Medicaid Managed Care
Final Rule

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Overview of Medicaid Managed Care Final Rule

- Final rule released April 25, 2016
- Transition to managed care in other states reflect CA’s own change
  - In 1992, 2.4 million Medicaid beneficiaries (8%) enrolled in capitated plans; by July 2013, number increased to 45.9 million Medicaid beneficiaries (73.5%)
  - Expansion of use of managed care with respect to geographic areas and benefits (long term services and supports, or LTSS)
Scope of Final Rule

- Final Rule addresses Medicaid and CHIP managed care; this presentation focuses on Medicaid only
- Final Rule primarily focuses on Managed Care Organizations ("MCOs"), Pre-paid Inpatient Health Plans ("PIHPs") and Pre-paid Ambulatory Health Plans ("PAHPs")
- Excludes application to certain health insuring organizations (county operated entities that meet certain requirements, e.g., operational prior to Jan. 1, 1986 or specifically identified by law)
Overview of Topics

- Use of Medicaid Managed Care Dollars
- Networks
- Quality Reforms
- Provider/Subcontractor Obligations
- Appeals and Grievances
Limits on Directed and Pass-Through Payments

- As discussed earlier in the program, California has provided increasingly large amounts of HQAF funded payments through managed care
- Follows shift in Medi-Cal from fee-for-service to managed care
- HQAF statute requires MCOs to pass HQAF-funded increase capitation payments to hospitals
New Regulations

- 2016 Final Rule and a January 2017 Final Rule place new restrictions on use of pass-through and directed payments effective July 1, 2017
- HQAF program approach will have to be modified to comply with new rules
CMS clarifies the standards for allowing a Medicaid managed care entity to provide alternative services in lieu of covered services under the state plan

- The State determines that the alternative service or setting is a medically appropriate and cost effective substitute;
- The plan does not require the enrollee to use the alternative service or setting;
- The approved in lieu of services are authorized and identified in the state-plan contract and will be offered at the option of the plan; and
- The utilization/cost of the alternative service is considered for calculating capitation rates, unless otherwise legally prohibited.
Institution for Mental Disease Carve-In (§ 438.6(e))

- Section 1905(a)(29) of the Medicaid Act prohibits the use of federal financial participation for services rendered to a beneficiary between 21 and 64 while patients at an IMD.
- Final rule permits capitation to be paid to plans for beneficiaries residing in IMD under specific circumstances:
  - IMD is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.
  - Length of stay no more than 15 days in a monthly capitation period.
  - Meets requirements for in lieu of services.
DHCS Position on IMD Exception

- DHCS appears to be declining this option for CA
- Could be because of the traditional capitation of inpatient psych services to counties
Network Adequacy Provisions

- State to develop time and distance standards at least for:
  - Primary care, adult and pediatric
  - OB/GYN
  - Behavioral health (mental health and substance use disorder), adult and pediatric
  - Specialist, adult and pediatric
  - Hospital
  - Pharmacy
  - Pediatric dental
Establishing time and distance standards

- Must include all geographic areas (but may be different for different areas)
- Must consider certain factors
  - Anticipated Medicaid enrollment
  - Expected utilization
  - Characteristics and health care needs of enrollee populations
  - Numbers and types of network providers required to furnish services
  - Number of network providers not accepting new patients
  - Geographic location of network providers (e.g., time, distance, means of transportation)
Establishing time and distance standards

- Must consider certain factors (cont.)
  - Ability of network providers to communicate with limited English proficient (LEP) and to provide access to enrollees with disabilities
  - The availability of triage lines or screening systems, as well as telemedicine, e-visits, or other technological solutions

- Special considerations for LTSS
- States may permit exceptions to network standards based on standards in the state-plan contract; states must monitor access to any exempted provider type
## CA Proposed Network Adequacy Plan (Selected Provider Types)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Time and Distance</th>
<th>Timely Access (Non-Urgent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>10 miles or 30 minutes from beneficiary’s residence</td>
<td>Within 10 business days to appointment</td>
</tr>
<tr>
<td>Specialty care</td>
<td>Based on county population:</td>
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<tr>
<td></td>
<td>Rural to small counties:</td>
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<tr>
<td></td>
<td>60 miles or 90 minutes</td>
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<td></td>
<td>Medium counties:</td>
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<tr>
<td></td>
<td>30 miles or 60 minutes</td>
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<tr>
<td></td>
<td>Large counties:</td>
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<tr>
<td></td>
<td>15 miles or 30 minutes</td>
<td>Within 15 business days</td>
</tr>
<tr>
<td>Hospitals</td>
<td>15 miles or 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>
CA Proposed Network Adequacy Plan

- DHCS to submit network certification to CMS
- DHCS monitoring of plans
  - Submission of data (APL 16-019)
  - Technical assistance
  - Corrective action plans
Access to Out of Network (OON) Services

- Emergency/post-stabilization services
- Family planning services
- If provider network unable to provide necessary services to an enrollee, plan must adequately and timely cover services out of network (§ 438.206(b)(4))
  - Cost to enrollee can be no greater than if services were furnished within the network
  - CMS declines to establish rate for OON services
  - State or plan may still require approval
Network Adequacy Scenario

The local health plan servicing a hospital’s service area refuses to contract with a hospital. What options are available to the hospital?

