CMS Regulations re: Medicaid Managed Care

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Why & Why Now?

- Almost 50% increase in Medicaid managed care in 4 years.
- Regulations last revised in 2002.
- Managed care includes increasing numbers of those with chronic and complex conditions
- Support the efforts to reform delivery systems for Medicaid & CHIP beneficiaries.

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Why & Why Now?

- OIG/HHS Access to Care: Provider Availability in Medicaid Managed Care (MMC)
- OIG State Standards for Access to Care In MMC
- GAO Report to the Committee on Finance, U.S. Senate Medicaid Integrity Increased Oversight Needed to Ensure Integrity of Growing MMC Expenditures
- OIG State and CMS Oversight of the MMC Credentialing Process
- OIG MMC: Fraud and Abuse Concerns Remain Despite Safeguards
- GAO MMC CMS Oversight of States Rate Setting Needs Improvement

Agenda

- Audience and Focus for today's webinar
- What, why and why now?
- Financial Considerations
- Infrastructure for Transparency & Quality of Services
- Specific Program Components
- Q&A

Note:

Extensive list of terminology & key terms included on pg. 31099 (3rd pg.) of the rule

Purpose of the Rule
Federal Register June 1, 2015

- "Modernize the Medicaid managed care regulations to reflect changes in the usage of Medicaid managed care delivery systems
- Align the rules with other major sources of coverage; Qualified Health Plans & Medicare Advantage Plans
- Strengthen actuarial soundness payment provisions to promote accountability of managed care rates
- Promote quality of care
- Ensure appropriate beneficiary protections
- Enhance policies related to program integrity

Timelines

- Webinar addresses proposed rule, which will change based on comments.
- Deadline for comments July 27, 2015
  - Refer to CMS-2390-P
- Rule to be effective January 1, 2017

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Dynamics & Tensions

- Is this an expanded federal **role** in the administration of the Medicaid program?
- Is it unduly tying the states' hands re: administration of the program?
- Does the rule establish the proper balance-among interests…consumer, advocacy organizations, providers, Plans, states?
- Does the rule establish the proper balance of quality/health goals, cost and individual experience/responsibility?

