Medicaid Managed Care: The New Mega Rules

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The Mega Rules

- CMS released the proposed rules on May 26, 2015
  - The Council provided a session at their December, 2015 conference on the draft rules
- On April 21, 2016, the final rules were published
  - They remained pretty much the same as published in draft form. Clarifications made and implementation dates established
- The first update to the rules since 2002
  - In 1991 2.7 million beneficiaries were in MC
  - In 2015 that number has increased to over 80% of the entire Medicaid population – 2.7 million or 73% of children

KEY GOALS OF THE MEDICAID MANAGED CARE RULES

- To Support State efforts to advance delivery system reform and improve quality of care
- Strengthen beneficiary experience of care and protections
- Strengthen program integrity by improving accountability and transparency
- Align key Medicaid and CHIP (Health Choice) requirements with other health coverage programs
MEDICAID MANAGED CARE

- Dramatic increase in managed care so CMS issued new draft regulations
  - To modernize the Medicaid MC regulatory structure to support delivery system reform to improve health outcomes, while managing costs
  
  Major categories include
  - Market alignment with Medicare and private payors
  - Cross market advertising
  - Grievances and appeals
  - Medical loss ratios
  - Standard contract provisions
  - Actuarial sound capitation rates
  - Beneficiary protections
  - Availability of services, assurances of capacity, network adequacy standards
  - Quality of care

FEDERAL MEDICAID MANAGED CARE RULES

- The rules have multiple, direct purposes:
  - To improve "the accountability of rates paid in the Medicaid managed care program"
  - To "ensure beneficiary protections" in the areas of provider networks, coverage standards, and treatment of appeals represent specific aims, and
  - To strengthen "program integrity safeguards"

- Churn between Medicaid-enrollees and FFM consumers requires higher level financial and health care integration

Managed Care In Medicaid

- All States except Connecticut (switched back to FFS in 2015), Alaska and Wyoming have some form and some part of their Medicaid program under managed care

- There are multiple Medicaid ways or authorities to conduct managed care. In NC we use:
  - PCCM – Primary Care Case Management – CCNC operates under a PCCM authority
  - Waivers – such as 1915b or PIHP model and a 1115 – NC operates the LME/MCO as 1915 B waiver. The Innovations waiver (1915c) waiver was moved under the 1915b waiver so that mc principles would also apply
  - PACE – Program for All Inclusive Care – there are currently 11 sites in NC and more want to come on board
Managed Care Programs

- MC Programs may be at risk or non risk bearing.
  - CCNC is a financial non-risk bearing approach
  - 1915 b/c or the LME/MCO waiver is risk bearing

- The Medicaid Transformation legislation requires the use of the 1115 Medicaid waiver to move the existing fee for service financial arrangement and the CCNC method of managed care under a risk bearing approach.

- As you know, the 1915b/c waiver remains a carve out for four years after the go live period of the 1115 waiver, unless CMS directs otherwise.

What Does These New Rules Mean for NC

- When the 1115 waiver goes live, the waiver must be in compliance with the rules - there is no grace period.

- For the current behavioral health (1915b/c waiver), and the CCNC contracts, NC DHHS/DMA will be modified to be in compliance with the rules as required with the implementation timelines.
  - In some programmatic areas, those changes will be minimal because of existing policy or requirements are already in compliance
  - For other areas, there will be significant changes

Keep in Mind

- All happening at the same time as the 1115 waiver negotiated with CMS and Division of Health Benefits (DHB) continues to play a larger role in Medicaid
- No new funding has been granted to the states to implement any of the provisions
- Changes proposed may require legislative action to access funding to implement the changes or cover increased costs. NC MUST implement the rules even if in conflict with existing NC legislation. Federal law or rule overrides NC law or rules if the State is to access federal dollars.
- Permits is different than require and MOST all changes will require some sort of approval either at the State or federal level
DELIVERY SYSTEM REFORM: INSTITUTIONS OF MENTAL DISEASE (IMDs) – January 5, 2016

- Permits state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21–64, that has a short term stay in an IMD
- Short term stay: no more than 15 days within the month, with flexibility to create longer stays by aligning stays over two consecutive months (14 days in one month and 14 in the next)
- Establishes rate setting requirements for utilization and price of covered services rendered in alternative setting of the IMD
- Provides funding for beneficiaries that were previously not covered by Medicaid
- Should ease demand for limited Medicaid beds in hospitals and decrease wait times for admission
- Provides an additional tool for MCOs to use for beneficiaries in crisis who can be stabilized and transitioned to treatment in less than 15 days
- Average crisis stabilization in North Carolina - as demonstrated in the Medicaid IMD Demo - was less than 9 days

DELIVERY SYSTEM REFORM: “IN LIEU OF SERVICES” July 5, 2016

- “In lieu of services” (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings
- Establishes contractual requirements for ILOS – Establishes rate setting requirements for ILOS
- Different than EPSDT
- “In lieu of” standard provides a basis for:
  - modification of the IMD exclusion short stays
  - departure from other state plan coverage limits, including limits on coverage, as well as limitations on coverage in certain otherwise legally permissible care settings, such as services in homes or schools, and
  - departure from limitations on the types of health professionals who can lawfully furnish care but whose participation is excluded under the state plan

