Medicaid Managed Care Final Rule
ACCSES Annual Conference

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What is the CPR Coalition?

CPR is a coalition of 47 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.
ACCSES’ Involvement in CPR

- 47 member organizations includes:
  
  ![ACCSES Logo]

- ACCSES is a very active member of CPR
  
  - 19/20 sign-ons since December 2014
CPR’s Steering Committee
Medicaid Managed Care: The New Normal

- Medicaid managed care = When states contract with private insurance plans to provide services to Medicaid beneficiaries

- Currently (as of April 2016):
  - 39 States and the District of Columbia
  - 72 million Medicaid beneficiaries total
    - Nearly 2/3 enrolled in Medicaid managed care

- Jargon
  - MCO: managed care organization
  - PIHP: prepaid inpatient health plan
  - PAHP: prepaid ambulatory health plan
Overview

- Published May 6; Effective July 6

- Modernizes managed care plans in Medicaid and Children’s Health Insurance Program (CHIP)

- Four key goals:
  - Align other health insurance coverage programs
  - Advance states’ efforts to improve delivery systems
  - Strengthen beneficiary experience and protections
  - Improve program accountability and transparency
Improving Alignment with Other Plans

- Establishes a MLR of 85% for all Medicaid managed care plans (like MA and large employers in the private health insurance market)
- Aligns appeals process
- Aligns scope of enrollee information and dissemination practices by:
  - Permitting Medicaid managed care plans to use a range of communication methods (i.e. mail, email, and website)
  - Requiring Medicaid managed care plans to post provider directories and drug formularies on websites
- States must appropriately screen and enroll all network providers
  - Current standard for M’are/M’aid FFS
Delivery System Reform

- Allows states to partner with Medicaid managed care plans to adopt value-based purchasing approaches, or multi-state or Medicaid specific delivery system reform initiatives.

- Establishes requirements for Medicaid managed care plans to cover services or settings that are an alternative to those covered under the State plan (“in lieu of services”).
Improving Quality of Care

- Requires state implementation of Quality Rating System (QRS) for all Medicaid managed care plans
  - Summary indicators are aligned with the Marketplace QRS, states can develop measures to reflect population
  - States must publically report on quality performance measures to increase transparency and facilitate consumer choice
  - States can request approval of an alternative QRS
- Extends requirements for external quality review (EQR) and managed care quality strategy to all types of managed care plans
Improving Quality of Care: Websites

- Requires state websites to post information on managed care plans accreditation status, state managed care quality strategies, and results of annual EQR
Improving Quality of Care: Accreditation

- States must publicly report, update, and confirm accreditation status of all of their contracted MCOs, PIHPs or PAHPs, at least annually.

- States maintain flexibility to determine which accreditation is required of each managed care plan and if the information will be used as part of the EQR process.
Improving Quality of Care: Accreditation

- States can use information from private accrediting entities recognized by CMS

- CMS will issue future comparability guidance, applicable to both Medicare reviews and private accreditation
Improving Quality of Care:
Network Adequacy

- States must validate all managed care plans’ network adequacy information as part of their annual EQR process
  - States have flexibility to determine provider network adequacy and access standards for MCOs, PIHPs or PAHPs
Improving Beneficiary Experience

- States must establish network adequacy standards in managed care for key types of providers, but have flexibility to set actual standards to better reflect local needs.
  - Must develop and implement **time and distance standards** for network primary and specialty care, behavioral health, OB/GYN, pediatric dental, hospital, and pharmacy providers.
  - Must develop and implement standards for **MLTSS** that include criteria for providers who travel to the enrollee...
Improving Beneficiary Experience

- States must assess and certify network adequacy of plans’ providers at least annually and when there is a substantial change to program design

- Plans must assess enrollees with special health care needs and/or needs for LTSS, develop a treatment plan based on the assessment, and ensure it is regularly updated

- Establishes standards for enrollment processes and informational notices to beneficiaries to ensure consistency among states
Improving Beneficiary Experience

- States must provide choice counseling services for any new enrollee or for enrollees with opportunity to change enrollment.

- States must develop and require MCOs, PIHPs, PAHPs, and Primary Care Case Managers to use definitions for managed care terminology for consistency purposes (i.e. durable medical equipment, habilitation services and devices, and rehabilitation services and devices).
Enrollment/Disenrollment Provisions

- States that passively enroll beneficiaries in health plans the states select must:
  - Notify the beneficiaries; and
  - Give them 90 days to change plans (and/or to elect to remain in FFS in the case of voluntary managed care)

- LTSS enrollees may disenroll if:
  - LTSS provider leaves the network; AND
  - The enrollee’s residence or employment would be disrupted as a result
Managed Long-Term Services and Supports (MLTSS)

- States must actively identify enrollees with LTSS needs
- Plans must comprehensively assess these enrollees
- Plans must adhere to person-centered planning provisions from CMS, and HCBS regulations
- States and plans must together create stakeholder advisory groups to oversee MLTSS programs
CMS’ Response to CPR Comments

- CPR Steering Committee submitted comments re: Medicaid managed care proposed rule July 2015

- Devices. “And devices” is added to “habilitation services” and “rehabilitation services” for consistency with terminology used for essential health benefits
  - Chose not to define individual services or include any specific services in the LTSS definition, in an effort to avoid limiting scope (i.e. orthotics, prosthetics, DME)
CMS’ Response to CPR Comments

- **Non-discrimination.** All Medicaid managed care plan contracts must comply with all applicable federal and state laws and regulations.
  - Can’t discriminate against providers re: provider’s race, color, national origin, disability, age or sex.

- **Transition of care.** States are required to describe their transition of care policy as part of their managed care quality strategy.
CMS’ Response: Network Adequacy

- Clarified states are required to post network adequacy standards on their own state public websites

- Believes it is overly prescriptive and detracts from appropriate state flexibility to provide a federal framework or approval of the states’ network adequacy standards
Questions?

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