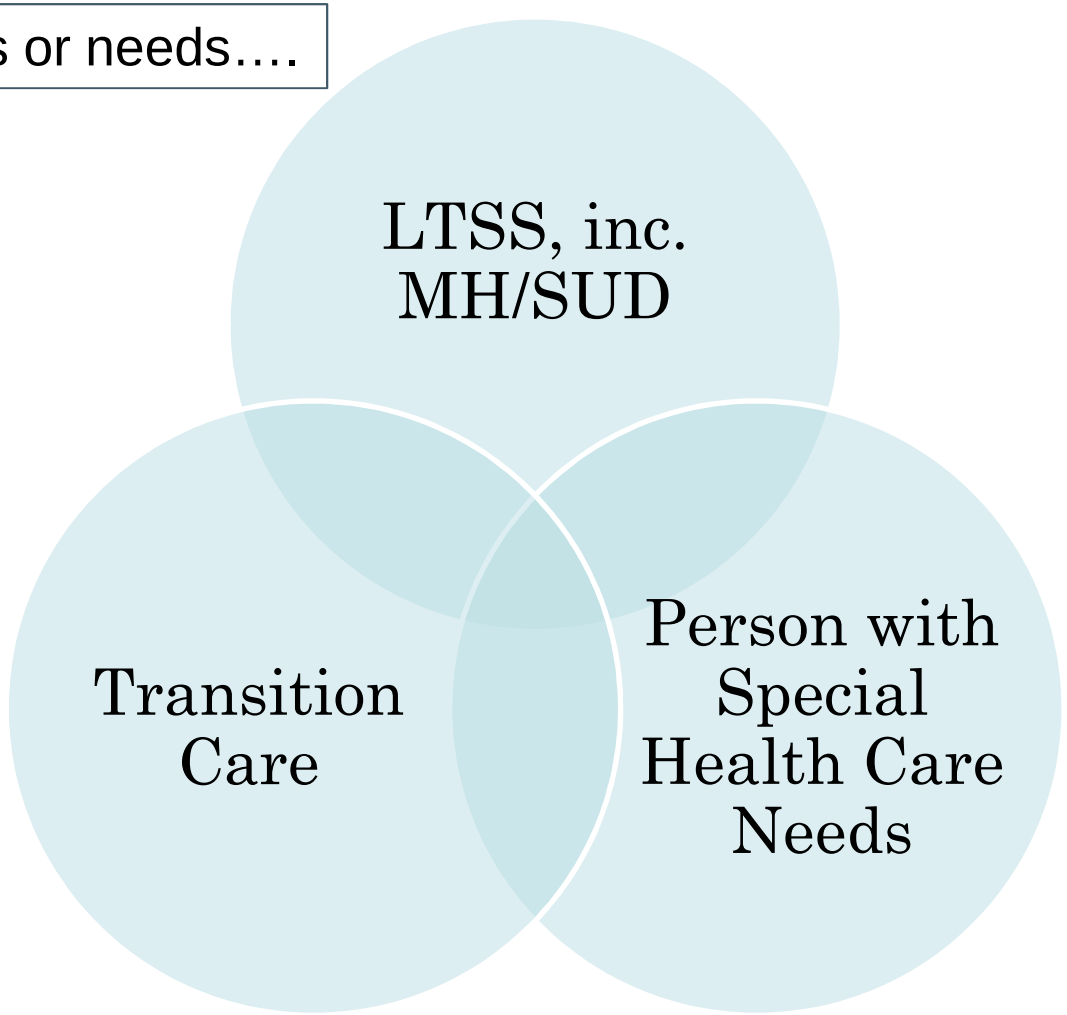
Who does this apply to?
Medicaid beneficiary served by these entities

- MCO-managed care organization
- PIHP-prepaid inpatient health plan
- PAHP-prepaid ambulatory health plan
- PCCM-primary care case management

- Above included in definition of managed care historically
- All of the above inc. in regulations, but not equally.
  - Webinar: we'll use term "**Plan**" for all of above, unless specified.
- Includes those receiving HCBS waivers, dual eligible contracts, ICF/IDD or NF, other LTSS; if in managed care
- Includes individuals with MH and SUD who may be receiving LTSS

Who does this apply to? Coordination & Continuity of Care

Person who has or needs….



Who does this apply to?

Managed Care Programs	Managed Care Entities	LTSS Contract
1932 (a)	MCO	1915(c)
1115(a)	PIHP	1915(i)
1915 (a)	PAHP	1915(k)
1915(b)	PCCM	Per 441.301(c)(4)
	HIO	*(Definition needs work, esp. re MH/SUD)*

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Primary Care Case Management (PCCM)

- CMS believes that some PCCM entities who contract with the state have evolved, PCCM will be redefined and some of these provisions extended to the PCCMs
- Case management plus any of the following: development of care plans, enrollee outreach & education, implementation of quality improvement activities or coordination with BH systems/ providers.
- Delivery system initiatives such as integrated care models, PCMH and ACOs would not be inc. in PCCM redefinition.

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CHIP & Medicaid Alignment

- CHIP 2009 requires alignment between Medicaid & CHIP. HHS will be specifying standards for CMS review of all managed care contracts.
- Some of these requirements, or similar, apply now
- Remember 3 options for states' CHIP program — applies to separate CHIP program. (i.e. NY, KY)
- CMS will extend care coordination standards, enrollee rights and existing emergency and post stabilization services requirements.

