Did You Know?

Individuals Receiving Medicaid Through a Managed Care Organization are Entitled to the Same Services They Would be Entitled to Under Traditional Medicaid

Medicaid is a joint federal-state program. The purpose of the Medicaid program is to enable states to furnish medical assistance to individuals and families whose income and resources are insufficient to meet their necessary medical expenses, and to furnish rehabilitation and other services to help such individuals and families ñattain or retain capability for independence and self-care.ò 42 U.S.C. 1396-1.

A state need not participate in the Medicaid program, but if it does, it must comply with all provisions of the federal Medicaid Act and its implementing regulations. According to federal law, a state Medicaid plan must do the following:

- designate a single state agency to administer or supervise the administration of the plan, 42 USC 1396a(a)(5), 42 CFR 431.10;
- make medical services available to all eligible recipients, 42 USC 1396a(a)(10)(A);
- make medical services available to eligible recipients that are not less in amount, duration, or scope than the medical services available to other eligible individuals, 42 USC 1396a(a)(10)(B)(i);
- make medical services available to an eligible recipient that are sufficient in amount, duration, and scope to reasonably achieve their purpose, 42 CFR 440.230(b);
- provide for granting an opportunity for a fair hearing before the state Medicaid agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness, 42 USC 1396a(a)(3);
- include reasonable standards, which shall be comparable for all groups, 42 USC 1396a(a)(17);
- provide care and services in a manner consistent with simplicity of administration and the best interests of the recipients, 42 USC 1396a(a)(19).

Rather than pay for Medicaid services directly (traditional fee-for-service Medicaid), states may require a Medicaid-eligible individual to enroll with a managed care entity as a condition of receiving such assistance. 42 USC 1396u-2. However, each state must assure that all services covered under the state Medicaid plan are available and accessible to enrollees of Medicaid managed care organizations (MCOs). 42 CFR 438.206(b).

Each contract between a state and a Medicaid MCO must:

- identify, define and specify the amount, duration, and scope of each service the MCO is required to offer, 42 CFR 438.210(a)(1);
- provide that those services be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, 42 CFR 438.210(a)(2);
- ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which those services are furnished, 42 CFR 438.210(a)(3)(i);

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- specify what constitutes ñmedically necessary servicesòin a manner that is no more restrictive than that used in the state Medicaid program, 42 CFR 438.210(a)(4).

Additionally, state Medicaid agencies must have procedures for monitoring and evaluating the quality and appropriateness of care and services to all managed care enrollees under the plan. 42 USC 1396u-2(c), 42 CFR 438.204(b), 438.202, 438.206.

In a series of cases, Excellus, an MCO in New York, attempted to use its company policy, rather than Medicaid policy, for determining coverage of speech generating devices. The cases proceeded to a fair hearing and in each case, the hearing officer used Medicaid criteria to determine that the device was covered. Matter of Melissa, FH # 5491690N (NY 8/4/10), Matter of D.M., FH # 5489634Y (NY 9/1/10), Matter of K.A., FH # 5530029R (NY 10/1/10), Matter of T.H., FH # 5539945L (NY 11/4/10), and Matter of Matthew, FH # 5546540R (NY 11/4/10). Itôs our understanding that in light of those decisions, Excellus has revised its policy regarding speech generating devices for Medicaid recipients.

In another administrative fair hearing involving a Pedicraft bed, Matter of Anonymous, FH # 3896517Q (NY 7/10/03), the hearing officer relied on the Medicaid definition of durable medical equipment (DME) rather than the MCOôs definition to overturn the MCOôs denial of the bed. The decision also held that the prior approval request should have been reviewed under the Early and Periodic Screening, Diagnosis and Treatment Program, a federally mandated Medicaid coverage category for Medicaid recipients under the age of 21.

Please feel free to contact us for copies of any of the hearing decisions we have referenced or if you have any questions or comments. Also, if you won a hearing or court appeal/lawsuit regarding managed care or any item of DME, please send us copies of the hearing decisions or court decisions/documents, so that we can share them with the AT network.

Those who are reading this post as an email are encouraged to use ñreply allòto share comments or questions that they want to reach all participants on the list serve. Use ñreplyòto communicate only with the person who did the posting.

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