

An Analysis of the Bush Administration's Proposed Medicaid Managed Care Regulations

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor, Health Law and Policy

Colleen Sonosky, J.D.
Senior Research Scientist

Hirsh Health Law and Policy Program
Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center

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Introduction and Findings in Brief

This analysis examines the Medicaid managed care Notice of Proposed Rulemaking (NPRM) issued by the Bush Administration, on August 20, 2001. This NPRM will replace the final Medicaid managed care regulation issued by the Clinton Administration in January 2001.¹ The NPRM focuses, in particular, on standards of care for children and adults with special health care needs,² performance standards applicable to individuals who face an elevated risk of medical underservice, consumer protections, and anti-discrimination. Following a brief overview of the federal and state legal framework applicable to Medicaid managed care, the analysis compares the major elements of the NPRM against the January rule and considers the implications of the changes for ongoing participation in Medicaid by the managed care industry.

In brief, while the NPRM retains a separate and detailed rule applicable to Medicaid managed care (and in some instances leaves the January rule virtually unchanged), the NPRM also proposed to alter the January rule in certain fundamental respects. The net effect of these alterations is to relax or eliminate certain standards and safeguards in favor of greater discretion on the part of states and the managed care industry to set the standard of performance within Medicaid-sponsored managed care arrangements. Furthermore, certain risk-based arrangements would be virtually exempt from federal regulation.

- *Children and adults with special health care needs:* The NPRM would eliminate specific standards related to continuity of care and the quality of care for populations with serious physical and mental health conditions.

¹ 66 Fed. Reg. 6228 (Jan. 19, 2001). The effective date of this regulation was delayed by the Bush Administration until August 16, 2002, 66 Fed. Reg. 43090 (August 17, 2001). The NPRM published in the August 20th Federal Register is a proposed rule allowing for additional time for public comment on the revisions made in the NPRM. See 66 Fed. Reg. 43614. Comments are due to DHHS on October 19, 2001.

² For purposes of this analysis the term "special health care need" encompasses any individual with a chronic physical or mental condition or disability whose need for medical care exceeds the actuarial norms that typically govern the design and structure of standard managed care products offered to public and private employer-sponsored health plans.

- *Discrimination against Medicaid beneficiaries:* The NPRM would eliminate the prohibition in the January rule against discrimination against Medicaid enrollees by managed care network providers. The rule would appear to permit states to contract with managed care entities offering products to multiple public and private group sponsors that segregate Medicaid beneficiaries into separate provider networks.
- *Persons at high risk of medical underservice:* The NPRM replaces certain regulatory standards contained in the January rule regarding the duties of states and managed care entities in the case of individuals who face an elevated risk of medical underservice. Specifically, the NPRM would alter federal performance standards for including homeless persons, migrant and seasonal farmworkers, and persons whose care requires special cultural considerations or whose primary language is other than English. In some cases, the standards are relaxed; in others they are removed.
- *External review of managed care entity performance:* The NPRM eliminates the January rule's requirement of external review of delays in care. Delays in care are a common action triggering external review under state managed care external review statutes and are a specific type of practice giving rise to external review under managed care patients rights legislation enacted in both the U.S. Senate and House of Representatives during 2001.³
- *Protecting access to health care during the appeals process:* The NPRM would virtually eliminate the right of beneficiaries under the prior rule to continued medical treatment during the appeals period in cases involving a decision by a managed care organization to reduce or terminate care. Because the right to continued assistance appears to be a Constitutionally protected one in the case of Medicaid, the effect of this rule is unclear.
- *Exemption of certain risk contractors from the rule:* The NPRM would reclassify certain managed care entities and would exempt entities classified as prepaid ambulatory health plans (PAHPs) (i.e., entities that accept financial risk for ambulatory care only) from most of the regulatory standards established under the NPRM.

