Medicaid Managed Care Final Rule

Modernizes and More Closely Aligns Medicaid Managed Care with Medicare Advantage and Exchange Requirements

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I. Background on Medicaid Managed Care
I. Background on Medicaid Managed Care

OVERVIEW

- Medicaid is largest U.S. payer (by headcount)
  - Covers 72 million Americans
  - $492 billion
  - Core financing source for safety-net hospitals and health centers that serve low-income communities, plus long-term care facilities
- 39 states contract with comprehensive Managed Care Organizations (MCOs) for Medicaid
  - More than 70 percent (46 million) of all Medicaid beneficiaries get at least some care through these entities
- CMS last issued comprehensive Medicaid managed care regulations in 2002

Rule also governs managed care under Children’s Health Insurance Program (CHIP)

## I. Background on Medicaid Managed Care

### Medicaid Enrollment Trends

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<th>Year</th>
<th>Total Enrollment</th>
<th>Medicaid Managed Care</th>
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### Source:


*Enrollment was above zero but under 500,000, thus was rounded down.
I. Background on Medicaid Managed Care

DEVELOPMENT TIMELINE

- **1962**: Medicaid Program enacted
- **1965**: HMO Amendments adds 50/50 rule for Medicaid risk plans
- **1962**: Section 1115 added to Social Security Act to allow for waiver of program requirements for pilot or experimental projects
- **1973**: Health Maintenance Organization Act
- **1976**: OBRA added 1915(b) freedom of choice waivers and replaced 50/50 with 75/25 rule
- **1981**: Arizona granted the first statewide Medicaid managed care waiver under Section 1115
- **1982**: Balanced Budget Act allows for mandatory managed care without waiver and eliminates 75/25 rule
- **1994**: Oregon statewide Medicaid managed care waiver approved, allowed for service prioritization
- **1997**: CMS releases changes to the Medicaid managed care rules
- **2002**: CMS releases first comprehensive changes to the Medicaid managed care rules in 14 years
- **2010**: Balanced Budget Act allows for mandatory managed care without waiver and eliminates 75/25 rule
- **2016**: ACA extends Medicaid drug rebate program to managed care, allows for expansion up to 138% of Poverty
I. Background on Medicaid Managed Care

**MOST STATES USE MEDICAID MANAGED CARE PLANS**

- WY
- WI
- WV
- WA
- VA
- VT
- UT
- TX
- TN
- SD
- SC
- RI
- PA
- OR
- OK
- OH
- ND
- NC
- NY
- NM
- NE
- NJ
- NH
- NV
- ND
- MA
- MD
- ME
- LA
- KY
- KS
- KY
- IN
- IL
- IN
- IN
- IA
- ID
- HI
- OK
- AR
- MS
- AL
- GA
- FL
- CO
- CA
- CT
- RI
- DE
- MD
- MA
- NH
- WY
- WV
- VT
- ME
- HI

Source: Adapted from data from the Kaiser Family Foundation, *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*, October 15, 2015.

AIM OF FINAL RULE

- Modernize managed care in Medicaid and CHIP to
  - Reflect changes in managed care delivery systems
  - Facilitate and support delivery system reform initiatives to improve outcomes and manage costs
  - Strengthen the quality of care provided to Medicaid beneficiaries and
  - Promote more effective use of data in overseeing managed care programs
- Revise MMC and CHIP rules to better align with Medicare Advantage (“MA”) and qualified health plans (“QHPs”) sold through ACA marketplaces
  - Improve experience for persons who move between coverage options due to changes in circumstances
  - Reduce administrative burden on regulators and issuers operating in multiple markets
- Encourages issuers in MA and ACA marketplaces to enter the Medicaid market; this rule modernizes the Medicaid managed care regulatory
What kinds of entities are affected?

