



Managed Care Final Rule: 2017 Implementation Updates

Sarah C. Brooks, Deputy Director, Health Care Delivery Systems

Lindy Harrington, Deputy Director, Health Care Financing

Department of Health Care Services

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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 CMS²

²CMS 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
<p>Member Handbook Template</p> <ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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
<p>Beneficiary Support Website</p> <ul style="list-style-type: none">• Website to contain specific MCP information and required information, such as Provider Directories and Prescription Drug Formularies	<ul style="list-style-type: none">• Developed Customer Service Portal³• 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
<p>Grievances and Appeals</p> <ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Contract amendment• Issued APL 17-006

³ Customer Service Portal: <https://www.healthcareoptions.dhcs.ca.gov/>



Quality of Care

Requirement	Implementation Approach
<p>Initial Health Assessment</p> <ul style="list-style-type: none">• Risk stratification should be completed for all members to help identify newly enrolled members who may need expedited services	<ul style="list-style-type: none">• 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
<p>Drug Utilization Review (DUR)</p> <ul style="list-style-type: none">• MCPs must operate a DUR program	<ul style="list-style-type: none">• Contract amendment• Issued APL 17-008• Deliverables submission



Program Integrity

Requirement	Implementation Approach
Records Retention <ul style="list-style-type: none">Retention period of 10 years	<ul style="list-style-type: none">Statutory changeContract amendment
Sanctions <ul style="list-style-type: none">Increased federal sanctions limit	<ul style="list-style-type: none">Statutory changeContract amendmentWill issue APL after statutes are enacted on July 1, 2018
Data Certification <ul style="list-style-type: none">Requirements related to certification of data, information, and documentation to be submitted	<ul style="list-style-type: none">Contract amendmentIssued APL 17-005Deliverables submission



Program Integrity (cont'd)

Requirement	Implementation Approach
Overpayments <ul style="list-style-type: none">Requirements on treatment of MCP recovery of overpayments to providers	<ul style="list-style-type: none">Contract amendmentIssued APL 17-003Deliverables submission
Subcontracts/Delegation <ul style="list-style-type: none">Requirements on MCPs for its subcontracted/delegated entities	<ul style="list-style-type: none">Contract amendmentIssued APL 17-004Deliverables submission
Annual Managed Care Report <ul style="list-style-type: none">Forthcoming CMS guidance on the content and format of the reportInitial report will be due after the contract year following the release of CMS guidance	<ul style="list-style-type: none">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