Financial Considerations

- Actuarial soundness and accountability of rates, including MHPAEA
- Medical Loss Ratio (MLR)
- Prohibitions on specificity of payment requirements

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Actuarial Soundness & Promoting Accountability of Payment Rates

- Greater specificity, incl. previously issued guidance from American Academy of Actuaries re: rate setting
- Require states to pay Medicaid Plans to "provide for all reasonable, appropriate & attainable costs" required.
- Capitation language recognizes that additional services may be necessary to comply with MHPAEA (438.3 (c))
- Payments from one rate cell must not cross subsidize other rate cells

Actuarial Soundness & Promoting Accountability of Payment Rates

- CMS review of rates will consider adequacy to allow Plan to meet network adequacy and access standards
- Incentive programs must be available to contractors with Plans, public and private
- Greater authority for CMS to disallow or defer availability of FFP for all, or part of payment rate to Plan; i.e. if inpatient hospital portion of rate is determined to not be actuarially sound, that portion could be disallowed.

Medical Loss Ratio (MLR)

- State need not impose any MLR, but, if it does, must use minimum MLR 85%, 15% retained for administrative functions and profit
- Numerator incl. a)claims, b) expenditures for compliance, fraud prevention, provider enrollment, various reporting activities, and c) expenditures that improve health care quality, HIT and external quality activity §438.8(e)
- With greater complexity of Medicaid populations…"CMS believes that the definition of activities that improve health care quality in Section 158.150 is broad enough to encompass…activities related to services coordination, case mgt and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS."
- Applies to MCO, PAHP, & PIHP; & rate years after 1/1/17

States Prohibited from Directing Plan Payments to Certain Providers

- But, there are exceptions with federal approval,
- Requiring Plans to participate in value based purchasing models (P4P, bundled payments, etc.)
- Require Plans to participate in multi payer delivery system reform or performance improvement
- Or requiring Plans to adopt minimum fee schedules or uniform rate increases across providers

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Infrastructure for Transparency & Quality of Services

- Requirements re: access & network adequacy
- Quality of care
- Coordination and continuity of care
- Appeals & Grievances
- Comprehensive system for program integrity
- Monitoring
- Quality measurement, reporting requirements
- Relationship with Subcontractors

Access & Network Adequacy

- Current law has requirements for access to care, reasonable timeframes, ensure continuity of care, adequate primary case and specialty care capacity.
- OIG identified significant variation among states re: network adequacy. Proposed rule addresses this.
- CMS would have authority to require time and distance standards for other provider types
- State must certify the adequacy of network annually, and if there is a significant change in the composition of the network.
- State can grant exceptions to their network adequacy requirements.

Access & Network Adequacy

- Requires "Time and distance standards" for various provider types and be specified in the Plan's contract. Could vary the time and distance by type of provider and geographic areas.
- Specific PROVIDER TYPES incl. primary care, specialists (adults & kids); OB-GYN, BH, hospital, pharmacy, pediatric dental, LTSS.
- Additional "ELEMENTS" that states must consider:
  - Health care providers ability to communicate with enrollee with limited English proficiency
  - Characteristics and health needs of the population

Access & Network Adequacy-LTSS

- Separate time and distance requirements for LTSS providers, inc. but not limited to, institutional, community and residential. Also for those traveling to the person's home.
- Reporting re sufficiency and geographic access, etc. would now inc. LTSS
- Beneficiary can disenroll with cause if their LTSS provider becomes an out of network provider.
- Requires each Plan to have a member advisory committee (438.110)

Access & Network Adequacy (cont.)

- Continue to require state standards for timely access to routine, urgent and emergency care.
- Timely and adequate access to out of network providers and no greater financial burden for out of network care.
- Plan provider selection procedures not discriminate against high risk clients or those specializing in their care. If provider excluded, must give written explanation.
- States publish standards on website.
- Plan directory must inc. MD/DO, specialists, BH, LTSS, and pharm; for each specialty, cultural/linquistic, physical accessibility.

Access: Info re: Benefits

- State or contracted representative would be required to provide potential enrollee with information related to covered benefits, including which benefits are covered by the plans, provider directory information, any cost sharing requirements, and requirements to provide adequate access to covered services including network adequacy standards.