- To attempt to become in-network?
- If it is out-of-network?
In-Network Options

• Request written reason why plan refuses to contract (42 CFR 438.12(a): “If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.”)

• Network adequacy requirements

• Administrative advocacy
Out-of-network Options

- Rogers rate for emergency services
- AB 1203 re: post-stabilization services
  - Requires hospital non-contracted with health care service plan that requires prior authorization for post-stabilization care to contact the plan upon stabilization
  - Plan has 30 minutes to respond; if not, service deemed authorized and plan liable for charges
Out-of-network Options

• Medi-Cal rates for post-stabilization services?
• CMS declined to set rates; rates are subject to state law
• Questionable continued authority of all plan letters (e.g., APL 13-004, available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-004.pdf)
Medicaid Quality Rating System

CMS Methodology Development:
- In consultation with experts
- Public engagement process with comment period

Alternative, State-Structured Methodology:
- Important to provide states with an option to tailor the star-rating system to state quality assessment needs
- Requires prior CMS approval
- Must yield performance information that is substantially comparable to CMS-developed methodology
Other Quality Reforms

- States must adopt a quality plan to identify, evaluate and reduce health disparities
- States must identify mechanisms to identify individuals who need long term services and supports or who have special health care needs
- Annual external quality reviews (already required for some plans)
- States must post on websites: information on managed care plan accreditation status, state managed care quality strategies, and the results of annual external quality reviews
CA Quality Plan

- DHCS Strategy for Quality Improvement in Health Care
- 7 Priorities:
  - Improve patient safety
  - Deliver effective, efficient, affordable care
  - Engage persons and families in their health
  - Enhance communication and coordination of care
  - Advance prevention
  - Foster healthy communities
  - Eliminate health disparities
Subcontracting and Delegation

- Medicaid managed care rule (§ 438.2) clarifies between “subcontractors” and “network providers”
- “Subcontractor” is an individual or entity that has a subcontract that relates directly or indirectly to the performance of the plan’s obligations under the contract with DHCS
- Definitions clarify that a “network provider is not a subcontractor by virtue of the network provider agreement”
Scenario: Subcontractor or Network Provider?

- Provider paid fee-for-service but agrees to pay for out-of-network referrals
- Hospital accepts payment on a capitation basis and pays other hospitals, but medical group reviews for medical necessity
- Provider rendering non-Medi-Cal benefit to Medi-Cal managed care enrollees
Key Subcontractor Obligations

- Compliance with “all applicable Medicaid laws, regulations, subregulatory guidance, and contract provisions”
- Permits on-site inspection by State, CMS and OIG of premises, physical facilities, and equipment where Medicaid-related activities or work is conducted
- Expanded record-keeping requirements
- Permits inspection, evaluation and audit by the State, CMS or OIG if the entity determines there is a reasonable possibility of fraud or similar risk
Key Subcontractor Obligations (cont.)

- APL 17-004
  - Subcontract must:
    - Specify all delegated activities, obligations and reporting responsibilities
    - Include subcontractor’s agreement to perform same
    - Provide for the revocation of responsibilities if plan determines that subcontract is not performing satisfactorily
  - Disclosure of subcontractor’s ownership and control/related entities
Key Subcontractor Obligations (cont.)

- APL 17-004
  - Plans responsible for ensuring subcontractors and delegated entities comply with all laws and regulations, contract requirements, reporting requirements and other DHCS requirements
  - Plans responsible for data submitted by subcontractors and for meeting care coordination requirements
Key Network Provider Obligations

- Must be credentialed by plans
- Subject to compliance programs and auditing, including 60-day overpayment notification
- Timely access to care
- Accessibility for beneficiaries with physical or mental disabilities
- Ensure all network providers are enrolled with the State
  - Need not provide services to FFS beneficiaries
  - Screening, enrollment, periodic revalidation
- Must meet marketing requirements
Scenario: New Contract
Provisions

- “Hospital shall report to Plan all cases of suspected fraud and/or abuse within 60 days of identification”
- “Hospital shall report to Plan all suspected overpayments within 30 days”
Appeals and Grievances

Increases uniformity between Medicaid managed care and MA/private insurers

- Minimize confusion for beneficiaries and increase efficiencies for plans with multiple service lines
- Change in language
  - “Adverse benefit determination” instead of “action,” which was expanded in Final Rule to explicitly include determinations of beneficiary cost-sharing
Appeals and Grievances (cont.)

Increases uniformity between Medicaid managed care and MA/private insurers

- Consistency of timeframes for submission of appeals
  - 60 days to file an appeal like in MA
  - 30 days to adjudicate standard appeals; 72 hours for expedited
Appeals and Grievances (cont.)

- Clarifies that appeal process only applicable to beneficiary disputes, not provider payment disputes
- Limits internal plan appeal to one level, after which access to State fair hearing process
  - Declines to permit direct access to fair hearing process
- Permits states to offer optional external, independent medical review process
Appeals and Grievances (cont.)

- APL 17-006 implements this requirement
  - Includes new notices for each type of action
  - Useful table in Attachment A for summarizing changes to requirements
  - Plans to establish, implement and maintain a grievance and appeal system to ensure receipt, review and resolution of grievances and appeals
Questions?
Thank you

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