By and large, the Preamble to the NPRM contains no explanation of why these changes were made. Taken together, they suggest a desire on the part of the Administration to retain at least some regulatory structure for Medicaid managed care while at the same time permitting states and contractors to administer their products in a manner that far more closely approximates the commercial market and avoids the customization of managed care systems that arises from the special coverage and service requirements of the Medicaid program and the reduced health status of many Medicaid beneficiaries. The NPRM also appears to sanction the establishment by contractors

³ S. 1052 and H.R. 2653 (107th Cong., 1st sess.).

with multiple lines of business that outright segregate their provider networks by member sponsorship. This proposal is virtually unprecedented in federal Medicaid law and triggers profound questions of accessibility, quality, and legality under federal Medicaid and civil rights laws. The regulation also appears to create virtually de-regulated risk-based managed care systems by contracting with PAHPs for most services.

Previous analyses conducted by the GW Center for Health Services Research and Policy indicate that many states have made considerable efforts to customize their managed care products to special needs populations through highly tailored purchasing agreements.⁴ The NPRM increases the importance of these state contracts since it re-assigns to states the primary role for determining the level of detail regarding standards of care for enrollees.

Background

1. *Sources of federal and state law applicable to the Medicaid managed care industry*

As with other forms of managed care, Medicaid-sponsored managed care arrangements operate within a complex legal structure that reflects both federal and state standards and as a result varies extensively from state to state. The principal sources of law that govern Medicaid managed care are as follows:

- *The federal Medicaid statute.* Since Medicaid was originally enacted in 1965, managed care has been an option for states.⁵ The federal Medicaid statute contains both general provisions that would apply to the provision of managed care⁶ as well as specific provisions that establish conditions of participation for managed care organizations and standards applicable to states that elect to require mandatory enrollment in Medicaid managed care arrangements.⁷

⁴ Sara Rosenbaum et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (The George Washington University Medical Center, School of Public Health and Health Services, Washington D.C., 1997, 1998, 1999, 2001). This is available at www.gwhealthpolicy.org.

⁵ Congressional Research Service, *Medicaid: A Source Book* (Washington D.C., 1993).

⁶ §1902(a)(4) of the Social Security Act, 42 U.S.C. 1396a(a)(4), requires that a state plan provide such methods of administration as are found by the Secretary of HHS to be necessary for the proper and efficient administration of a state's Medicaid plan. §1902(a)(8) of the Social Security Act, 42 U.S.C. §1396a(a)(8), requires that medical assistance be furnished with "reasonable promptness." §1902(a)(30) of the Social Security Act, 42 U.S.C. §1396a(a)(30), requires that state plans provide payment levels that are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that they are available to the general population in the geographic area.

⁷ §1903(m) of the Social Security Act, 42 U.S.C. 1396b(m) (conditions of participation for MCOs); §1932 of the Social Security Act, 42 U.S.C. 1396u-2 (relating to state option mandatory managed care arrangements). States can also mandate enrollment in managed care through Secretarial waivers granted under §§1915 and 1115 of the Social Security Act. In the case of mandatory enrollment operated under Secretarial waivers, federal conditions of waiver approval may establish alternative or additional conditions of approval., see 66 Fed. Reg. 43618. The extent to which the

- *Federal Medicaid regulations:* For over 20 years the United States Department of Health and Human Services has maintained specific federal regulations applicable to Medicaid managed care arrangements and entities.⁸ These regulations have been supplemented by specific conditions of approval imposed as part of the Secretary's §1115 demonstration authority, as well as his authority to permit states to operate freedom of choice waiver programs under the Medicaid statute itself.⁹
- *Other sources of federal law:* As recipients of federal financial assistance, Medicaid managed care organizations are subject to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and other federal civil rights laws. In addition, managed care organizations are public accommodations within the meaning of the Americans with Disabilities Act and are prohibited from discriminating on the basis of disabilities.¹⁰ Federal fraud and abuse laws, such as anti-bribe and kickback legislation and the Federal False Claims Act, also apply to Medicaid managed care organizations.¹¹
- *State law:* States may regulate Medicaid managed care arrangements in several ways. First, states may establish specific conditions of participation and regulatory performance requirements for their managed care organizations that participate in Medicaid.¹² Second, a state may apply general legislative and regulatory standards applicable to the managed care industry to Medicaid managed care products. Examples of such state laws are general state laws applicable to managed care companies and products, consumer protection statutes, fraud statutes, statutes establishing managed care liability laws, and other state laws. The extent to which state laws apply to or exempt Medicaid managed care products and organizations is unclear.

