Georgetown University
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NHeLP
NATIONAL HEALTH LAW PROGRAM

Medicaid/CHIP Managed Care Regulations: Ensuring Accountability & Transparency

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Children in Managed Care

- CMS finalized sweeping changes to Medicaid and CHIP managed care regulations in May 2016
- Regulations set minimum standards; states have flexibility to do more
- Many opportunities for legal and health advocates to take action

Flag potential actions for legal and health advocates

Why are these rules so important?

11% of children in Medicaid/ CHIP are enrolled in FFS

22% of children in Medicaid/ CHIP are enrolled in PCCMs

66% of children in Medicaid/CHIP are enrolled in MCOs

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Source: CMS Medicaid Managed Care Enrollment Report 2013

Managed Care Project

- Series of six explainer briefs and webinars
  1. Looking at the Rule through a Children's Lens (6/17)
  2. Improving Consumer Information (6/23)
  3. Enhancing the Beneficiary Experience (7/19)
  4. Assuring Network Adequacy and Access to Services (8/5)
  5. Advancing Quality (9/8)
  6. *Ensuring Accountability and Transparency (9/29)*
- Fall meeting in D.C. with child health and legal advocates to strategize over implementation
- Thanks to Robert Wood Johnson Foundation

Our Topic Today: Ensuring Accountability & Transparency

- Contracting Requirements
- Medical Loss Ratio
- Actuarial Soundness & Rate Setting
- Website Posting Requirements
- CHIP

Flag potential actions for legal and health advocates

CONTRACTING REQUIREMENTS

Kelly Whitener

Managed Care Contracts

- Fundamental legal document defining the responsibilities of the state and the plan
- Historically difficult to obtain, but now must be posted on the state's website*

Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)
Primary Care Case Management Entities (PCCM entities)

No later than the rating period starting on or after July 1, 2017

* 42 C.F.R. § 438.602(g)(1)

Managed Care Contracts

Review your state's managed care request for proposals and resulting contracts to make sure they comply with Medicaid statute, regulations, and case law, as well as any relevant state law. Contracts should also have provisions to hold plans accountable for meeting the standards, such as sanctions. For further guidance on this issue, see NHeLP's [Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care.](http://www.healthlaw.org/publications/managed-care-toolkit-march-2015#.V-qzgJMrIWp)*

* http://www.healthlaw.org/publications/managed-care-toolkit-march-2015#.V-qzgJMrIWp

Standard Contract Requirements §438.3(a)

- States must submit contracts to CMS for review and approval, at least 90 days prior to the desired effective date.

Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)

Effective as of July 5, 2016

Enrollment Discrimination Prohibited§438.3(d)

- Plans must accept eligible individuals in the order in which they apply
- Plans cannot discriminate on the basis of health status, need for health services, race, color, national origin, sex, sexual orientation, gender identity, or disability

Managed Care Organizations (MCO)
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Effective as of July 5, 2016

Services that may be Covered§438.3(e)

- Plan contracts must describe the services the plan is required to cover as well as those services that may be covered voluntarily
- Plans may provide alternative services or deliver services in alternative settings under new “in lieu of” provisions

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Effective as of July 5, 2016

Compliance with Applicable Laws §438.3(f)

- Plans must comply with federal laws outside of Medicaid, like the Civil Rights Act, the Americans with Disabilities Act, and now, section 1557 of the Affordable Care Act
- Section 1557 prohibits discrimination on the basis of race, color, national origin (including immigration status and English language proficiency), sex, age, or disability

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Discrimination

Individuals who believe that plans have discriminated against them may file a complaint with the Office of Civil Rights at HHS. For more information on filing a complaint and link to the OCR complaint form, consult the HHS website.*

* http://www.hhs.gov/civil-rights/for-individuals/section-1557/

Compliance with Conflict of Interest Safeguards§438.3(f)

- States and plans must comply with conflict of interest safeguards to ensure state employees responsible for overseeing the plans are impartial
- State employees may be prevented from having a financial interest in plans while in those roles and even after leaving state employment in some cases

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Effective as of July 5, 2016

Inspection and Audit of Records§438.3(h)

- Plans must provide the state and CMS with access to financial records of the plan and any subcontractors
- Inspections and audits can occur at any time and can include not just the related documents but also the physical premises, facilities, and equipment

Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)
Primary Care Case Management Entities (PCCM entities)

Effective for the rating period beginning on or after July 1, 2017

Subcontracts §438.3(k)

- All subcontracts must fulfill the managed care requirements for the service or activity delegated to them

Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), and Primary Care Case Management Entities (PCCM entities) subcontracts

Effective for the rating period beginning on or after July 1, 2017

Subcontracts §438.230

1. The plan maintains the ultimate responsibility for complying with all the terms and conditions of its contract with the state
2. If the plan delegates any of its obligations to a subcontractor, the delegated activities must be specified in the contract & the subcontractor must agree to comply with the state's terms
3. Subcontractors are subject to the same audit and inspection standards as plans
4. All subcontracts must allow for termination or other remedies if the state or plan decides the subcontractor is not performing satisfactorily

Parity in Mental Health and Substance Use Disorder Benefits §438.3(n)

- The mental health and substance use disorder parity requirements may be met through different arrangements
  - MCO provides all benefits
  - MCO provides some benefits and PIHP/PAHP provides others
  - MCO provides some benefits and the state provides others through FFS
- Compliance must be demonstrated in the contract and supporting documents submitted to CMS

States, MCOs, and any PIHP or PAHP providing services to MCO enrollees

Effective as of July 5, 2016

Parity

The specifics of mental health and substance use disorder parity are complicated. Moreover, they are evolving, given how recently the parity rule was finalized. Advocates should watch for additional guidance from CMS and from support centers, including NHeLP.*

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* https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html

Long Term Services and Supports§438.3(o)

- Services that could be authorized through a home and community based waiver must meet certain standards, like:
  - Integrated in the community
  - Selected by the individual
  - Ensure individual rights of privacy, dignity, and respect

MCOs, PIHPs, and PAHPs that include LTSS as a covered benefit

Effective as of July 5, 2016

Additional Rules for PCCMs & PCCM Entities§438.3(q)

- PCCMs and PCCM entities must meet some of the same availability of services and beneficiary protections that apply to MCOs:
  - Provide for reasonable hours of operation, including 24-hour emergency care
  - Restrict enrollment to beneficiaries who live near one of the delivery sites
  - Have sufficient numbers of providers to ensure prompt and high quality treatment
  - Prohibit discrimination based on health status or need for health care services
  - Allow enrollees to disenroll

Primary Care Case Management (PCCM)
Primary Care Case Management entities (PCCM entities)

Effective for the rating period beginning on or after July 1, 2017

Additional Rules for PCCM Entities§438.3(r)

- Additionally, PCCM entities must submit their contracts to CMS for review and approval
- CMS will be looking for compliance with the applicable contracting, consumer information, and quality provisions

Primary Care Case Management entities (PCCM entities)

Effective as of July 5, 2016

Covered Outpatient Drugs§438.3(s)

Four new requirements for plans that provide outpatient drugs:

1. States and plans must cover all outpatient drugs that are within the scope of the statute
   - Plans must cover drugs that are within the scope of the contract, even if they are not on the formulary (drugs not on the formulary may be covered through a prior authorization process)
   - States must cover drugs outside the scope of the contract but within the scope of the statute

MCOs, PIHPs, and PAHPs that provide outpatient drugs

Effective as of July 5, 2016

Covered Outpatient Drugs§438.3(s)

2. Plans must report all drug utilization data so that the state has all the information necessary to bill manufacturers for drug rebates
3. Plans must have a drug utilization review program to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes
4. Plans must have a prior authorization program
   - Plans must respond to request for prior authorization within 24 hours
   - Plans must dispense a 72-hour supply of a covered outpatient drug in an emergency situation

Recordkeeping§438.3(u)

- Plans and subcontractors must retain certain records for at least 10 years
  - Enrollee grievances & appeals
  - Base data
  - MLR reports
  - Program integrity data and documentation*

Managed Care Organizations (MCOs)
Prepaid Inpatient Health Plans (PIHPs)
Prepaid Ambulatory Health Plans (PAHPs)
Subcontractors

Effective as of July 5, 2016

*See 42 C.F.R. 438 Subpart H

MEDICAL LOSS RATIO

Sarah Somers

Medical Loss Ratio§438.8

- Basic Rule: Each plan must report a MLR calculated according to the regulations
  - If states choose to set a minimum, it must be at least 85%

Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)

Effective for rating period beginning on or after July 1, 2017

Medical Loss Ratio§438.8

- **Definition:** the amount a plan spends to provide covered services compared to the total capitation payment revenue
- **Equation:**

Incurred service claims + health quality expenditures + fraud reduction

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adjusted premium revenue

Medical Loss Ratio§438.8

- **Incurred claims:** direct claims, unpaid claims, withholds from providers
  - Must **deduct** overpayment recoveries, drug rebates, e.g.
- **Health quality improvement**: activities related to EQR, HIT, or others likely to increase desired health outcomes, grounded in evidence
  - **Not** cost containment or marketing

Medical Loss Ratio§438.8

- **Adjusted premium revenue:** premiums minus local taxes, licensing fees, and regulatory fees

Medical Loss Ratio§438.8

- States *are not required* to:
  - Set a minimum MLR
  - Require refunds from plans if MLR not met
- States *must:*
  - Require each plan to report MLR and related items

Urge your state to require a minimum MLR of 85 percent if it does not do so already.

ACTUARIAL SOUNDNESS AND RATE SETTING

Sarah Somers

Actuarial Soundness and Rate Setting

- Key Terms:
  - **Base Data**: historical data used to develop capitated rates (e.g. encounter data)
  - **Rating Period:** time period for which managed care rates are being developed
  - **Risk adjustment:** methodology accounting for health status of enrollees and risk that there will be greater service costs for them

Actuarial Soundness§438.4

- Basic Rule: Rates must be projected to meet all reasonable and appropriate costs necessary to provide covered benefits to enrollees

Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)

Phased in from July 5, 2016 to rating period beginning on or after July 1, 2019

Actuarial Soundness§483.4

- Rates must be:
  - certified by an actuary
  - approved by CMS
- Must be developed so that plan will achieve a MLR of at least 85%
- May not vary based solely on rate of FFP for different eligibility categories

Rate Setting §438.5

- Steps to set rates:
  - Identify and consider **base utilization and price data**
  - Develop and **apply trends in cost and utilization** of services by actual experience of Medicaid beneficiaries
  - Develop the **non-benefit** part of the rate to account for operational expenses (e.g. admin costs, licensing fees)
  - Take into account past **Medical Loss Ratios**
  - Select **risk adjustment methodology** using generally accepted methodology
  - Make other **necessary adjustments**

Rate Setting§483.5

- States must provide and use base data consisting of
  - All validated encounter data
  - FFS data
  - Audited financial reports reflecting coverage of the Medicaid population for at least the three most recent years before the rating period
    - States that cannot meet that standard may ask for an exception but must have corrective action plan to come into compliance with regulation

Actuarial Soundness and Rate Setting

This is a highly technical area of the regulations. CMS has provided additional written guidance explaining these requirements. See [CMS 2016 Medicaid Managed Care Rate Development Guide] and [CMCS Informational Bulletin, Addendum to 2016 Medicaid Managed Care Rate Development Guide.]

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf
https://www.medicaid.gov/federal-policy-guidance/downloads/cib070116.pdf

WEBSITE POSTING REQUIREMENTS

Kelly Whitener

Website Posting

- States must operate a website*
- Provisions throughout the rule require certain information to be posted on the state's website

Encourage your state to provide opportunities for website testing and feedback, and to explore the advantages of having all related consumer materials posted on the state's website as a single source of consumer information, rather than linking to individual plan websites.

*42 C.F.R. § 438.10(c)

Website Posting

- Enrollee handbook
- Provider directory
- Drug formulary
- Annual managed care program report
- Network adequacy standards
- Documentation of compliance with availability & accessibility of services
- Plan contract
- Accreditation status
- Quality rating
- State quality strategy
- Quality measures and performance outcomes
- Quality strategy reviews
- Annual EQR report
- Plan ownership & control information
- Audit results

CHIP

Kelly Whitener

CHIP Contracting Requirements

General Rule

- Medicaid's standard contracting provisions are generally applicable to CHIP at §457.1201
- Medicaid's subcontracting requirements are also applicable to CHIP at §457.1233(b)

Notable Differences

- CMS reviews CHIP contracts but does not require prior approval
- Submission of CHIP rates is only required on request
- Provisions related to dual eligibles, LTSS, and outpatient drugs do not apply to CHIP

