Managed Care Final Rule: 2017 Implementation Updates

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DMHC Financial Solvency Standards Board Meeting
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Agenda

1. Final Rule Overview and Implementation Approach
2. July 1, 2017 Policy Implementation
3. Directed Payments
4. 2018 Provisions and Beyond
5. Questions & Open Discussion

Final Rule Overview

Background

- First major overhaul of the managed care regulations since 2002
- Directed at states to ensure compliance with Medicaid managed care plans (MCPs) and downstream effects to beneficiaries

Recurring Themes

- Aligns Medicaid with other health insurance coverage programs
- Adds many consumer protections to improve quality of care and the beneficiary experience
- Improves State accountability and transparency
- Includes Long Term Services and Supports (LTSS) needs

Implementation Dates

- Effective July 5, 2016
- Phased implementation over three years, starting with the July 1, 2017 contract rating period

Implementation Approach

Internal Evaluation

- Conducted gap analysis of Final Rule provisions in contrast with current requirements to identify impact and needs
- Consulted with areas across the Department for input on policy and operational considerations

Stakeholder Input

- Reviewed draft materials, deliverables, and/or processes with MCPs prior to implementation
- Engaged stakeholder groups including the DHCS Stakeholder Advisory Committee, Managed Care Advisory Group, topic-specific workgroups
- Consulted external partners such as the Department of Managed Health Care (DMHC)

Plan Guidance

- Provided guidance to MCPs via All Plan Letters (APLs) and contract amendment
- Policy guidance and deliverables provided as available
- Roll out contract amendments per implementation year
- Contract included all required provisions, terms and definitions per CMS[2]

[2]CMS Contract Checklist:
https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

July 1, 2017 Policy Implementation

CMS June 30 Informational Bulletin

- CMS issued an informational bulletin (CIB)[1] on June 30, 2017 regarding the July 1, 2017 managed care rule requirements
- The CIB indicates that CMS is undertaking a review of the managed care rule which, given its length, will take time
- Given the July 1, 2017 effective date of certain requirements, CMS indicated that on a case-by-case basis they could use their enforcement discretion to not penalize states that are unable to come into compliance and provide specified information to CMS
- Notably, CMS indicates this discretion will not generally apply to the financial requirements, such as pass through payments

[1] CMS Informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf

Summary of 2017 MCP Activities

Beneficiary Experience

- Model Handbook
- Beneficiary Support website
- Grievances and Appeals

Quality of Care

- Initial Health Assessment
- Drug Utilization Review

Program Integrity

- Records Retention
- Sanctions
- Data Certification
- Overpayments
- Subcontracts

Financing

- Medical Loss Ratio Reporting
- Directed Payments

Beneficiary Experience

Requirement	Implementation Approach
Member Handbook Template • MCPs are required to use the State-developed model enrollee handbook • Content includes a summary of benefits and coverage, as well as information on the beneficiary's rights and responsibilities	• Stakeholder review • Issued to MCPs early October 2017 • Deliverables submission • MCPs will be expected to utilize the template at their next formal submission to the Department

Beneficiary Experience (cont'd)

Requirement	Implementation Approach
Beneficiary Support Website • Website to contain specific MCP information and required information, such as Provider Directories and Prescription Drug Formularies	• Developed Customer Service Portal[3] • Website links to other DHCS programs (i.e., Dental Managed Care, Mental Health Services) • Contains reporting requirements, such as MCP accreditation status, audit results, network certification, and Annual Program Report
Grievances and Appeals • New timeframes for filing and resolution • New process to exhaust the MCP's internal appeal process before proceeding to a State Fair Hearing • Revised notice templates	• Contract amendment • Issued APL 17-006

[3] Customer Service Portal: https://www.healthcareoptions.dhcs.ca.gov/

Quality of Care

Requirement	Implementation Approach
Initial Health Assessment • Risk stratification should be completed for all members to help identify newly enrolled members who may need expedited services	• Contract amendment • MCPs are now responsible for sending, updating, and compiling the Health Information Form (HIF), which meets the requirement for risk stratification at 90 days • Deliverables submission
Drug Utilization Review (DUR) • MCPs must operate a DUR program	• Contract amendment • Issued APL 17-008 • Deliverables submission

Program Integrity

Requirement	Implementation Approach
Records Retention • Retention period of 10 years	• Statutory change • Contract amendment
Sanctions • Increased federal sanctions limit	• Statutory change • Contract amendment • Will issue APL after statutes are enacted on July 1, 2018
Data Certification • Requirements related to certification of data, information, and documentation to be submitted	• Contract amendment • Issued APL 17-005 • Deliverables submission