Third, virtually all states that purchase managed care set extensive performance standards under their managed care contracts. State managed care contracts are quite complex and address numerous areas of performance.¹³

Administration will permit mandatory managed care arrangements operated under waivers to function outside of specific federal regulatory standards applicable to state option systems is unclear under the NPRM.

⁸ 42 C.F.R. §424, 42 C.F.R. §431.55

⁹ This demonstration authority, codified at §1915(b) of the Social Security Act, are known as "§1915(b) waivers." 42 U.S.C. §1396n(b).

¹⁰ *Woolfolk v Duncan*, 872 F. Supp. 1381 (E.D. Pa., 1995) (managed care entities are covered by the ADA); *Bradgon v Abbott* 524 U.S. 624 (1998) (clarifying that health providers are a public accommodation under the ADA)

¹¹ Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY, 1997, 2001-2 Supplement)

¹² For example, Maryland has codified extensive regulations establishing conditions of participation for its MCOs.

¹³ *Negotiating the New Health System*, op cit., is a compendium of Medicaid managed care contract language organized in 7 chapters (enrollment; coverage and benefits; service duties; public health and social service agency relationships; quality assurance, data, and reporting; business terms and relationships; and payment). The language is available in a searchable database on www.gwhealthpolicy.org

Finally, state common law (i.e., judicial law) principles applicable to the managed care industry, in particular, judicial principles regarding the liability of managed care organizations for substandard medical care, may apply to Medicaid products.¹⁴

Regardless of the standards that federal law may prescribe, a state may elect to establish more stringent standards of performance and external accountability. Unlike employer-sponsored health plans and Medicare-sponsored managed care arrangements,¹⁵ federal Medicaid law does not preempt state laws that may impose quality of care, consumer protections and performance standards beyond those prescribed under federal law.

Even though states have the power to regulate Medicaid managed care and virtually all do so (at least through the terms of their contracts), federal requirements are crucial since they establish the minimum standards under which the managed care industry must operate if it elects to participate in Medicaid. With more than half of all Medicaid beneficiaries – and a quarter of all beneficiaries with disabilities – enrolled in Medicaid managed care arrangements,¹⁶ these minimum standards are influential in determining the standard of care that beneficiaries receive.

2. The January 2001 Medicaid managed care regulation

The January 2001 rule issued by the Clinton Administration represented an effort to expand and strengthen the minimum federal standards that apply to state Medicaid managed care systems.¹⁷ In general, the rule establishes a set of standards for those contractors that typically accept at least some financial risk for their services. These two classes of contractors are managed care organizations (MCOs), which operate under comprehensive service agreements, and prepaid health plans (PHPs) whose contractual agreements are more limited than those used in MCO arrangements¹⁸ applicable to Medicaid managed care. In addition, the rule sets forth certain standards of operation and performance for primary care case management systems (PCCMs), which typically are fee-for-service contractors that perform certain case management functions for an added administrative fee.

¹⁴ Jones v Chicago HMO Ltd. of Ill., 191 Ill. 2d 278 (2000) (holding that under traditional principles of corporate medical liability originally applied to hospitals, a Medicaid HMO may face corporate medical liability for its failure to maintain a provider treatment network that is sufficiently accessible to assigned Medicaid-sponsored members, where the inability to secure covered treatment is shown to be a proximate cause of death or injury).

¹⁵ *Law and the American Health Care System*, op. cit.

¹⁶ Kaiser Commission on Medicaid and the Uninsured, Medicaid Managed Care (2001 fact sheet), <http://www.kff.org/content/2001/2068b/2068b.pdf>.

¹⁷ A proposed rule was issued on September 29, 1998 (63 Fed. Reg. 52022). Over 300 comments were received and addressed in the January 19, 2001 final rule (66 Fed. Reg. 6228).

