

Medicaid Managed Care Final Rule: Analysis & Implications

Joe Greenman, Shareholder, LanePowell

Mark Reagan, Managing Partner, Hooper, Lundy & Bookman P.C.

Narda Ipakchi, Director of Managed Markets, AHCA



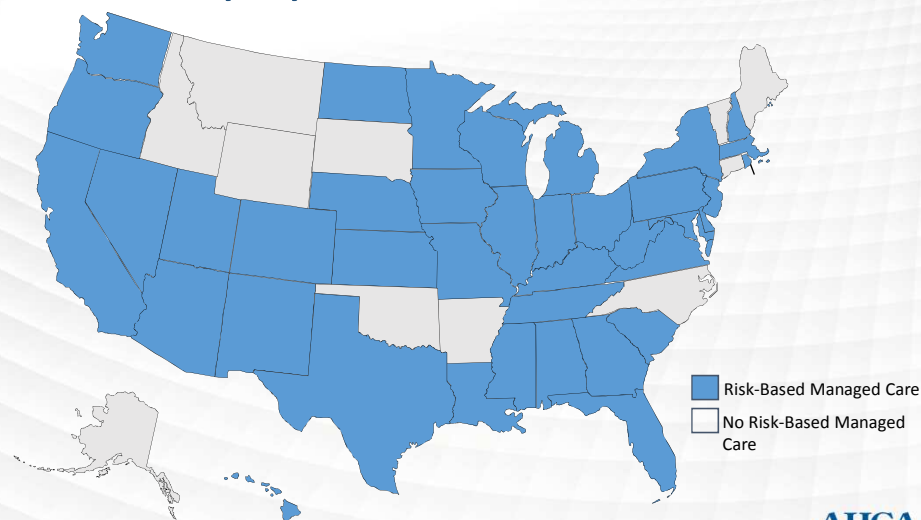
Goals of Today's Discussion

- Understand key Medicaid Managed Care Final Rule provisions
- Discuss opportunities to prepare for and/or inform changes to MLTSS programs under new regulations
- Understand how AHCA/NCAL can help support and ready the industry for coming changes



Background and Overview

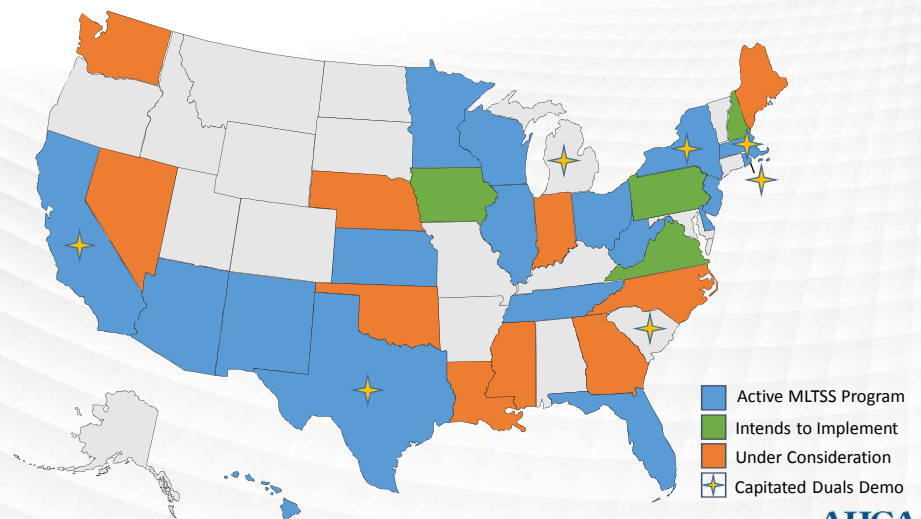
Managed Care Is Dominant Delivery System for Medicaid



Source: Kaiser Family Foundation. "Key Findings on Medicaid Managed Care." December 2014

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States Are Increasingly Adopting MLTSS Programs



Source: Health Management Associates. MLTSS Network Adequacy: Meeting the Access Requirements of an Emerging Market February 2016.

