflect the standards of care adopted by most physicians and health care providers in the state. To facilitate this, health plans should enlist practicing physicians in the development of their medical necessity and preauthorization standards.
7. Similar regulatory standards should be applied to Medicaid plans as those applied to commercial managed care plans, including accreditation by an established third party accrediting body and licensing by a state insurance department or equivalent licensing body. To encourage health plans to enter their Medicaid program, some states loosened the regulation of managed care entities serving their Medicaid populations. Unfortunately, some health plans managed by persons of questionable ethics took advantage of this and entered the Medicaid market, misused state payments to health plans and ceased business abruptly, leaving patients and providers with the bill. Medicaid managed care plans should be treated no differently than commercial plans.
8. Background checks should be conducted by the state on health plan owners and managers, with prohibitions against granting of an HMO license to anyone with a criminal background. As noted above, to protect against the abuse of their programs by those with a record of legal actions against them, states should not contract with health plans owned, operated or managed by persons who have been subject to criminal or civil prosecution.
9. Health plans should be required to report to the appropriate state agency the total compensation of health plan executives and the percentage of their Medicaid payments utilized for health care services and medical care. Patients and the public have a right to