Managed Care Final Rule Implementation Updates

Sarah C. Brooks, Deputy Director, Health Care Delivery Systems
Lindy Harrington, Deputy Director, Health Care Financing
Alani Jackson, Chief, Medi-Cal Dental Services Division
Karen Baylor, Deputy Director, Mental Health and Substance Use Disorder Services

Department of Health Care Services

Agenda

1. Final Rule Overview and Implementation Approach
2. Year in Review: 2017 Implementation by Program
3. Looking Ahead: 2018 Provisions and Beyond
4. Questions & Open Discussion

Final Rule Overview

Background

- First major overhaul of the managed care regulations since 2002
- Directed at states to ensure compliance by 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
- Updates actuarial rate-setting standards and requirements

Implementation Dates

- Effective July 5, 2016
- Phased implementation over three years, starting with the July 1, 2017 contract rating period

General Implementation Approach

Internal Evaluation

- Conducted gap analysis of Final Rule provisions compared 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 applicable plans prior to implementation
- Engaged stakeholder groups
- Consulted external partners

Plan Guidance

- Issued policy guidance via All Plan Letters (APLs), County Information Notices, 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 CMS[2]

[2]CMS Contract Checklist:
https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

2017 Implementation by Program

Managed Care Health Plans

Summary of 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

MCP Implementation

Medi-Cal Managed Care Plan 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 for the July 2017 implementation is contingent on legislation and will be issued by 2018:**
  - Sanctions

MCP Implementation (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

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% above the Schedule of Maximum Allowances for selected procedures
- Risk-based rate add-on will be developed based on anticipated utilization of selected procedures

Dental Managed Care Plans

Dental MCP Implementation

Dental Managed Care Plan APLs

- **(6) APLs issued to meet the immediate effective date:**
  - Standard contract requirements, and access and cultural considerations (APL 16-014)
  - General provisions and definitions (APL 16-013)
  - Notice of sanction and pre-termination hearing (APL 16-011)
  - Special rules for temporary management (APL 16-010)
  - Public Health Regulation, State Plan Requirements(16-019)
  - Compliance with Applicable Laws and Conflict of Interest Safeguards (APL 16-020)

Contract Amendment

- Submitted to CMS on April 7, 2017

Dental MCP Activities

Beneficiary Experience

- Model Handbook
- Beneficiary Support website
- Grievances and Appeals

Quality of Care

- Initial Assessment

Program Integrity

- Records Retention
- Sanctions
- Data Certification
- Overpayments
- Subcontracts

Financing

- Medical Loss Ratio Reporting

Mental Health Plans and Drug Medi-Cal Organized Delivery System (DMC-ODS)

MHP Implementation

Mental Health Plan County Guidance

- Crosswalk identifying impact of Final Rule
- Draft MHP contract and comparison crosswalk
- Established DHCS/CBHDA Final Rule workgroup
- Provided extensive training and technical assistance
- County Information Notices (in-progress):
  - Grievance and appeal system with revised notices
  - Provider directory requirements
  - Provider credentialing
  - Overpayment recoveries and reporting
  - Indian enrollee requirements
  - Data and information reporting and certification
  - Language assistance requirements

MHP Implementation

Contract Amendment

- Submitted to CMS on June 28, 2017
- DHCS is working through CMS' comments

Deliverables

- SMHS Beneficiary Handbook
- Uniform Notice Templates

Compliance Monitoring

- Annual Review Protocol for Specialty Mental Health Services FY17/18

Summary of MHP Activities

Beneficiary Experience

- Grievance and Appeal Systems
- Information Requirements
- Language Assistance

Quality of Care

- Quality Assessment and Performance Improvement
- Monitoring and Data Reporting Requirements

Program Integrity

- Records Retention
- Provider Selection
- Compliance Program
- Transparency
- Subcontracts

DMC-ODS Implementation

Intergovernmental Agreement

- Submitted to CMS on March 29, 2017
- Finalized and approved on June 14, 2017

Active DMC-ODS Counties

- Contra Costa
- Marin
- Los Angeles
- Riverside
- San Francisco
- San Mateo
- Santa Clara

Summary of DMC-ODS Activities

Beneficiary Experience

- Member Handbook
- Beneficiary Support Website
- Annual Beneficiary Satisfaction Surveys

Quality of Care

- Expansion of Services
- Network Adequacy
- EQRO

Program Integrity

- Readiness Reviews
- Provider Screening
- Provider Enrollment
- Compliance Workshops

Looking Ahead:
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