- Applies to all Medicaid Managed Care ("MMC") entities, including
  - Managed Care Organizations ("MCOs")
  - Prepaid Inpatient Health Plans ("PIHPs")
  - Prepaid Ambulatory Health Plans ("PAHPs")
  - Managed Long-Term Services and Supports ("MLTSS") programs

- New types of entity -- "PCCM [Primary Care Case Management] Entities"
  - Reflects entities conducting "enhanced" PCCM services, paid more robust capitation
  - CMS would hold PCCM Entities to the same standards as other MMC entities

- Does not apply to ACOs or Primary Care Medical Homes
II.b. Major Provisions of the Final Rule – Network Adequacy
II.b. Major Provisions of the Final Rule

**NETWORK ADEQUACY**

- States must set time and distance standards for providers of:
  - Pharmacy
  - Primary care (adult and pediatric)
  - OB/GYN
  - Mental health/Substance use disorder (adult and pediatric)
  - Pediatric dental
  - Specialists (adult and pediatric) (can be further defined by states)
  - Hospital
  - Other providers if applying such standards “promotes the objectives of the Medicaid program”

*Exceptions allowed if monitored by the state*

- Other factors states must consider
  - Expected Medicaid enrollment and utilization of services
  - Characteristics and health needs of the covered population
  - Number and types of health care professionals required to provide covered services
  - Number of network providers that are not accepting new Medicaid patients
  - Geographic location and accessibility of both providers and enrollees
  - Ability of providers to ensure accessibility and required equipment for the disabled
  - Reasonable accommodations
  - Providers’ ability to communicate in a “culturally competent” manner
  - Availability of technological solutions

- States may apply additional factors which need not be the same or applied uniformly across a state or across provider types
II.b. Major Provisions of the Final Rule

NETWORK ADEQUACY

- States are also advised to look to
  - The state’s network adequacy standards for commercial insurance
  - MA plan network adequacy standards
  - Historical patterns of Medicaid utilization
- Timeliness would be assessed as routine, urgent, or emergency care
- Publish network adequacy standards for transparency
- MMC entity required to document network adequacy for state review at least yearly... and when a significant change to operations would affect capacity and services
- External Quality Review Organization must validate plans’ network adequacy for the previous 12 months
- MLTSS must have distinct network adequacy standards
  - Based on the same factors as for medical services
  - May vary, based on whether the enrollee or provider must travel to provide services
  - Should consider strategies “to ensure the health and welfare of enrollees using LTSS and to support community integration of individuals receiving LTSS”
II.c. Major Provisions of the Final Rule – Medical Loss Ratio
II.c. Major Provisions of the Final Rule

MEDICAL LOSS RATIO

- States must develop capitation rates so that managed care plans can be expected to reasonably achieve at least an 85 percent MLR
  - States may choose higher minimum

- Standards for calculating the MLR are consistent with those for MA and the private market with some variation due to unique characteristics of the Medicaid and CHIP

- Calculates the MLR over a 12-month period

- States may collect remittances if MMC entity has MLR <85 percent (with FMAP percentage returned to the federal government)

- CMS acknowledges its lack of enforcement authority over Medicaid MLR
  - However, CMS will use its authority over approval of capitation rates to ensure that rates are adequate to enable plans to show an expected MLR of 85 percent or higher
II.c. Major Provisions of the Final Rule

MEDICAL LOSS RATIO

- Incurred claims consist of all claims costs for covered state plan services, including, for example
  - Incentive and bonus payments paid and expected to be paid to providers
  - Anticipated coordination of benefits recoveries

- Amounts which must be deducted from incurred claims include, for example
  - Prescription drug rebates
  - Overpayment recoveries
  - Amounts paid, including to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services

\[
\text{Medicaid MLR} = \frac{\text{Incurred claims + Quality Improvement Expenditures}}{\text{Premium Revenue - Federal & State Taxes, Licensing & Regulatory Fees}}
\]
Quality improvement activities include those related to service coordination, case management and activities supporting state goals for community integration.

Detail not stated in regulation leaving it to individual states to determine which activities qualify as quality improvement.