DELIVERY SYSTEM REFORM: PAYMENT REFORMS

- Apply to rating periods for contracts starting on or after July 1, 2017
- Clarifies state payment-related tools for managed care plan performance, including
- Requirements for withhold arrangements to encourage managed care plans to meet quality or performance targets established through the contract
- Requirements for incentive arrangements that meet quality or performance targets established through the contract
- Reimbursement standards or fee schedules for providers that deliver a particular covered service to support timely access to care
- Acknowledges that states may require managed care plans to engage in value-based purchasing initiatives
- Permits states to set min/max network provider reimbursement levels for network providers that provide a particular service
- Transition period for pass-through payments to hospitals, physicians and nursing facilities
MODERNIZATION: NETWORK ADEQUACY

- Contracts starting on or after July 1, 2018
- States will develop and implement time and distance standards for:
  - primary care – adult and pediatric;
  - specialty care – adult and pediatric;
  - behavioral health (mental health and substance use disorder) – adult and pediatric;
  - OB/GYN, hospital, pharmacy, and
  - pediatric dental
- States will develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- Managed care plans will certify the adequacy of the networks at least annually

MODERNIZATION: INFORMATION REQUIREMENTS

- Contracts starting on or after July 1, 2017
- States will operate a website that provides specific managed care information including each managed care plan’s handbook, provider directory, and formulary
- States will develop definitions for key terms and model handbook and notice templates for use by the managed care plans
- States and managed care plans may provide required information electronically if the information is available in paper form upon request and free of charge

IMPROVING QUALITY: QUALITY RATING SYSTEM

- States must implement a QRS no later than 3 years from the date of a final notice published in the Federal Register
- States must implement a quality rating system (QRS) for Medicaid and CHIP managed care plans and to report plan performance for MCOs, FIMs, and PAHPs
- CMS expects to implement the QRS over 5 years including:
  - A public engagement process to develop a proposed QRS framework and methodology using summary indicators adopted by the Marketplace QRS
  - Publication of the proposed QRS in the Federal Register with comment period, followed by notice of the final Medicaid and CHIP QRS
- States will have flexibility to adopt alternative QRS, with CMS approval
QUALITY OF CARE

- Extends managed care quality strategy, QAPI, and external quality review (EQR) to PAHPs and to PCCM entities whose contracts include financial incentives.
- Adds two new elements to states’ managed care quality strategies related to health disparities and long term services and supports.
- Adds new mandatory EQR activity to validate network adequacy.
- Improves transparency of quality information.
- Data from claims integrated with electronic health records via HIEs or global data warehouses can be used to ensure the right treatment is provided at the right time at the right cost—strengthening healthcare quality and financial integration.
- Applies 60 days after publication.
- Applies July 1, 2018.
- Applies no later than one year from the issuance of the EQR protocol.
- Applies no later than the rating period for contracts starting July 1, 2017 for QAPI and posting of accreditation status; applies July 1, 2018 for QS and EQR.

ENROLLMENT AND SUPPORTS

- Enrollment:
  - Applies to rating periods for contracts starting on or after July 1, 2017.
  - States retain flexibility to design their enrollment processes to best meet population needs and programmatic goals.
  - States will be required to provide notices to explain implications of enrollees’ choices as well as all disenrollment opportunities.
  - Improved information content and distribution methods.

Supports

- Applies to rating periods for contracts starting on or after July 1, 2018.
- Establishment of a beneficiary support system.
- An independent system to provide choice counseling and assist enrollees post-enrollment with unbiased information on managed care plan or provider options and answers to related questions for Medicaid beneficiaries.
- Access to personalized assistance—whether by phone or in person—to help beneficiaries understand the materials provided by managed care plans or the state, to answer questions about each of the options available, and to facilitate enrollment with a particular managed care plan or provider.
- Particularly important for beneficiaries receiving long term services and supports (LTSS).
CARE COORDINATION

- Contracts starting on or after July 1, 2017
- Sets standards for care coordination, assessments, and treatment plans
- Requires that Medicaid and CHIP managed care plans coordinate and ensure that individuals make smooth transitions between settings of care to enhance access to services, and complete an initial health risk assessment within 90 days of enrollment for all new beneficiaries
- Must assess enrollees with special health care needs and/or using long term services and supports and develop a treatment plan based on the assessment and ensure that it is regularly updated

MANAGED LONG TERM SERVICES AND SUPPORTS

- Rule implements elements of CMS’ May 2013 MLTSS guidance, such as:
  - Creates a structure for engaging stakeholders in the ongoing monitoring of MLTSS programs
  - Requires a deliberative state planning process, which includes standards for a state’s readiness reviews of managed care plans and specific information to be provided to beneficiaries transitioning from fee-for-service to managed care
  - Provides that MLTSS programs must be implemented and operated consistent with federal laws, including the Americans with Disabilities Act
  - Encourages payment methodologies that reflect the goals of MLTSS programs to improve the health of populations, support beneficiaries’ experience of care, support community integration of enrollees, and control costs
  - Requires the creation of an independent beneficiary support system that serves as a centralized point of contact for choice counseling along with other services and supports to help individuals navigate the managed care delivery system
  - Requires person-centered processes to ensure that beneficiaries’ medical and non-medical needs are met and that they have the quality of life and level of independence they desire