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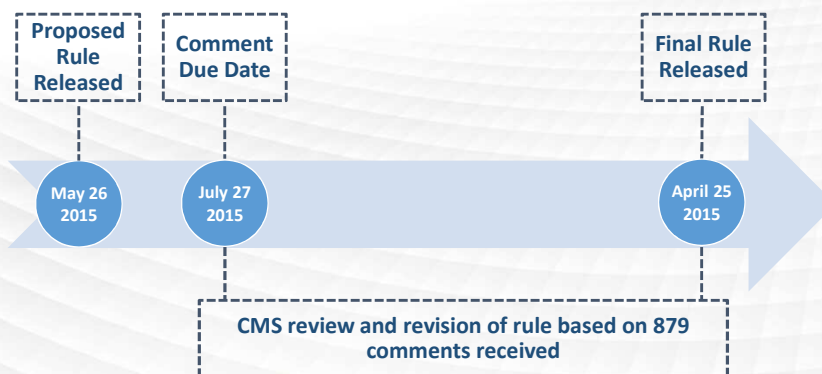
Need for Overhaul of Medicaid Managed Care Rules

Medicaid managed care regulations were last updated in 2002. CMS is modernizing the regulations to address key issues, including:

- Beneficiary experience
- Quality improvement
- Program and fiscal integrity
- Strengthening delivery of LTSS
- Alignment with Medicare Advantage (MA) and Marketplace plans (QHPs)
- Delivery system reform efforts

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Timeline for MMC Rule Overhaul



Implementation dates vary by provision, with some effective on date of publication while others are effective beginning July 2017 or later



Overarching Themes

- States will continue to maintain flexibility on key program elements
 - Opportunity for state-level advocacy
- CMS acknowledges growth in Medicaid managed long term services and supports (MLTSS)
 - Enhanced provisions for LTSS
 - Strong emphasis on community living
- Standardization and alignment across markets
 - Increased simplicity for health plans seeking to offer products for dual-eligibles



Payment Provisions

Actuarial Soundness

CMS Principles

- Rates are sufficient and appropriate for the anticipated service utilization of the populations and services for the period that the rates are effective
- An actuarial rate certification should provide sufficient detail, documentation and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final rate
- Transparent and uniformly applied rate review and approval process

Medical Loss Ratio

- Plans must calculate and report MLR in plan year 2017; MLR experience must be factored into future rate setting
- State has **option** to:
 - Adopt minimum MLR standard, which must be at least 85%. May set > 85% MLR but must leave room for “reasonable” administrative expenses
 - Require plans to remit payments for failure to meet MLR

MLR Calculation

$$\begin{array}{r}
 \text{Incurred Claims} \\
 + \\
 \text{Healthcare Services/} \\
 \text{Quality Improvements*} \\
 \hline
 \text{Premium Revenue} \\
 - \\
 \text{Applicable Federal/State Taxes} \\
 \text{/Licensing Fees} \\
 \hline
 = 85\%
 \end{array}$$

§ 438.8

Implementation Date: Contracts after 7/1/17

*Quality improvement activities include care management, service coordination, disparity reduction and readmission prevention activities, etc.

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State and Plan Payment Arrangements

Risk Sharing Arrangements

- Includes reinsurance, risk corridors and stop-loss limits
- Must be:
 - Outlined in plan/state contract
 - Consistent with actuarial sound rule, rate development rule, and generally accepted actuarial principles and practices

Incentive Arrangements

- Plan may receive additional funds over and above the capitation rate for meeting a specified target
- Limited to 105% of approved capitation
- Must be:
 - Linked to quality goals/performance measures and not conditioned on IGTs
 - Not renewed automatically
 - Made available to public and private contractors under same terms of performance

Withhold Arrangements

- Portion of capitation is “withheld” pending achievement of particular outcomes
- No limit -- total withhold must be “reasonable” considering plan’s cash flow and impact on solvency and reserves
- Must be:
 - Linked to quality goals/performance measures and not conditioned on IGTs
 - Not renewed automatically
 - Made available to public and private contractors under same terms of performance

§ 438.6(b)

Implementation Date: 7/1/17

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Plan Payments to Providers

State Medicaid Agency prohibited from directing expenditures made by MCOs **except***:

- 1 To require MCOs to implement VBP Models
- 2 To require MCO participation in multi-payer delivery system reform initiatives
- 3 To require MCOs to adopt minimum and/or maximum fee schedules or uniform increases across provider types

*Requires Federal Approval

§ 438.6(c);
Implementation Date: Contracts after 7/1/17



Minimum Criteria for State-Directed Provider Payment Arrangements

The state must demonstrate, in writing, that the arrangement:

- Is based on the utilization and delivery of services
- Directs expenditures equally for classes of providers
- Expects to advance at least one of the goals and objectives in the state's quality strategy
- Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the state's quality strategy
- Does not condition network provider participation in the arrangement on the network provider entering into or adhering to IGTs
- May not be renewed automatically