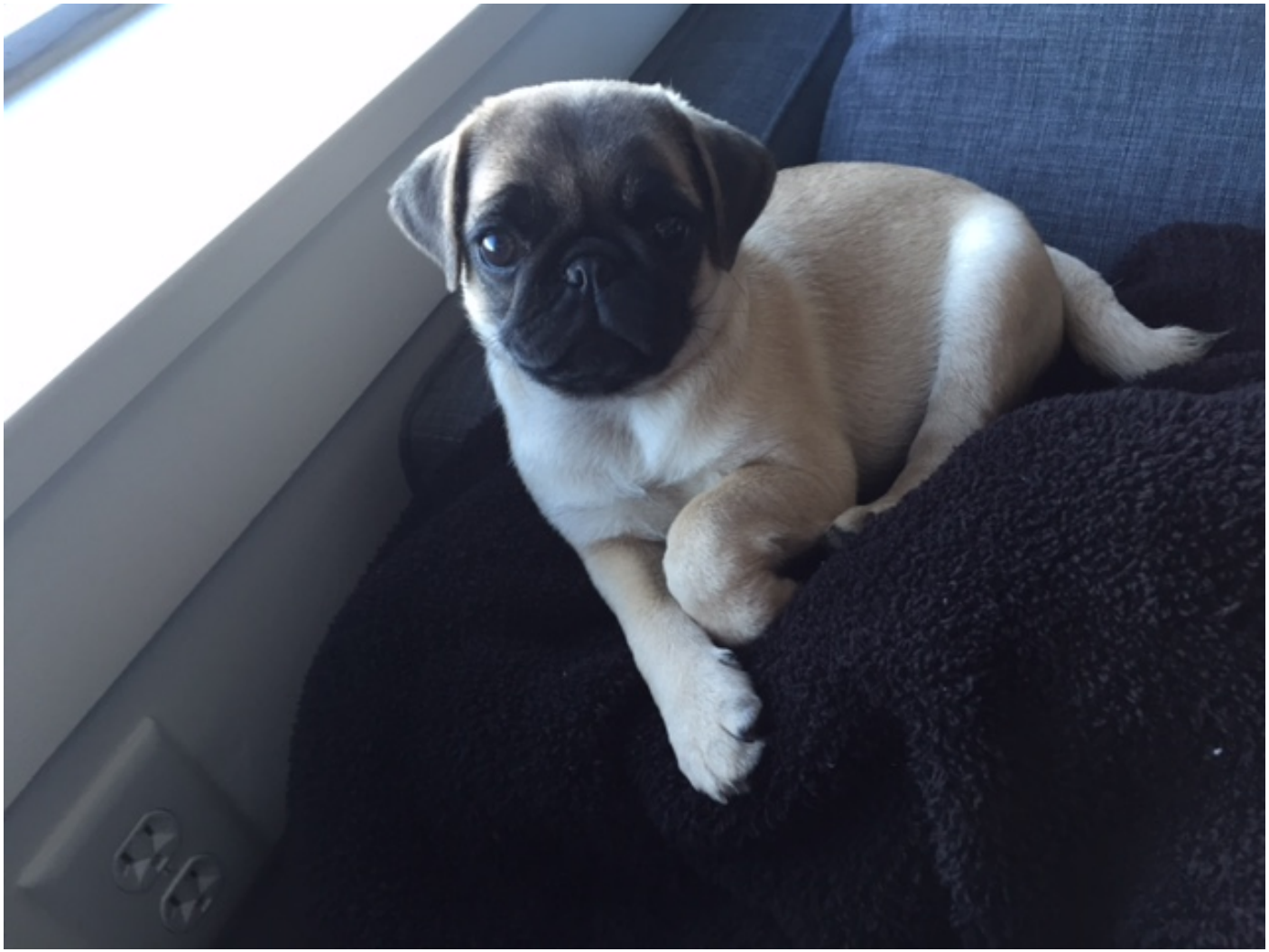
CHIP Payment Rate Requirements

Rate Development Standards

- CHIP rates are not subject to as many requirements
- Rates must be based on public or private rates for comparable services & populations
- States must provide a description of how rates are developed upon request

Medical Loss Ratio

- Applicable to CHIP at §457.1203(c)



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