MACPAC

Medicaid Managed Care

Final Rule

Medicaid and CHIP Payment and Access Commission
Moira Forbes

Overview

- Background on Medicaid managed care regulation
- Significant provisions in the final rule
- Areas of future Commission work

Regulatory Background

- Medicaid managed care programs are regulated by 42 CFR Part 438, first proposed in 1998 and finalized in 2001
- On May 27, 2015 CMS published a notice of proposed rulemaking to modernize the rule
  - improved consistency across states
  - stronger beneficiary protections
  - greater federal oversight
  - increased complexity
  - new costs

Commission Comments

- Commission submitted a comment letter supporting an updated rule
- Encouraged CMS to finalize the rule quickly to provide clarity and consistency, ensure that implementation is carefully staged and adequately resourced
- Urged CMS to consider state burden
- Supported a consistent national method for calculating a medical loss ratio, but encouraged CMS to factor in Medicaid differences

Regulatory Response to Commission Comments

- Final rule includes a three year roll-out schedule to allow states to come into compliance and CMS to develop oversight mechanisms
- Final rule includes a medical loss ratio provisions with standard consistent with those applied by Medicare Advantage and the private market with some variation to account for the unique characteristics of the Medicaid and CHIP programs

Overview of Significant Provisions

Payment and Rate Setting

- Puts into regulation greater standards for capitation rate development
- Adds specific bounds to some aspects of rate setting but also provides explicit permission for states to implement certain payment methods
- Phases out the ability of states to make pass-through payments to hospitals, nursing facilities, and physicians

In Lieu of Services

- Puts into regulation longstanding guidance regarding when and which services may be covered "in lieu of" state plan services
  - medically appropriate and cost effective substitute for the covered service or setting
  - enrollee cannot be required to use the alternative service or setting
  - approved in lieu of services are authorized and identified in contract and offered at plans' discretion
  - in lieu of services are taken into account in developing capitation rates

Institution for Mental Diseases (IMD) Exclusion

- Beginning on the effective date of the rule, allows states to make monthly capitation payments to MCOs for enrollees aged 21-64 who have a short term (<15 day) stay in an IMD
- For purposes of rate setting, the state may use IMD utilization but not the costs associated with services to patients in an IMD

Medical Loss Ratio (MLR)

- CMS proposed that an MLR of at least 85% be calculated and used in the development of actuarially sound capitation rates
- Final rule includes this requirement, with additional specificity regarding medical loss standards and oversight
- Final rule does not require plans, as a matter of contract compliance, to meet a specific MLR

Managed Long-Term Services and Supports (MLTSS)

- Codifies much of the subregulatory guidance for MLTSS plans released in 2013, including:
  - requirement for stakeholder engagement
  - person-centered treatment and service planning for enrollees with long term services and supports needs
  - disenrollment for cause if certain support providers leave the network
  - additional data gathering and sharing among plans and providers
  - transition plans when a beneficiary moves from fee for service (FFS) to managed care or between plans

Network Adequacy

- By July 1, 2018, states must implement time and distance standards for:
  - adult and pediatric primary, specialty, and behavioral health care
  - obstetric services
  - hospitals
  - pharmacies
  - pediatric dental services
- CMS did not add federal network standards
- Plans must annually certify network adequacy

Program Integrity

- Requires plans to implement additional program integrity procedures
- Requires state rate-setting process to take into account overpayments recovered by managed care plans
- By July 1, 2018, all providers contracting with managed care must be screened, enrolled, and revalidated as in the FFS program
  - Not required to participate in FFS program

Outpatient Prescription Drugs

- Clarifies that when a managed care plan provides Medicaid drug coverage, it must provide coverage under the same terms as the state
  - e.g., cover all medically necessary drugs even if not included in the plan's formulary

Provisions Affecting Dually Eligible Beneficiaries

- Few provisions directly address dually eligible beneficiaries
- Some states will now delegate the state's responsibility for coordination of benefits to managed care plans
- Aligns procedural aspects of appeals and grievances process for Medicaid managed care and Medicare Advantage
  - Creates consistency but does not integrate processes for dually eligible beneficiaries

Quality Rating System and Quality Strategy

- States must implement a quality rating system (QRS) for Medicaid and CHIP plans and publicly report plan performance
- States do not have to develop statewide quality strategies for FFS and managed care
- Extends quality strategy and external quality review requirements to some primary care case management models
- State quality strategies have to address health disparities and LTSS

Appeals and Grievances

- Aligns Medicaid managed care rules for appeals and grievances with rules for Medicare managed care, private health insurance, and group health plans
- Requires enrollees to exhaust managed care appeals before state fair hearings instead of going outside or directly to state fair hearing

Enrollment Process

- By July 1, 2018 states must establish an independent beneficiary support system to provide enrollment choice counseling and assist enrollees post-enrollment
- States do not have to cover beneficiaries in FFS for 14 days prior to being assigned to a managed care plan
- Makes numerous changes to enrollment information and communication requirements to improve content and distribution methods

CHIP

- Goal of new rule is to align CHIP, exchange, and Medicaid standards where practical to ensure consistency across programs
- Scope of the CHIP regulations is narrower than the revisions and amendments to Medicaid
- Final regulations for CHIP are aligned with the revisions made for Medicaid where appropriate without imposing additional requirements or significant new burdens on CHIP when possible

Next Steps for MACPAC

- Update managed care analyses
  - Enrollment and spending trends
  - Issue briefs
- Initiate new projects
  - Program integrity
  - MLTSS
- Assess the effect of the final rule on specific areas of Commission interest
- Monitor the roll-out of various provisions

MACPAC

Medicaid Managed Care

Final Rule

Medicaid and CHIP Payment and Access Commission
Moira Forbes