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EPSDT
Contracts with the Plans must include provisions

- Specify "medically necessary services"
- May not arbitrarily deny or reduce services because of diagnosis, type of illness or condition.
- Services covered by Plan must be no less than FFS in amount, scope and duration & requires that service is "sufficient to reasonably achieve the purpose for which it is furnished"
- Permits Plans to place appropriate limits on service, on the basis of criteria or for utilization control
- Specifies that MCO meet requirements for EPSDT when determining medical necessity, inc. physical, mental…to correct or ameliorate.

Emergency & Poststabilization Services

- Must be paid for, even if out of network
- Emergency can not be limited by list of diagnosis or symptoms
  - Can't be denied payment for failure to notify Plan up to 10 calendar days
  - Determination of whether person is sufficiently stabilized rests with ER doc or provider treating
- Poststabilization coverage & payment per 422.113(c)

Quality of Care

Transparency

- Require states to develop a managed care quality rating system based on a) clinical quality management, b) member experience, and c) plan efficiency, affordability and management (438.334)

Alignment with other systems

- Plan must undergo a performance review at least as stringent as that of private accreditation entities, prior to contracting with state. (State determined process or accept CMS recognized accrediting organizations)

Consumer/stakeholder engagement

- For LTSS, Plan must have an advisory committee

Quality of Care (cont.)

Choice Counseling (438.71)

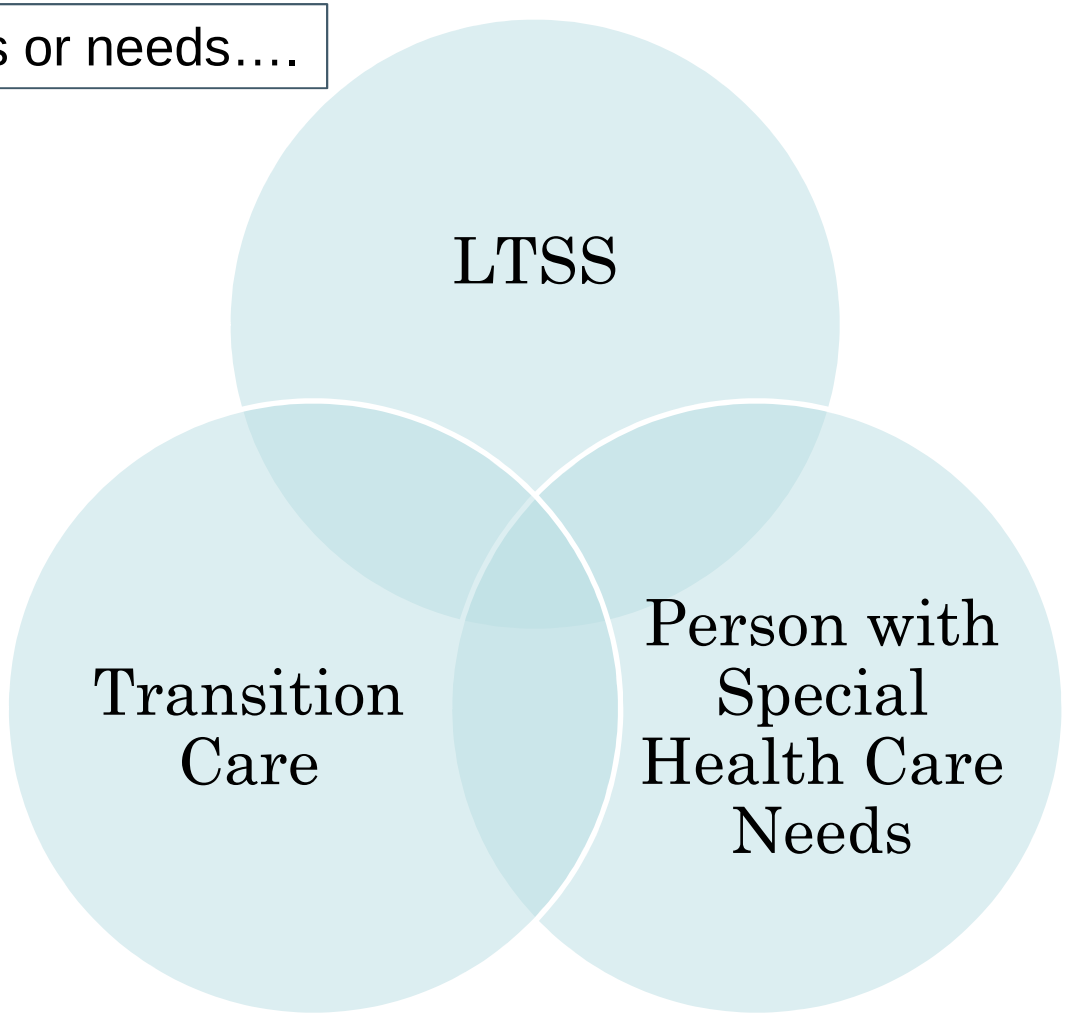
- Proposes the establishment of a choice counseling program to provide information and services to beneficiaries to help them make enrollment decisions
- *More on this in later slides*