- Establishes standards for coordination and referral by the managed care plan when services are divided between contracts or delivery systems to ensure that the beneficiary’s service plan is comprehensive
- Sets standards to evaluate the adequacy of the network for MLTSS programs, the qualifications and credentialing of providers, and the accessibility of providers to meet the needs of MLTSS enrollees
- Requires managed care plans to participate in efforts by the state to prevent, detect, and report critical incidents that adversely impact enrollee health and welfare
- Requires states to incorporate MLTSS–specific elements into their quality strategies
- Requires transition plans when beneficiary moves from FFS to managed care or into a new managed care plan

Parts are 2017 and 2018 implementation
**STRENGTHENING COMMUNICATION**

- Expands managed care plans’ ability to communicate with beneficiaries by permitting states and managed care plans to use a range of electronic communication methods, including email, texts, and website posting for the dissemination of required information, while ensuring that beneficiaries can obtain paper materials upon request and at no cost.

- Ensures that information is accessible to individuals with limited English proficiency by providing the enrollee materials (such as provider directories, member handbooks, appeal and grievance notices, and other informational notices) include information in each state’s prevalent languages explaining the availability of oral interpretation services or written translations, if requested.

- A large print tag line for the visually impaired is also required.

- Ensures managed care plans frequently update provider directories and post the information on the managed care plan websites, which will ensure managed care plans are actively monitoring the status of their contracted providers and that potential enrollees and enrollees have up-to-date and accurate information about available providers.

- Requires that the provider directories include information such as provider’s group/site affiliation, website URL and physical accessibility for enrollees with physical disabilities, as well as certain information about the managed care plan’s drug formulary.

**ACTUARILY SOUND CAPITATION RATES**

- July 1, 2017

- Establishes standards for the documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification.

- Requires that differences among capitation rates for covered populations must be based on valid rate development standards.

- Permits certain mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval.

- Permits states to increase or decrease the certified capitation rate by 1.5% (overall 3% range) without submission of a new rate certification (July 1, 2018).

**PROGRAM INTEGRITY**

- Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse.

- Requires managed care contracts to address treatment of recovered overpayments by managed care plans and to take these amounts into account in the rate setting process.

- Network providers will be screened, enrolled and revalidated as done in FFS.

- Network providers are not required to participate in the FFS program.

- States can require managed care plans or a third party to conduct the screening process.

- July 1, 2017 and July 2018.
The Affordable Care Act and this rule condition payment of FFP on timely, accurate, and complete reporting of encounter data. For contracts starting on or after July 1, 2017, States must require that managed care plans:
- Collect and submit encounter data sufficient to identify the provider rendering the service;
- Submit all encounter data necessary for the State to meet its reporting obligation to CMS; and
- Submit encounter data in appropriate industry standard formats (i.e., ASC X12N 837, ASC X12N 835, NCPDP).

Managed care plans are required to calculate and report their MLR experience for each contract year. States have the flexibility to set a standard higher than 85% and/or impose a remittance requirement. Expenditures for program integrity activities in the MLR calculation will align with a future standard adopted in the private market rules. Actuarially sound rates are set to achieve a MLR of at least 85%.

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Ensures all providers participating in managed care networks are screened and enrolled by the state Medicaid program. Requires that all providers in Medicaid, who order, refer, or furnish services under the managed care program are appropriately screened and enrolled. Does not require providers who participate in the Medicaid managed care plan network to also provide services to individuals enrolled in a state’s Medicaid fee-for-service program. Managed care plans will be able to execute temporary network provider agreements, subject to requirements, pending the outcome of the screening and enrollment process to support network development.

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Definitions and timeframes for resolution of appeals are generally consistent with the private market and Medicare Advantage.

Extends managed care appeals and grievance requirements to Pre-paid Ambulatory Health Plans (PAHPs).

Managed care plans will perform one level of internal appeal for enrollees to use before proceeding to a State Fair Hearing.

States have the option to offer enrollees an external review so long as that process does not extend overall timeframes for the appeals process.

In North Carolina, NC General Statute §108D-11 outlines LME/MCO appeals process, generally:

- Beneficiaries have 30 days to file an appeal.
- LME/MCOs have 45 days to resolve the appeal.
- Expect to see some changes requested with appeal process as the result of the implementation of Medicaid Reform.

Starting on or after July 1, 2017, Medicaid standards not applied:
- Prior approval of plan contracts
- Enrollment protections related to choice of plans (which is not required in CHIP)
- Rate-setting standards and certification
- Managed long-term services and supports

Resources:

- DHHS/DMA websites and Bulletin Updates
State Implementation of the Mega Rules
Adolph Simmons, DMA

DMH/SU/IDD Updates
Lisa Haire, DMH/SU/IDD

QUESTIONS