Pass-through payments as directed by the state that are not tied to utilization or quality are not included in either the numerator or the denominator, for example:
- Graduate medical education payments or supplemental payments for uncompensated care.
II.d. Major Provisions of the Final Rule – Setting Actuarially Sound Capitation Rates
II.d. Major Provisions of the Final Rule

SETTING ACTUARIAL SOUNDED CAPITATION RATES

- Aims to ensure that MCO, PIHP, and PAHP Medicaid rates are developed in a transparent and consistent manner across MMC programs

- Incorporates principles of actuarial soundness:
  - Rates should be sufficient and appropriate for the anticipated service utilization of the populations and services covered and compensate plans for reasonable non-benefit costs
  - Capitation rates should promote program goals, such as quality of care, improved health, community integration of enrollees, and cost containment
  - Actuarial rate certification should give sufficient detail, documentation, and transparency of rate-setting components
  - Transparent and uniformly applied rate review and approval process based on actuarial practices should ensure that both the state and CMS act effectively as fiscal stewards and in the interests of beneficiary access to care

- Sets forth the types of data to be used for rate setting and the level of documentation/detail so CMS can more effectively review and approve rates
II.d. Major Provisions of the Final Rule

SETTING ACTUARILY SOUND CAPITATION RATES

- States need to certify each individual rate per rate cell as actuarially sound
  - “Rate cell” is a set of mutually exclusive categories of enrollees defined by one or more characteristics for the purpose of determining the capitation rate,
    - May include age, gender, eligibility category, and region or geographic area
  - May no longer use capitation rate ranges

- States are given flexibility to increase or decrease the certified capitation rate by one and a half percent without the need to submit a revised rate certification for CMS’ review and approval

- State may use risk sharing arrangements, incentive arrangements, and withholds arrangements to reward MCOs, PIHPs, and PAHPs for meeting performance targets specified in the contract
  - Contracts would need to include a description of any risk sharing mechanisms and those mechanisms must be computed on an actuarially sound basis
II.e. Major Provisions of the Final Rule

QUALITY OF CARE STANDARDS

- Quality provisions of Final Rule seek to enhance transparency, align quality measurements with other systems of care where possible, and strive to improve consumer and stakeholder engagement.

- Proposed changes center on:
  - Quality Performance review and approval process
  - Development of a quality rating system
  - Expansion of the comprehensive quality strategy to encompass FFS and MMC
  - Data and information disclosure to increase accountability
  - Standards for performance measures and topics for performance improvement projects
  - Revisions to the external quality review system
II.e. Major Provisions of the Final Rule

QUALITY OF CARE STANDARDS

Quality Performance Review and Approval Process ("QPRAP")

- States must
  - Require through contract that each MCO, PIHP, PAHP, and certain PCCM entities establish and implement an ongoing comprehensive quality assessment program for the services it provides to enrollees
  - Review at least annually the impact and effectiveness of the QPRAP of each entity

- QPRAPs must include
  - Performance Improvement Projects ("PIPs")
  - Collection and submission of performance measurement data
  - Mechanisms to detect both underutilization and overutilization of services
  - Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, including those in MLTSS

- Information from annual reviews must be publicly available on the state’s website
II.e. Major Provisions of the Final Rule

QUALITY OF CARE STANDARDS

Quality Rating System ("QRS")

- State may use CMS-defined QRS or develop its own subject to CMS approval
- Based on (but not identical to) summary indicators used in Exchange QRS
  - Clinical quality management
  - Member experience
  - Plan efficiency, affordability and management
- Refined by robust public process, including notice and comment, over 3-5 years
- Methodology reassessed every 2-3 years to accommodate changes
- Did NOT finalize proposal to allow states to rely on the MA 5-star ratings for dual eligible plans
- States must post ratings online to help beneficiaries to make informed decisions
II.e. Major Provisions of the Final Rule

**QUALITY OF CARE STANDARDS**

**External Quality Review**

- The Secretary will develop protocols for External Quality Review ("EQR")
- State must contract with EQR Organization ("EQRO")
- EQR activities include
  - Validation of network adequacy for prior 12 months, different from assessing availability of services (required)
  - Validation of compliance with MCO, PIHP and PAHP standards for previous 3-year period (required)
  - PIP validation
  - Validation of encounter data (optional)
  - Administration of consumer or provider surveys on quality of care (optional)
- State may rely on results of Medicare review or private accreditation survey instead of requiring EQR performance of required EQR activities
II.f. Major Provisions of the Final Rule – Appeals and Grievances
II.f. Major Provisions of the Final Rule