Comprehensive quality strategy for FFS & managed care, at least every 3 years, & publicly available 438.330 & 438.340

- Requires assessment of quality & appropriateness of LTSS, inc. community integration; and PSHCN.
- Must assess under/overutilization.
- Must include Transition of Care policy
- May use CHIP child core measure sets.

Coordination & Continuity of Care People with Priority Considerations

Person who has or needs….



Coordination & Continuity of Care People with Priority Considerations

LTSS

- 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 provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Transition Care

- Continued access to services during a transition when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. (438.62)

Person with Special Health Care Needs

- Identified by the State & determined through an assessment to need a course of treatment or regular care monitoring

Coordination & Continuity of Care Enrollment & Assessment

- Mandatory enrollment requires 14 days FFS to allow active choice
- Requires procedures for passive enrollment to enhance continuity of care
- Limits without cause disenrollment to 1st 90 days, then annually thereafter
- Require Plans to make "best effort" to "conduct an initial assessment of each enrollees needs" within 90 days of enrollment
- Require Plans to ensure that providers share an enrollee health record.

Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- State must address in contract with Plans & must identify LTSS/PSHCN to the Plan
- LTSS/PSCHN must be identified in the state's comprehensive quality improvement strategy
- Plan must have process to "comprehensively assess" needs, using appropriate professionals or LTSS service coordinator or the Plan, as appropriate.

Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- IF the state requires Plans to produce a treatment or service plan, AND if the LTSS or PSHCN is determined to need a course of treatment or regular care monitoring, the plan shall be…
  - Developed by the provider, with enrollee participation
  - Developed by a person trained in person centered planning (per 441.301(c)(1) & (2))
  - Approved by Plan timely, if approval is necessary,
  - Reassessed at least every 12 months OR when circumstances change significantly OR request of person (441.301(c)(3))

Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- Plan must provide enrollees with special health care needs direct access to specialists (does not specify same requirement for LTSS)
- CMS maintains the statutory requirement that prevents states from mandating enrollment in managed care for children under 19 y.o. who are eligible based on disability, receive SSI under Title XVI or are foster children. However, CMS allows mandatory inclusion under waiver authority. (438.50)

Coordination & Continuity of Care: Transition of Care Policy

- Require states to have a 'transition of care' policy with minimum standards, inc. allowing individual to receive care from current provider for a period of time.
- Transition to or between any/all types of managed care entities
- For those who would **"suffer serious detriment to their health or be at risk of hospitalization or institutionalization"** if services were not continued.
- Maintain access to provider for period of time, even if provider out of network (not limited to LTSS or persons with special health care needs)
- Ensure referral to other qualified providers and that records are transferred.