§ 438.6(c)
Implementation Date: 7/1/17



Additional Criteria for VBP and Delivery System Initiatives

State must also demonstrate that the arrangement:

- Makes participation available, using the same terms of performance, to a class of providers providing services
- Uses a common set of performance measures across all participating payers and providers;
- Does not dictate the amount or frequency of payment; and
- Does not allow the State to recoup unspent plan funds

§ 438.6(c)(ii)
Implementation Date: 7/1/17



Phase Out of Pass-Through Payments

CMS has long expressed concerns regarding pass-through payments

- Pass-through payments are supplemental payments that states direct managed care plans add to contracted payment rates to specific provider types
 - Typically funded by provider assessments and/or intergovernmental transfers (IGTs)
 - Not directly linked to services or quality under the plan/provider contract
- Final rule phases out states' ability to use pass-through payments
 - Hospitals provided with ten year transition (until July 1, 2027)
 - Physicians and nursing facilities provided with a 5-year transition (until July, 1 2022)

42 CFR 438.6(d)
Implementation Date: 7/1/17



Recovery of Overpayments

Final rule requires that network providers report and return overpayments within 60 days of identification

- State can determine whether plan retains overpayment recoveries (must be specified in contract)
- States are required to specify the process, timelines and documentation required for reporting/payment of overpayment recoveries
- Plans must report recoveries to state on annual basis
- Recoveries must be factored into future rate development
- CMS clarifies that overpayment policies do not apply to recoveries made under the False Claim Act or other investigations

§ 438.608(c)(3)
Implementation Date: 7/1/17



Plan Networks

Network Adequacy

Provider-Specific Criteria

- Time and distance standards specific to classes of network providers:
 - Primary care
 - Behavioral health
 - Hospital
 - Pediatric dental
 - OB/GYN
 - Specialists
 - Pharmacy
 - LTSS
- Standards must take into consideration:
 - Anticipated enrollment
 - Expected utilization
 - Unique needs/characteristics of population enrolled
 - Number/type of providers necessary
 - Number of network providers not accepting new patients
 - Provider location
 - Provider ability to communicate with limited English proficient (LEP) enrollees and to provide access to enrollees with mental/physical disabilities
 - Availability of triage lines or screening systems/telemedicine/e-visits, or other technological solutions



Additional LTSS Criteria

- Must include criteria for providers who travel to the enrollee to provide services
- Must take into consideration:
 - Elements that would support enrollee choice
 - Enrollee health and welfare and support for community integration
 - "Other considerations" in the best interest of LTSS enrollees

§ 438.68
Implementation Date: 7/1/18



Network Inclusion



Continues existing policy prohibiting discrimination in participation, reimbursement or indemnification of any provider acting within the scope of license/certification under State law, solely on the basis of license/certification

- Plans may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- Plan must provide rationale for decision not to contract with individual/groups of providers
- Does not require contracting beyond what is necessary to meet enrollee needs
- Plans may continue to use different reimbursement amounts for different specialties or different practitioners
- Plans may continue to establish quality/cost control measures

§ 438.12
Implementation Date: 7/1/17



Network Provider vs. Subcontractor

CMS clarifies that network provider ≠ subcontractor

Network Provider Obligations

- Provide timely access to care
- Accessible for beneficiaries with physical or mental disabilities
- Undergo state screening/enrollment process
 - Does not obligate network providers to also render services to FFS beneficiaries
 - May include periodic revalidation

Subcontractor Obligations

- Compliance with “all applicable Medicaid laws, regulations, subregulatory guidance, and contract provisions”
- Permits on-site inspection by State, CMS and OIG of premises, physical facilities, and equipment where Medicaid-related activities are performed
- Expanded record-keeping requirements
- Permits inspection, evaluation and audit by the State, CMS or OIG if the entity determines there is a reasonable possibility of fraud or similar risk

§ 438.2, §438.230
Implementation Date: 7/1/17



Quality

Quality Rating System

- Requires states to adopt a Medicaid managed care quality rating system (QRS) modeled on the systems for the Marketplace and MA
 - State option to develop alternative QRS that includes ratings that are substantially comparable to the CMS QRS
- Measures will assess performance related to:
 - Clinical quality management
 - Member experience
 - Plan efficiency, affordability and management
- Quality rating system development will be informed by public engagement process
 - Expected proposed rule in **2017**
 - Final rule in **2018**
 - Implementation by **2021**