APPEALS & GRIEVANCES

- Aligns Medicaid/CHIP appeals and grievance processes with those for MA and QHPs
  - Current differences hinder creation of a streamlined process across the public and private managed care sectors, creating unnecessary administrative complexity for those participating across product lines

- Appeals and grievances requirements are extended to PAHPs

- MMC plans must offer one level of internal appeal after which beneficiaries may request a state fair hearing, similar to rules for individual QHP products and MA
  - Plan failure to meet timeframes deems enrollee as meeting exhaustion requirements

- Providers would be allowed to appeal on behalf of beneficiaries with written consent from enrollees (changed from proposed rule which said without consent)

- Timing for resolution of appeals would be reduced
  - For standard appeal determinations to 30 days from 45
  - For expedited appeal determinations to 72 hours from 3 working days
II.f. Major Provisions of the Final Rule

APPEALS & GRIEVANCES

- Procedural protections for appeals are strengthened
  - Clarifies information that must be considered in an appeal and that which must be made available to beneficiaries
  - Requires implementation of reversal of adverse benefit determination within 72 hours

- Timeframe for enrollees to request a state fair hearing extended from a maximum of 90 days to 120 calendar days

- Continuation of benefits while appeal is pending
  - MMC plans would no longer be able to stop any services pending determination of appeals
  - States may allow recoupment from enrollee if adverse determination upheld so long as the same standard is applied to both FFS and managed Medicaid
II.g. Major Provisions of the Final Rule – State Monitoring Standards
II.g. Major Provisions of the Final Rule

**STATE MONITORING STANDARDS**

- States must
  - Implement a monitoring/oversight system to address, at a minimum:
    - Administration and management
    - Appeal and grievance systems
    - Claims management
    - Enrollee materials and customer services
    - Finance, including MLR reporting
    - Information systems, including encounter data reporting
    - Marketing
    - Medical management, including utilization management
    - Program integrity
    - Provider network management
    - Quality improvement
    - Delivery of LTSS

  - Submit annual program assessment to CMS and post the assessment publicly
  - Use data collected from its monitoring activities to improve the performance of its managed care program
  - Conduct readiness assessments of each MCO, PIHP, PAHP and PCCM entity as follows:
    - Prior to start of a new managed care program, when a new contractor enters an existing program or when the state adds new benefits, populations, or geographic areas to the scope of its contracted managed care plans
  - Readiness review would, at baseline, assess: plan operations and administration, service delivery, financial management and systems management
II.h. Major Provisions of the Final Rule – Information Requirements
II.h. Major Provisions of the Final Rule

INFORMATION REQUIREMENTS

- Changes made to strengthen MMC beneficiary information dissemination rules, more closely align with MA and commercial, better reflect technology advances, recognize cultural/linguistic diversity of Medicaid beneficiaries
- Apply consistently across MMC plans, including MCOs, PIHPs, PAHPs, PCCM and PCCM entities, with respect to enrollee materials
- States and MMC entities must make materials available in prevalent languages
  - To include taglines on availability of written materials in those languages and oral interpretation in understanding the materials
- MMC entities must also make available vital documents in each prevalent non-English language in the MMC’s service area, to include
  - Provider directories
  - Member handbooks
  - Formulary
  - Other notices critical to obtaining services
- MMC entities also must post provider directories on their websites in a CMS-specified machine-readable file and format
II.i. Major Provisions of the Final Rule – Managed Long-Term Services & Supports
II.i. Major Provisions of the Final Rule

MANAGED LONG-TERM SERVICES AND SUPPORTS

- In 2004, eight states (AZ, FL, MA, MI, MN, NY, TX, and WI) had implemented MLTSS programs. By January 2014, 12 additional states had implemented MLTSS programs (CA, DE, IL, KS, NC, NM, OH, PA, RI, TN, VA, WA)

- New requirements on MLTSS when provided through MCOs, PIHPs and PAHPs
  - Enrollment and benefits complaint mechanism
  - Education
  - Assistance with grievances, appeals, and fair hearings, and
  - Review of program data to identify and resolve systemic issues