¹⁸ An MCO contract is one that covers both inpatient hospital care and one or more of the other required categories of medical assistance services. An MCO contract also may cover any three of the required services. §1903(m)(2)(A) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A).

The January rule focused on several major domains: services to persons with special health care needs;¹⁹ access safeguards for certain groups of individuals at elevated risk for medical underservice; managed care-specific consumer protections in the areas of information and disclosure, access, quality, and grievances and appeals (many of which are based on the broader patients bill of rights debate); and reconciling these managed care-specific protections with certain Constitutionally protected safeguards applicable to welfare entitlement beneficiaries, specifically the Constitutional right to a fair hearing in the case of actions to deny, reduce or terminate benefits and continued assistance under certain circumstances.

The August 2001 NPRM

The August 20th NPRM retains the basic structure of the January rule, maintaining a comprehensive set of federal regulatory standards in effect for state Medicaid programs and the Medicaid managed care industry. In substantial part, the NPRM preserves the domains of the January rule and, in substantial part, tracks the content of the January rule that it proposes to replace.

At the same time however, the NPRM makes certain significant changes from the January rule; together these changes have the effect of re-delegating to states and the managed care industry certain basic decisions about what the standard of care will look like for managed care enrollees (in particular enrollees with special needs and elevated risk for medical underservice). Furthermore, the NPRM would: (1) place important limits on access to external review of the conduct of managed care organizations; (2) make certain state actions related to managed care unreviewable through the fair hearing process; and (3) cut off access to continued treatment in the case of certain actions by managed care entities and their networks to reduce or terminate treatment.

The decision on the part of the Bush Administration to revise the January rule to extend greater latitude to states and managed care entities to set the standard of care is one that reflects a preference on the Administration's part for greater policy decision-making at the state and private enterprise level. However, it is unclear whether the Department's proposals to eliminate the regulations affording beneficiaries certain due process rights (e.g., external review of treatment delays and delays in the appeals process, full access to the fair hearing process, and continuation of assistance following initial actions to reduce or terminate care) will have a legal effect, in light of basic Constitutional requirements in the area of welfare administration.

The table that accompanies this analysis summarizes selected aspects of the January rule and the August NPRM and permits comparison of important differences and similarities.

¹⁹ These provisions were based in part on a Report to Congress submitted by CMS (formerly HCFA), *Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care*, available at <http://www.hcfa.gov/medicaid/11060rpt.pdf>.

1. *Standards of Care for Persons with Special Health Care Needs*

In customizing managed care to be able to reasonably accommodate the situation of persons with special physical or mental health care needs, the January rule identified several major areas for federal standards:

- the use of contracting managed care organizations that can demonstrate their networks have capabilities in the provision of specialized physical and mental health services and sufficient provider networks to meet specialized needs;
- the identification of persons with special needs at the time of enrollment so that contractors are on notice regarding the special contractual duty of care they have assumed;²⁰
- a rapid assessment and development of a treatment plan;
- the use of medical necessity standards that delineate the extent to which coverage is available in cases where functioning must be attained or maintained, not merely restored following an episodic illness or injury;
- to the extent that practice guidelines are used to guide treatment decisions (and potentially determine patient compensation) such guidelines are adjusted for the patient population to whom they apply and are valid and scientifically derived or the products of consensus in the field;
- protections in the event of breaks in the continuity of care (e.g., movement from fee-for- service into managed care or movement among plans);
- quality improvement systems that consider special needs populations and provider education regarding the state's special needs populations; and
- adequately maintained and accessible primary care patient records.

