Managed Care Final Rule: 2017 Implementation Updates

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DMHC Financial Solvency Standards Board Meeting
October 18, 2017
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 CMS²

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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:
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>
<tbody>
<tr>
<td><strong>Member Handbook Template</strong>  &lt;br&gt;• MCPs are required to use the State-developed model enrollee handbook  &lt;br&gt;• Content includes a summary of benefits and coverage, as well as information on the beneficiary’s rights and responsibilities</td>
<td>• Stakeholder review  &lt;br&gt;• Issued to MCPs early October 2017  &lt;br&gt;• Deliverables submission  &lt;br&gt;• MCPs will be expected to utilize the template at their next formal submission to the Department</td>
</tr>
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### Beneficiary Experience (cont’d)

<table>
<thead>
<tr>
<th>Requirement</th>
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</table>
| **Beneficiary Support Website**    | • 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**         | • Contract amendment  
• Issued APL 17-006                                                                                                                                 |
| • 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 |  

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

### Initial Health Assessment
- Risk stratification should be completed for all members to help identify newly enrolled members who may need expedited services.

- **Implementation Approach**
  - 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

- **Implementation Approach**
  - Contract amendment
  - Issued APL 17-008
  - Deliverables submission
# Program Integrity

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Implementation Approach</th>
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<tbody>
<tr>
<td><strong>Records Retention</strong></td>
<td>• Statutory change</td>
</tr>
<tr>
<td>• Retention period of 10</td>
<td>• Contract amendment</td>
</tr>
<tr>
<td>years</td>
<td></td>
</tr>
<tr>
<td><strong>Sanctions</strong></td>
<td>• Statutory change</td>
</tr>
<tr>
<td>• Increased federal</td>
<td>• Contract amendment</td>
</tr>
<tr>
<td>sanctions limit</td>
<td>• Will issue APL after</td>
</tr>
<tr>
<td></td>
<td>statutes are enacted on</td>
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<tr>
<td></td>
<td>July 1, 2018</td>
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<tr>
<td><strong>Data Certification</strong></td>
<td>• Contract amendment</td>
</tr>
<tr>
<td>• Requirements related</td>
<td>• Issued APL 17-005</td>
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<tr>
<td>to certification of</td>
<td>• Deliverables submission</td>
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<tr>
<td>data, information, and</td>
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<tr>
<td>documentation to be</td>
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<td>submitted</td>
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### Program Integrity (cont’d)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Implementation Approach</th>
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<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>
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<tr>
<td>providers</td>
<td></td>
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<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</td>
</tr>
<tr>
<td>• Forthcoming CMS guidance on the</td>
<td>Service Portal website</td>
</tr>
<tr>
<td>content and format of the report</td>
<td></td>
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<tr>
<td>• Initial report will be due after</td>
<td></td>
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<tr>
<td>the contract year following the</td>
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<tr>
<td>release of CMS guidance</td>
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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