Program Integrity (cont'd)

Requirement	Implementation Approach
Overpayments • Requirements on treatment of MCP recovery of overpayments to providers	• Contract amendment • Issued APL 17-003 • Deliverables submission
Subcontracts/Delegation • Requirements on MCPs for its subcontracted/delegated entities	• Contract amendment • Issued APL 17-004 • Deliverables submission
Annual Managed Care Report • Forthcoming CMS guidance on the content and format of the report • Initial report will be due after the contract year following the release of CMS guidance	• Will be posted on the Customer Service Portal website

Implementation Status

APLs

- (3) APLs issued in 2016 to meet the **immediate effective date**:
  - Provider Preventable Conditions Reporting (APL 16-011)
  - Provider Credentialing and Recredentialing (APL 16-012)
  - Access to Care for Transgender Beneficiaries (APL 16-013)
- (5) APLs issued for the **July 2017 implementation**:
  - Overpayments (APL 17-003)
  - Subcontracts (APL 17-004)
  - Data Certification (APL 17-005)
  - Grievances and Appeals and revised notices (APL 17-006)
  - Drug Utilization Review (APL 17-008)
- (1) APL is contingent on legislation and will be issued by 2018:
  - Sanctions

Implementation Status (cont'd)

Contract Amendment

- Submitted to CMS on April 2, 2017
- DHCS is working through CMS comments

Deliverables

- Issued deliverables list to MCPs in April 2017
- DHCS review of all deliverables

Directed Payments

Directed Payments

Pass-Through Payments

- Impermissible under the Final Rule, subject to a 10-year phasedown

Allowable Directed Payment Mechanisms

- Value-based purchasing models
- Delivery system reform and/or performance improvement initiatives
- Minimum or maximum fee schedules, and uniform dollar or percentage increases

Proposed Directed Payments

Hospital Directed Payments

- Public Hospital Directed Payment Program
- Public Hospital Quality Improvement Program
- Private Hospital Directed Payment Program

Physician Directed Payments

- Proposition 56 Physician Directed Payments (for 13 E/M codes)

Dental Directed Payments

- Proposition 56 Dental Directed Payments

Goals

- Maintain/improve quality of and access to care
- Improve encounter data reporting

Submitted to CMS on June 30, 2017

Public Hospital Directed Payment Program

Providers Subject to Directed Payment

- Designated Public Hospitals (DPHs) and University of California (UC) systems
- Multiple classes of providers

Uniform Dollar or Percentage Increase

- Pooled amount
- Proxy PMPM will be developed based on current expenditure levels
- Proxy PMPM will be adjusted and paid to MCPs based on actual utilization (as reported in encounter data)

Public Hospital Quality Improvement Program

Providers Subject to Directed Payment

- DPHs and UCs
- Multiple classes of providers

Quality Incentive Pool

- Pooled amount
- Participating DPHs and UCs must report on at least 20 of 25 quality measures
- Proxy PMPM will be developed based on current expenditure levels
- Proxy PMPM will be adjusted and paid to MCPs based on actual performance on quality measures

Private Hospital Directed Payment Program

Providers Subject to Directed Payment

- Private hospitals

Uniform Dollar Increase

- Pooled amount
- Proxy PMPM will be developed based on current expenditure levels
- Proxy PMPM will be adjusted and paid to MCPs based on actual utilization (as reported in encounter data).

Proposition 56
Physician Directed Payments

Providers Subject to Directed Payment

- Primary Care Physicians (PCPs)
- Specialty Physicians
- Mental Health Outpatient Providers (MHOPs)

Uniform Dollar Increase for 13 E/M Codes

- 10 PCP/Specialty and 3 MHOP procedure codes
- Risk-based rate add-on will be developed based on anticipated utilization of the 13 procedures

Proposition 56
Dental Directed Payments

Providers Subject to Directed Payment

- Dental providers

Uniform Percentage Increase

- 40% more than the Schedule of Maximum Allowances for selected procedures
- Risk-based rate add-on will be developed based on anticipated utilization of selected procedures

2018 Provisions and Beyond

Forthcoming Final Rule Activities

No later than July 1, 2018

- Managed Care Quality Strategy

July 1, 2018 contract rating year

- Network Adequacy Standards
- Provider Screening and Enrollment
- Annual Network Certification
- Choice Counseling and Navigation Assistance
- Annual Managed Care Report
- Actuarial Certification to a Single Rate

2019 and beyond

- External Quality Review Organization (EQRO) Validation of Network Adequacy
- Quality Rating System
- Minimum 85% Medical Loss Ratio Target in Rate Setting

Questions & Open Discussion