Testimony of  
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House Committee on Appropriations – Health, Mental Health, and Social Services  
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Thank you for the opportunity to testify before the Committee on this important issue. My name is Cora Walker and I am the Health Law and Policy Fellow at Saint Louis University School of Law where my research primarily focuses on Medicaid, state and federal health reform, and private health insurance.

The goal of Medicaid managed care should be to improve access to high-quality care as well as control costs. Not only can better quality care lead to better health outcomes for Missourians, investing in quality has the potential to help control rising health care costs in several ways. First, quality improvement can help facilitate better management of chronic conditions. Secondly, a high quality Medicaid managed care program can lower costs by reducing overuse, underuse, and misuse of health care.

Today, I want to share with you information from recent national surveys that offer important insight into the quality of care provided by Missouri’s Medicaid managed care plans.

I. Two out of three Missouri Medicaid managed care plans rank in the bottom half nationwide.¹

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that accredits managed care plans and certifies a wide range of health care organizations. Each managed care plan participating in Medicaid in Missouri is required to pursue and achieve NCQA accreditation during the contract period.

Annually, NCQA evaluates and ranks Medicaid managed care plans, private plans and Medicare Advantage plans. NCQA’s standardized measures allow for meaningful comparisons among Medicaid managed care plans nationwide and serves as an important resource for understanding how Missouri’s plans are doing compared to other states.

¹ The third plan did not submit data for evaluation.
This year NCQA ranked 136 Medicaid managed care plans based on performance in three categories of quality: consumer satisfaction, quality of care, and NCQA Accreditation. NCQA ranked two of Missouri’s three Medicaid managed Care health plans, Health Care USA and Missouri Care Health Plan. The state’s third Medicaid managed care plan, Home State Health Plan, was not ranked because it did not submit data. Home State Health Plan was also not accredited until August 2014.

Both Health Care USA and Missouri Care Health Plan ranked in the bottom half of Medicaid managed care plans nationwide.

- **Healthcare USA of MO ranked #84 out of 136, placing it in the bottom 40% of plans.**
- **Missouri Care Health Plan ranked #109 out of 136, placing it in the bottom 20%.**

These NCQA rankings tell us Missouri managed care plans have room for improvement.

**II. Nationally, fewer than one-half the primary care and specialty providers listed as part of Medicaid managed care networks actually accept patients.**

A December 2014 study by U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that fewer than half the primary care and specialty providers listed as part of Medicaid managed care networks were actually accepting patients. 43% of providers could not be found at the location listed by the plan. Another 8% were not accepting new patients.

The OIG used a “secret shopper” study to test whether the providers listed by Medicaid managed care plans as part of their networks were actually accepting new patients. This national study does not tell us about the situation in Missouri. However, it does raise concerns that about solely relying on plans’ provider directories to accurately reflect whether patients can find a network provider who will treat them.

**III. Conclusion**

As you consider the appropriation for Medicaid managed care, I urge you to also consider the need for increased Medicaid managed care transparency and accountability to ensure that patients have timely access to good, quality care.

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3 The study is available at [http://assets.fiercemarkets.com/public/healthcare/oig-medicaid-access.pdf](http://assets.fiercemarkets.com/public/healthcare/oig-medicaid-access.pdf)
Medicaid managed care plans should be required to report and post online a set of standardized quality measures so that consumers and lawmakers can assess how well Medicaid managed care plans measure up in providing care such as preventive services, screenings and prenatal care as well as recommended treatments for conditions like diabetes and heart disease. Plans should also have to report and share consumer satisfaction surveys about providers and services.

Medicaid managed care organizations should also be required to report on their provider networks so that there is publicly available information about managed care networks.

Moreover, Missouri should also require an annual secret shopper survey of Medicaid managed care organizations to directly test, as OIG did, whether plans have in place the provider networks they claim in the papers they file with the state and the provider directories they make available to patients.

Attached is suggested bill language.

Thank you for your time.
Model Bill Language for Missouri Medicaid Managed Care Accountability and Transparency Standards

208.999. 1. Managed care organizations shall be required to provide to the department of social services, on at least a yearly basis, and the department of social services shall publicly report within thirty days of receipt, including posting on the department’s website, at least the following information:

(1) Medical loss ratios for each managed care organization compared with the eighty-five percent medical loss ratio for large group commercial plans under Public Law 111-148 and, if applicable, with the state’s administrative costs in its fee-for-service MO HealthNet program;

(2) Total payments to the managed care organization in any form, including but not limited to tax incentives and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization.

2. Managed care organizations shall be required to post all of their provider networks online and shall regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan shall not be so listed.

3. The department of social services shall be required to contract with an External Quality Review Organization, an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of MO HealthNet managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets, not to exceed ten-thousand dollars annually. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing shall be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed health plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in MO HealthNet at all, not participating in MO HealthNet under the plan which listed them and was being tested, or participating under that plan but only for existing patients.

4. Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis requiring the plan to take prompt and effective corrective action, and for the imposition of sanctions against the offending managed care organization as determined by the department.

5. The provider compensation rates for each category of provider shall also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to
commercially insured individuals, as required by federal law, and compared, if applicable, to the state's own provider rates for the same categories of providers.

6. Managed care organizations shall be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

(1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service;

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to MO HealthNet enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

(3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the timeframe data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

7. Managed care organizations shall be required to disclose the following information:

(1) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures;

(2) Consumer satisfaction survey data;

(3) Enrollee telephone access reports including, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(4) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

(5) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last thirty days, or have not recently been hospitalized;

(6) Results of network adequacy reviews including geo-mapping, stratified by factors including provider type, geographic location, urban or rural area, any findings of adequacy or inadequacy, and any remedial actions taken. This information shall also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new
patients;

(7) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and

(8) Any additional reported data obtained from the managed care plans which relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

208.1000. 1. Fee for Service Medicaid program shall be required to report publicly by posting on the department of social services web site as well as through other means, on at least a yearly basis,