§ 438.334

Implementation Date: No later than 3 years from the date of a final notice published in the Federal Register



State Quality Strategy

- Requires states to adopt a comprehensive quality strategy to assess and promote quality in managed care
- CMS withdrew proposal to adopt a comprehensive quality strategy that would apply to both FFS and managed care
- For MLTSS, quality provisions will emphasize community living, person-centered approach to care
 - Plans must develop mechanisms to assess quality and appropriateness of care to enrollees between settings of care and as compared to treatment/service plan

§ 438.340

Implementation Date: 7/1/18



Beneficiary Protections

Enrollment/Disenrollment

Beneficiary Choice

- CMS declined to adopt requirement that states provide 14 days of FFS coverage during “enrollment choice period” for beneficiaries
- States that employ “passive enrollment” may enroll the beneficiary into a plan simultaneous with providing a “period of time” to make an active choice
- Beneficiaries have the right to change plans without cause within 90 days of initial enrollment as well as every 12 months
- For LTSS enrollees, disruption in residence or employment qualifies as “cause” for disenrollment (§438.56(d)(2)(iv)) – Implementation 7/1/17



§ 438.54
Implementation Date: 7/5/16

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Auto-Enrollment and Plan Assignment

- States must seek to preserve existing provider- beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries
- Existing relationship to be established via previous State managed care or FFS records encounter data, or beneficiary contact
- Provider is considered to have “traditionally served” Medicaid beneficiaries if it has experience in serving Medicaid population



§ 438.54
Implementation Date: 7/5/16

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Appeals and Grievances

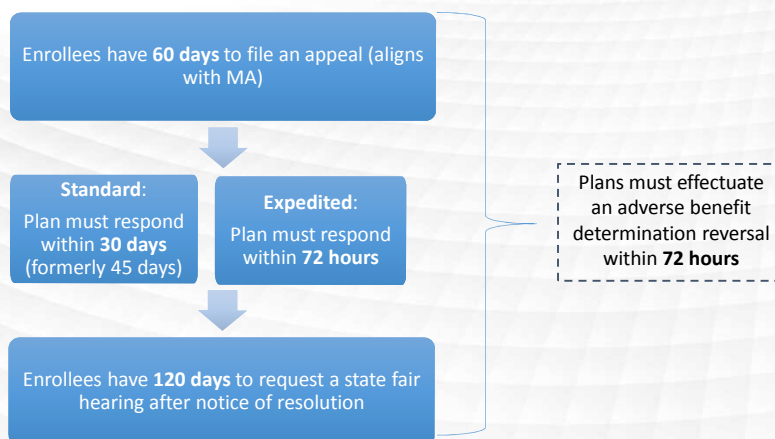
- Limits plans to single level of internal appeal state fair hearing
- Declines to permit direct access to fair hearing process
- Allows, but does not require, external, independent medical review process
- Providers must obtain patient consent to file appeal
- “Adverse benefit determination” may include determinations of beneficiary cost-sharing
- Clarifies that appeal process only applicable to beneficiary disputes, not provider payment disputes
- Precludes individual/subordinate from making grievance and appeal decisions after initial determination



§ 438.404, § 438.406, § 438.408, § 438.410
Implementation Date: 7/1/17

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Timeline for Appeals



§ 438.404, § 438.406, § 438.408, § 438.410
Implementation Date: 7/1/17



In Lieu of Services

Final rule clarifies which services may be covered by a plan “in lieu of” services set out in State Medicaid Plan

- State determines alternative service/setting is a medically appropriate and cost-effective substitute and specifies approved in lieu of services in plan contract
- Plans may offer the approved in lieu of services at their own discretion but may not require enrollee to use alternative services or settings
- Utilization/actual cost of in lieu of services are taken into account in ratesetting unless a statute or regulation specifies otherwise

§ 438.3(e)(2)
Implementation Date: 7/5/16



Key LTSS Provisions

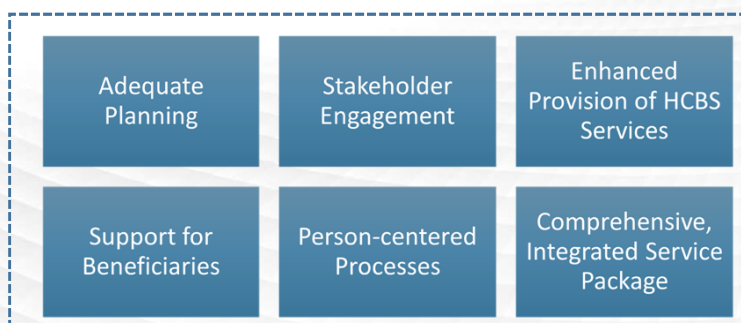
LTSS Definition

Long-term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

§ 438.2
Implementation Date: 7/5/16

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CMS MLTSS Principles



Adequate Planning



Standards apply broadly to all managed care programs but specifically calls out LTSS in the regulations

