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 CMS²

²CMS Contract Checklist:
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

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Implementation Approach</th>
</tr>
</thead>
</table>
| **Member Handbook Template**     | • 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 |
| • 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 |


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

[^3]: Customer Service Portal: [https://www.healthcareoptions.dhcs.ca.gov/](https://www.healthcareoptions.dhcs.ca.gov/)
## Quality of Care

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Implementation Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records Retention</strong></td>
<td>• Statutory change&lt;br&gt;• Contract amendment</td>
</tr>
<tr>
<td>• Retention period of 10 years</td>
<td></td>
</tr>
<tr>
<td><strong>Sanctions</strong></td>
<td>• Statutory change&lt;br&gt;• Contract amendment&lt;br&gt;• Will issue APL after statutes are enacted on July 1, 2018</td>
</tr>
<tr>
<td>• Increased federal sanctions limit</td>
<td></td>
</tr>
<tr>
<td><strong>Data Certification</strong></td>
<td>• Contract amendment&lt;br&gt;• Issued APL 17-005&lt;br&gt;• Deliverables submission</td>
</tr>
<tr>
<td>• Requirements related to certification of data, information, and documentation to be submitted</td>
<td></td>
</tr>
<tr>
<td>Requirement</td>
<td>Implementation Approach</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Overpayments</strong></td>
<td>• Contract amendment</td>
</tr>
<tr>
<td>• Requirements on treatment of MCP</td>
<td>• Issued APL 17-003</td>
</tr>
<tr>
<td>recovery of overpayments to</td>
<td>• Deliverables submission</td>
</tr>
<tr>
<td>providers</td>
<td></td>
</tr>
<tr>
<td><strong>Subcontracts/Delegation</strong></td>
<td>• Contract amendment</td>
</tr>
<tr>
<td>• Requirements on MCPs for its</td>
<td>• Issued APL 17-004</td>
</tr>
<tr>
<td>subcontracted/delegated entities</td>
<td>• Deliverables submission</td>
</tr>
<tr>
<td><strong>Annual Managed Care Report</strong></td>
<td>• Will be posted on the Customer Service Portal website</td>
</tr>
<tr>
<td>• Forthcoming CMS guidance on the</td>
<td></td>
</tr>
<tr>
<td>content and format of the report</td>
<td></td>
</tr>
<tr>
<td>• Initial report will be due after</td>
<td></td>
</tr>
<tr>
<td>the contract year following the</td>
<td></td>
</tr>
<tr>
<td>release of CMS guidance</td>
<td></td>
</tr>
</tbody>
</table>
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

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

<table>
<thead>
<tr>
<th>No later than July 1, 2018</th>
<th>July 1, 2018 contract rating year</th>
<th>2019 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Quality Strategy</td>
<td>Network Adequacy Standards</td>
<td>External Quality Review Organization (EQRO) Validation of Network Adequacy</td>
</tr>
<tr>
<td></td>
<td>Provider Screening and Enrollment</td>
<td>Quality Rating System</td>
</tr>
<tr>
<td></td>
<td>Annual Network Certification</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Choice Counseling and Navigation Assistance</td>
<td>Minimum 85% Medical Loss Ratio Target in Rate Setting</td>
</tr>
<tr>
<td></td>
<td>Annual Managed Care Report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actuarial Certification to a Single Rate</td>
<td></td>
</tr>
</tbody>
</table>
Questions & Open Discussion