The NPRM maintains each category of the January rule but modifies its requirements in certain important ways. For example, the NPRM would retain the obligation on the part of the state to identify special needs members at the time of enrollment and would require the use of treatment

²⁰ Courts consider managed care to be a contractual health care undertaking, thereby creating a duty of reasonable medical care on the part of the entity. *Law and the American Health Care System*, op. cit. This is particularly important in the case of Medicaid beneficiaries who frequently are auto-assigned to plans and providers and play no role in the selection of their sources of care. See *Jones v Chicago HMO Ltd.*, supra, note 12.

plans. However, the NPRM would eliminate the provision in the January rule that persons identified as having special needs be screened within 30 days. In addition, the NPRM would give states discretion over who are the special needs populations whose identification triggers a higher standard of care on the part of its contractors.

The NPRM's Preamble encourages, but does not require, states to use the definition contained in the agency's 2000 Report to Congress on managed care and persons with special needs.²¹ Thus, while the January rule defines "special needs" to include all SSI recipients, a state could under the NPRM limit its MCOs' higher service standards only to children with physical disabilities.²² The NPRM does not explain the basis for eliminating the 30-day screening requirement.

Similarly, the January rule requires states to have continuity of care mechanisms in place when special needs patients transfer into managed care or among plans. This requirement tends to be addressed to some degree in many state MCO contracts.²³ The NPRM eliminates this requirement without explanation.

With respect to medical necessity, the NPRM retains the important provision in the January rule requiring state contracts to clarify the medical necessity standard to be used and whether "attain and maintain" are considered to fall within the purview of coverage. As with the January rule, however, the NPRM does not mandate this level of medical necessity definition as a *contractual* matter.²⁴

2. Access to Care for Persons at Risk of Medical Underservice

The January rule identified several specific safeguards for persons at risk of medical underservice because of status, language and culture:

²¹ 66 Fed. Reg. 43635. See supra note 20.

²² Were an MCO to have specific information about the special needs status of an enrollee and fail to exercise reasonable care in furnishing and arranging for treatment, an emerging body of caselaw related to managed care medical liability suggests that the entity could face both vicarious and corporate liability charges. Whether a state's narrowing of who is "special" and thus entitled to the protection of formal notice would absolve the MCO of a duty to make reasonable efforts to ascertain the health of the patients whose care it has undertaken is unclear and probably would depend on the terms of the contract as well as the standards of practice within the industry as a whole.

²³ *Negotiating the New Health System*, op. cit., Table 1.4 (special enrollment procedures).

²⁴ At least in the case of children, the EPSDT program would appear to require the use of such a standard as a state plan requirement. In states whose MCO contracts do not incorporate "attain and maintain" standards, this level of coverage would be extra-contractual. See Sara Rosenbaum and Colleen Sonosky, Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and Medicaid Managed Care Contracts, available at http://www.gwhealthpolicy.org/medicaid_publications_epsdt.htm.

- special disenrollment protections for migrant farmworkers and homeless persons who are autoenrolled into managed care arrangements;
- access to written information in any non-English language that is “necessary for effective communication with a significant number or percentage of enrollees;”
- oral interpretation services free of charge; and
- a requirement that risk contractors “ensure that services are provided in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.”

The NPRM proposes to revise or eliminate some of these standards. The special disenrollment protections for migrant farmworkers and homeless persons would be eliminated. The specific cultural competency service requirement would be replaced with a general requirement to participate in whatever cultural competency program a state may elect to offer.

3. Discrimination Against Medicaid Beneficiaries

Federal civil rights laws prohibit federally assisted contractors from discriminating on the basis of race, sex, disability or handicap, and age. In addition, the January rule specifically prohibited risk contractors to demonstrate that their network providers “do not discriminate against Medicaid beneficiaries.” Because discrimination on the basis of payer status is not a prohibited activity under existing civil rights statutes, the January rule represents an additional safeguard for ensuring that contractors’ networks are indeed open to Medicaid beneficiaries and that beneficiaries are not faced with a heightened risk of inadequate access to care, particularly specialized services. This protection has also been included in nearly 30 state Medicaid managed care contracts.²⁵ The NPRM eliminates this non-discrimination provision with no explanation.²⁶

The elimination of this provision could have significant implications for Medicaid beneficiaries enrolled in managed care with respect to their access to the contractors' network of primary care and specialty providers. Indeed, the very premise of managed care is that contractors undertake to furnish adequate access to care, and a non-discrimination provision thus would appear to be basic to the ability to carry out the contractual promise of care. A contractor conceivably could run “separate but equal” specialty and primary care networks, but in many parts of the country the

²⁵ *Negotiating the New Health System*, op. cit., Table 3.10 (anti-discrimination provisions).