- State must consider unique characteristics of LTSS in monitoring/evaluation activities, including readiness reviews
- Additional standards for enrollee and potential enrollee communication/marketing materials, including information on transitions of care, contact information, and provider directories



Stakeholder Engagement

- State must ensure the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of a State's managed LTSS program
- Composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement



§438.70
Implementation Date: 7/1/17

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Enhanced Provision of HCBS

- Restates that all MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C. decision
- Managed care contracts covering LTSS must provide services that could be authorized through a waiver under section 1915(c) or SPA through section 1915(i) or 1915(k) be delivered consistent with the settings standards in the final HCBS rule



§ 438.3(o)
Implementation Date: 7/5/16

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Support for Beneficiaries

CMS outlines four functions of a Beneficiary Support System for LTSS

- An access point for complaints and concerns about managed care enrollment and access
- Education on enrollees' grievance and appeal rights
- Assistance in navigating the grievance and appeal process
- Review and oversight of LTSS program data

§ 438.71(d), § 438.816
Implementation Date: 7/5/16



Person Centered Processes

Requires identification, comprehensive assessment and person centered planning for MLTSS enrollees

- **Beneficiary assessment** to identify special conditions that require a course of treatment or regular course monitoring
- Development and approval of a **treatment/service plan**
 - Review/revision at least every 12 months or when enrollee's circumstances or needs change significantly, or upon enrollee request
- **Direct access to specialists** for enrollees with special health care needs

§ 438.208
Implementation Date: 7/1/17



Comprehensive, Integrated Service Package

CMS seeks to ensure robust coordination and referral, particularly when services are divided between contracts or delivery systems so that the enrollee's service plan is comprehensive and person-centered

- All plans must coordinate care between settings of care as well as with services received through fee-for-service, other delivery system and/or any other plan
- Final rule includes provision that plans must also coordinate with the services the enrollee receives from community and social support providers

§ 438.208
Implementation Date: 7/1/17

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Provider Considerations

Considerations for Providers

- **Payment**
 - Providers must work with states to understand desired methodology for transition of pass-through payments to allowable alternative structures
 - Regulations continue to allow states to establish rate "floors" for certain services
 - Stakeholder engagement critical to ensuring state-directed payment arrangements incorporate unique needs of LTSS providers
- **Quality**
 - Providers will need to understand measures and their role in improving plan performance
 - States/Plans may design provider incentive programs and value-based contracting arrangements around QRS measures and performance



Considerations for Providers (Continued)

- **Network Adequacy**
 - States continue to retain flexibility in development of network adequacy standards
 - Provider input is critical to informing state-selected criteria
 - Unclear how HCBS settings will factor into network adequacy criteria
- **Provider/Beneficiary Protections**
 - States may recognize the provider as an authorized representative of the enrollee
 - Providers must pay particular attention to the demonstrated plan readiness to pay claims
 - (i.e., provider education, end to end systems testing, readiness to accommodate existing plans of care or existing providers during transition periods as defined in state contracts)



Next Steps

Next Steps

- CMS indicated that there will be additional guidance to provide clarity and further direction on key provisions
 - CMS [Webinar Series](#)
 - o May 26th: Program Integrity
 - o June 2nd: Rate Setting, MLR, and Delivery System Reform
 - o June 9th: CHIP Managed Care
 - o June 16th: Covered Outpatient Drugs
- AHCA continues to analyze the final regulations to assess provider implications and to identify questions for CMS clarification
- Members should work with State Affiliates to engage with their state Medicaid agency, local managed care plans, and other relevant stakeholders to inform decision-making on key provisions

AHCA Resources

AHCA Resources

- MLTSS Toolkits
 - State Affiliate Toolkit: Advocacy Considerations for States Implementing MLTSS
 - MLTSS Member Contracting Guide
- Antitrust Guidelines for Nursing Centers in MLTSS Environments
- Managed Care Principles





Questions?



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