Recap

#1 Managed Care-Medical	Carved Out HCBS 1915(c)
• Rule applies to medical services • Coordinate all services per 438.208 (b)(2)	• LTSS requirements DON'T apply • Might be specified as Person with special health care needs • Might meet Transition Care Policy

#2 Managed Care-Medical	Managed Care HCBS (1915c or Duals)
• Rule applies to medical services • Coordinate all services per 438.208 (b)(2)	• LTSS requirements DO apply • Might be specified as Person with special health care needs • Might meet Transition Care Policy

Consumer Appeals & Grievances

- Appeal timeframes require quicker response
  - 30 days for appeal, rather than 45 days
  - 72 hours for expedited appeal, rather than 3 business days
- If requested, the enrollee's benefit must be continued during an appeal, until state fair hearing is reached, or 10 days after the plan mails the adverse decision to the enrollee.
- Plan may recover cost of services during appeal, if decision is adverse
- Grievance must be addressed within 90 days.

Plan Readiness Reviews & Annual Assessment

- Inc. readiness reviews prior to start dates and submit results to CMS before Plan contract can be approved.
- Readiness review addresses: operations and administration, service delivery system, financial management, and systems management.
- Requires state to submit annual program assessment within 150 days of end of Plan period of performance.

Monitoring, Quality Measurement & Availability of Data

- Require states to have a monitoring system that addresses 14 specified areas.
- Comprehensive annual quality assessment and performance improvement program provided to state for services furnished under plan
- 61 separate submissions of information from states and Plans, est. cost of $112m

Comprehensive System for Program Integrity Required of State

- Screen, enroll and reevaluate all network providers
- Review ownership and control disclosures submitted by plans and subcontractors
- Conduct routine checks of federal databases for exclusion status and ownership interest
- Conduct or contract for period independent audits of encounter and financial data of Plans (at least once every 3 yrs.)
- Review and investigate whistleblowers re: integrity issues, re: plans, subcontractors or network providers.
- Make available plan contracts, state independent audits and data reports in variety of specified areas.

Subcontract Relationships

- Propose to model plan subcontracting arrangements after the Medicare Advantage program; w/ ultimate responsibility remaining with the managed care plan.
- Subcontractors must: agree to perform delegated activities, reporting requirements; comply with Medicaid laws, regs, contracts; give the state, CMS, HHS Inspector General, Comptroller General or designees, the right to audit, evaluate and inspect activities related to the contract.

Specific Program Components

- New flexibility associated with IMD exclusion
- Increased focus and accountability associated with LTSS
- Role for Choice Counseling

Current IMD-What is it? Institutions for Mental Disease

- Since enacted in 1965, Medicaid excludes coverage for the payment of Medicaid services for ADULT patients (21-64) in an IMD. (SSA§1905(a)(29)(B))
- IMD defined as hospital, NF or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care to persons with mental diseases, including medical attention, nursing care and related services. 42CFR §435.1010
- New proposal does not apply for children under 21 or 65 plus

Clarification of Current Policy- "In Lieu of " Services

- MCOs (or PIHP) could be paid monthly cap rate if served in IMD (438.3(u))
- "so long as the facility is an inpatient hospital facility or subacute facility providing crisis residential services" and
- It's a short term stay for MH/SUD of less than 16 days in the period of the "monthly capitation payment".
- Current policy re MCO's flexibility to provide services in cost effective alternatives; "in lieu of services"
- This alternative can't be mandated by the MCO, but can be used as an option

IMD Example

- Let's assume Mary is served by Molina, so they receive a monthly capitation payment to serve her.
- In past, if Mary was admitted to an IMD, she would not lose Medicaid eligibility per se, but Medicaid couldn't pay for her services
- Per proposed rule, now, if she is admitted for MENTAL HEALTH or AOD services on July 20 and discharged on Aug. 10, MCO will receive normal monthly payment for both July and August.
  - Total of 21 days, but 11 days in July and 10 days in August

Resource:
http://www.vorys.com/publications-1517.html

Ohio may use the new option

- The Administration has expressed support for the use of this option
- Trade off will be use of managed care for BH because the option requires a capitated arrangement
- Will be important that provider and Plan monitor where IMD exclusion starts and stops to ensure payment

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LTSS

- Definition: 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 provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
- Incorporated into the definition of capitation payments for Plans

LTSS: Guidance in10 Areas

Rule seeks to codify 2013 Guidance (Reference on slide 54)

1. Adequate Planning: States must develop appropriate monitoring and accountability programs: readiness reviews, adhere to new standards regulating materials distributed to enrollees and potential enrollees.