²⁶ Were an MCO to fail to provide contractual treatment within medically reasonable timeframes, it could of course face medical liability. *Jones v Chicago HMO*, supra, note 12.

capacity to offer completely duplicate networks of oncologists, radiologists, obstetricians, pediatricians, cardiologists, psychiatrists and psychologists is non-existent.

4. Consumer Safeguards

The accompanying table illustrates that the January rule sets forth numerous consumer safeguards in a broad range of areas. Most of these safeguards have been preserved either in their original form or in somewhat modified form. However, several have been modified significantly or deleted in the NPRM. Among the most important are the following:

- The January rule made treatment delays (i.e., the failure to provide treatment in a timely fashion) subject to the external appeals process. Treatment delays are a basis for external appeals under pending House and Senate patients bill of rights legislation, and treatment delays are one of the most commonly addressed issues in state managed care regulations. The NPRM would remove treatment delay as an appealable and externally reviewable matter, leaving a contractor with no external review of its treatment timelines other than periodic quality performance reviews. No explanation for this decision to remove delays from external review is furnished in the NPRM. The inability to challenge delay in treatment has its greatest implications for persons with special needs.
- The NPRM would virtually eliminate the provision in the January rule that clarifies the ability of patients receiving ongoing health care to maintain existing treatment levels through the fair hearing process pending a final decision on a contractor's action to reduce or terminate care. The NPRM vastly narrows the conditions under which assistance can be continued to those cases in which the MCO literally overrides a standing treatment order by a treating provider and reduces or terminates care. Left out of the equation are those cases in which the decision to stop or reduce care is made *by the treating provider* (including providers that have been incentivized through risk based compensation systems). As managed care systems move ever more definitively away from intermediary "micro-management" and toward the active use of practice guidelines and incentive plans aimed directly at influencing the conduct of treating providers acting as agents of the contractor, the loss of the right to temporarily halt a proposed reduction or termination pending an impartial review appears to raise fundamental questions of safety for plan members with serious illnesses and conditions. It also raises important Constitutional questions because of a long line of cases that treat decisions by private contractors to reduce or end treatment as "state action" for Constitutional due process purposes.

The NPRM does not provide an explanation for this change. However, it appears to reflect an assumption on the part of the Administration that contractor decisions to reduce or terminate care do not amount to “state action” under legal precedent.²⁷

- Finally, the NPRM would alter grievance procedures by extending from 72 hours to three business days the amount of time contractors may take to make an expedited review and also by allowing states to unilaterally grant contractors up to 14 additional days if the contractor can justify the delay. The NPRM would also eliminate the lengthy procedural standards established in the January rule for the conduct of the grievance and appeals process.

5. Application of the Managed Care Standards to the Industry

The NPRM makes a significant change in the scope of the January rule by exempting from most of the rule a new class of risk contractor known as “prepaid ambulatory health plans” (PAHPs), which are risk contractors capitated for ambulatory care only. In states that use large provider groups to furnish primary and specialty ambulatory care on a risk basis, this change would essentially permit the state to avoid requirements applicable to risk contractors by limiting its market to capitated ambulatory groups and paying directly for inpatient care. Such an arrangement would, of course, hold major implications for persons with greater than average physical and mental health needs who would no longer enjoy the levels of safeguards and protections applicable to entities that are capitated for both inpatient and outpatient care. The extent to which states are moving to this model of ambulatory capitation is not clear, nor does the NPRM explain why limiting risk to ambulatory care reduces the necessity of certain standards in the areas of consumer safeguards, standards of care for persons with special needs, and consumer safeguards. Indeed, because the capitation may be less generous, problems related to underservice and underpayment may be more likely in such settings.