- Regulation provides new requirements on MLTSS in support of the 10 key principles for MLTSS set out in 2013 guidance

- Adequate program planning
- Stakeholder engagement
- Enhanced home and community-based services
- Payment alignment
- Beneficiary support and protections
- Person-centered process
- Comprehensive, integrated service package
- Qualified providers
- Participant protections
- Quality
II.j. Major Provisions of the Final Rule – Other

**BENEFICIARY ENROLLMENT PROVISIONS**

- States may passively enroll beneficiaries effective upon eligibility determination, subject to the enrollees’ right to opt-out or elect a different managed care plan.

- CMS declined to finalize 14-day choice period to affirmatively choose a plan or opt for FFS.

- For passive or default enrollment:
  - States must seek to “preserve provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid”.
  - If not possible, states must equitably distribute beneficiaries among available plans and may not arbitrarily exclude any plans.
  - Additional assignment criteria are permitted, to reflect:
    - Beneficiary location and preferences
    - Previous plan assignment
    - Access needs for disabled beneficiaries
    - Quality and procurement considerations
III. Key Takeaways
III. Key Takeaways

- CMS goal: harmonization across MMC, MA, QHPs
  i. Administrative simplification
  ii. Continuity for beneficiaries as they move between markets

- Provider impact: Generally positive
  i. Floor on MMC medical spend thanks to minimum MLR, actuarial soundness
  ii. More emphasis/value on health care quality
  iii. Consistency across Medicaid, Medicare, commercial managed care

- Impact on health plans: Neutral to positive
  i. Actuarial soundness promotes adequate capitation rates
  ii. State-to-state consistency lessens burden on multi-state issuers

- Impact on states: Variable
  i. Potentially heavy transition burden on states w/ most developed MMC
Questions?

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IV. Appendix
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FEDERAL AUTHORITIES FOR MEDICAID MANAGED CARE DELIVERY

- Section 1915(a) of the Social Security Act (the SSA)
  - Allows states to implement a voluntary managed care program

- State plan amendment (SPA) under section 1932 of the SSA
  - Allows states to implement mandatory managed care program
  - Does not allow for inclusion of dual eligibles, American Indians/Alaska Natives, or children with special health care needs

- Section 1915(b) of the SSA (waiver authority)
  - Allows states to pursue a waiver to implement mandatory managed care, including for those excepted under a SPA

- Section 1115(a) of the SSA (waiver authority)
  - Allows states to pursue waiver to implement mandatory managed care for all beneficiaries as part of a demonstration project
  - State may request approval to provide services not typically covered by Medicaid
IV. Appendix

PROVISIONS ELIGIBLE FOR WAIVER UNDER SSA 1915(b) & 1115

- **Statewideness (section 1902(a)(1) of the SSA)**
  - Waiver allows states to implement managed care in specific areas of the State (generally counties/parishes) rather than the entire state

- **Comparability of Services (section 1902(a)(10) of the SSA)**
  - Waiver allows states to provide different benefits to beneficiaries enrolled in a managed care delivery system as compared to those in fee-for-service Medicaid

- **Freedom of Choice (section 1902(a)(23)(A) of the SSA)**
  - Waiver allows states to require beneficiaries to receive their Medicaid services only from a managed care plan or primary care provider

- **Allows for payment of costs not otherwise eligible under section 1903 of the SSA (Section 1115 only)**
IV. Appendix

PERCENTAGE OF MEDICAID POPULATION IN MCOS

Source: Adapted from data from the Kaiser Family Foundation, Medicaid Reforms to Expand Coverage, Control Costs, and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016, October 15, 2015.
IV. Appendix

PERCENTAGE OF MEDICAID POPULATION IN PCCMS

Source: Adapted from data from the Kaiser Family Foundation, Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016, October 15, 2015.
IV. Appendix

PERCENTAGE OF MEDICAID POPULATION IN FFS (NO COMPREHENSIVE MMC)

Source: Adapted from data from the Kaiser Family Foundation, Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016, October 15, 2015.