2. Stakeholder Engagement: States must create and maintain a stakeholder group in order to solicit stakeholder input in the design, implementation, and oversight of the MLTSS program. Seems to contemplate something other than MCAC.

3. Enhanced Provision of Home and Community-Based Services: All MLTSS programs must be consistent with the Americans with Disabilities Act and the U.S. Supreme Court's decision in Olmstead, bias toward community-based care over institutional care.

LTSS: Guidance in10 Areas

4. Alignment of Payment Structures and Goals: Payment to Medicare managed care plans should support the goals of MLTSS programs to improve health, improve experience of care, support community integration, and reduce costs.

5. Support for Beneficiaries: Beneficiary support systems must provide support to beneficiaries both pre and post enrollment in a Medicaid managed care plan. Requires an access point for complaints and concerns, resources and education on enrollee grievance rights, assistance in filing and appealing grievances, and review of program data to inform the state Medicaid agency on systemic issues.

6. Person-Centered Processes: States must establish processes, including comprehensive needs assessments and service planning, with the objective of improving quality of life and independence.

LTSS: Guidance in10 Areas

7. Comprehensive Integrated Service Package: States must promote robust coordination and referral between settings of care.

8. Qualified Providers: Provides guidelines to states for network adequacy standards. These include credentialing and time and distance standards. CMS not dictating the standards, but gives authority to states to establish standards regarding utilization, population needs, the number of providers and their geographic mix, the ability to communicate with enrollees with limited proficiency in English, in order to ensure access to services for enrollees with physical or mental disabilities.

LTSS: Guidance in10 Areas

9. Participant Protections: Plans must participate in state efforts to prevent, detect, and remediate incidents that adversely impact enrollee health and welfare, as well as the achievement of quality outcomes described in person centered plan.

10. Quality: States should incorporate MLTSS-specific provisions within their existing quality standards, including specific quality of life assessment mechanisms and assessment of appropriateness of care.

LTSS Summary

- Reinforces existing HCBS setting requirements
- Operationalizes the integration of managed care and LTSS
- Focus on network adequacy
- More data collection than current
- More stakeholder engagement
- Requires specific quality standards for LTSS

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Choice Counseling (438.71)

State must provide system of support for all beneficiaries, include, at a minimum:

- Choice counseling for all beneficiaries
- Training for network providers specified.
- Assistance to enrollees to understand mgd care
- Assistance to those requesting/receiving LTSS… access; education grievance, rights; assistance if requested; data/oversight re: systemic issues.

Counselors would have to follow conflict of interest standards, excluding Plans or providers from serving as Choice Counselors

Take Aways

- Greater consistency across states managed care programs. Little here is new, it hasn't been consistently utilized.
- Increased Plan accountability will trickle down to providers as well – data, data, data
- Recognizes the intersection of managed care and traditionally FFS specialty systems-BH, IDD, Child Welfare. Adds protections for more vulnerable populations.

Wrap Up

- Questions & Discussion
- Resources:

Summary of Managed Long Term Services and Supports Programs Essential Elements
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html

Guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html

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Vorys Health Care Advisors, LLC helps health care providers, business decision makers and professional associations achieve their objectives in a constantly changing governmental and business health care environment and assists them in making well informed, strategic and tactical decisions tailored to their individual goals, needs and aspirations.

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Vorys health care attorneys are trusted and experienced professionals who counsel clients on the legal and regulatory issues facing the health care industry. Whether the matter involves the day-to-day operations of a health care facility or issues associated with regulatory compliance, complex litigation, corporate compliance, fraud and abuse, or payor and reimbursement arrangements, our attorneys are fully equipped to address client health care needs.

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