²⁷ Courts that have considered this issue in the Medicaid managed care and long term care context have held managed care contractors to the same Constitutional requirements that apply to state agencies and have required the provision of pre-termination level benefits where a request for a fair hearing is made within 10 days of the action. See *J.K. v Dillenberg*, 836 F. Supp. 694; *Daniels v Wadley*, 926 F. Supp. 1305 (M.D. Tenn., 1996); vac. in part on other grounds, *Daniels v Mehnke* 146 F. 3d 1330 (6th Cir., 1998). These cases all reject the notion that a private contractor acting administering some or all parts of a Medicaid plan for a state agency alters otherwise public decisions into private conduct. Similar rulings in the area of long-term care also have been handed down. See *Catanzano v Wing*, 103 F. 3d 223 (1996). The Supreme Court’s 1999 decision in *American Manufacturing v Sullivan*, 119 S. Ct. 2762 (finding no state action in the case of privately administered but state mandated worker compensation programs) raises some questions about the Medicaid rulings, but as a non-means tested, state mandated but privately administered program, the workers compensation system would seem sufficiently distinguishable from Medicaid managed care, where private contractors agree to carry out state duties under federal law.

Conclusion

The findings from this analysis suggest that the NPRM retains much of the structure and many of the elements of the January rule. At the same time, the NPRM generalizes certain standards of care in the case of special needs populations and persons at risk for medical underservice so as to return more discretion over specific standards of care to states and the managed care industry. The NPRM eliminates certain standards altogether, such as the prohibition against discrimination on the basis of sponsorship status and the right to external review of treatment delays.

Because the NPRM offers no virtually explanation for the standards it relaxes or eliminates, it is difficult to ascertain the basis for the Administration's decisions. But it may be safe to assume that officials viewed the prior rule as having an adverse impact on the willingness of companies to participate in Medicaid. This has of course been a major concern in the case of Medicare+Choice in recent months and at least one study suggests that the industry viewed the Medicaid regulations as burdensome.²⁸

Whether the changes contained in the NPRM— including relaxation in the standards of care and in access requirements and the reductions in consumer safeguards – have the effect of bringing more contractors into the Medicaid system remains unclear. To be sure, many of the changes are substantial, but many provisions from the January rule remain unchanged. Regardless of the regulation, contractors remain subject to federal statutory and Constitutional requirements, and whether the issue is accessibility or procedural protections, these standards are considerable in and of themselves. Moreover, many states use managed care contracts that are at least, if not more, rigorous than even the January rule.²⁹

Finally, the managed care industry faces important legal requirements as a matter of state statutory, regulatory and common law. Managed care organizations that undertake to furnish care to the Medicaid population enter into a course of care that is well recognized for its complexity and the prevalence of special needs populations. Under prevailing common law principles of medical liability, were a managed care entity to fail to deliver a professionally reasonable level of managed care to its enrollees, it could face medical liability to the same extent that such liability is faced by other health care corporate enterprises such as hospitals and nursing homes.

One question that remains open under the NPRM is whether it signals or reflects the growth of a specific form of managed care, i.e., the prepaid ambulatory health plan that manages only outpatient care. To the extent that PAHPs operating on a risk basis assume greater responsibility

²⁸ Nancy Beronja, et al., Impact of the Proposed Medicaid BBA Regulation on Medicaid Managed Care (November 2000). Prepared for the *Informed Purchasing Series* of the Center for Health Care Strategies, Inc., www.chcs.org

²⁹ *Negotiating the New Health System*, op. cit. A forthcoming *Issue Brief* from the most recent contract database will analyze selected provisions from the January rule and the NPRM to assess how they are included in managed care contracts.

for care and services in an ambulatory setting, and states move away from the use of comprehensive contracts, then a regulation that exempts this emerging industry from access, quality, disclosure, and accountability standards would seem to raise important questions. This is a trend that is worth watching, particularly in the context of care of individuals with chronic physical and mental health conditions, disease management programs, and other specialty or primary care arrangements that undertake risk for ambulatory services only and that link to directly funded sources of inpatient care.