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Medicaid Managed Care Final Rule: Calculating Medical Loss Ratio, Complying With Network Adequacy Standards and More

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Medicaid Managed Care Final Rule

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August 3, 2016

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Agenda

- **Introduction**
- **Final Regulation: Key Components**
  - Medical Loss Ratio
  - Actuarial Soundness
  - Pass through Payments
  - Benefit Flexibility
  - Network Adequacy/Flexibility
  - Provider Screening & Enrollment
  - Other Provider Program Integrity Provisions
  - Grievances and Appeals
- **Best practices for Compliance**
- **Q&A**

Introduction

- Overview
- Themes of Rule
- Who is impacted and how
- Long Term Services and Support (LTSS) integrated throughout Rule

Plan Rate Setting

Medical Loss Ratio (MLR) and Actuarial Soundness

- Rationale in Adopting MLR Standards: To promote consistency between state Medicaid, commercial (ACA and state law), and Medicare Advantage (MA) MLR requirements
- CMS: MLR reporting valuable tool to ensure that capitation rates for MCOs are actuarially sound and adequately based on reasonable expenditure for covered services. 81 Fed Reg 27,837 (May 6, 2016)
- CMS: Benefits to having a common national standard for MLR:

1) Greater transparency for use of Medicaid funding
2) Will allow comparisons across states and facilitate better rate setting
3) Will facilitate better comparisons to MLR in private market and MA
4) Will reduce administrative burden on managed care plans by providing a consistent approach to ensuring financial accountability for plans with multiple product lines and/or operating in multiple states

MLR Requirements (§§ 438.4, 438.5, 438.8, 438.74)

- MLR is the percentage of premiums spent on incurred claims and quality/other activities
- Medicaid Managed Care Medical Loss Ratio (MLR) Formula:

$$\text{Medicaid Managed Care MLR} = \frac{\text{Health Care Claims} + \text{Quality Improvement Expenses} + \text{Other Activities}}{\text{Premium Revenue Collected} - \text{Taxes, Licensing \& Regulatory Fees}}$$

  - Numerator: Total of incurred claims, expenditures on activities that improve health care quality and certain other activities
  - Denominator: Adjusted premium revenue collected, taking into consideration adjustments for enrollment, excluding federal or state taxes and licensing or regulatory fees

MLR Calculation/Applicability

- Generally the same type of calculation as established by the private market MLR under ACA, with some variation built in due to differences in Medicaid programs and populations
  - e.g. MCO pass-through payments are excluded. § 438.8(e)(2)(v)(C)
- Differences in Medicaid plans and commercial plans create slightly different requirements affecting calculation
- Current MLR examples:
  - ACA: 85% commercial, large group MLR (effective 2011; reporting began 2012)
  - ACA: 80% commercial, individual and small group MLR (effective 2011; reporting began 2012)
  - Medicare Advantage: 85% (effective 2014)
  - States: Variable
- MCOs must report MLR annually; different than three year reporting cycle now in place for private plans under ACA
- Final Rule expands MLR to Medicaid Managed Care no later than rating period for contracts starting on or after July 1, 2017 instead of January 1, 2017 as proposed

MLR Reports/Usage

- Plan reporting obligations based on available and consistent information
- Minimum MLR threshold: 85%
- No maximum MLR included
- Use of MLR Reports
  - Actuarial Soundness: major use
  - Remittances: No requirement if MLR not met, but states retain discretion to require remittances for failure to meet

Actuarially Sound Rates (§ 438.4)

- Defined as those projected to provide for all reasonable, appropriate, and attainable costs under the terms of the contract for the time period and population covered under the contract
- Revises current definitions, creating new standards for states and actuaries – includes six additional new requirements in addition to prior standards
- An actuarial rate certification should provide sufficient detail, documentation and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final capitation rate
- Specificity and transparency are key

CLARIFICATION OF PLAN SPENDING

Maximum/Minimum Fee Schedules, Value Based Purchasing and Pass-Through Payments

Clarification on Plan Spending (§ 438.6)

- **State may only direct plan's expenditures for:**
  - Adoption of a minimum or maximum fee schedule for particular services or provide a uniform increase for providers of particular services
  - Value based purchasing models
  - Participation in a multi-payer delivery system reform or performance improvement initiative

"Minimum Fee Schedule" or "Uniform Increase" Approval

- **For approval:**
  - Must be based on the utilization and delivery of services;
  - Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;
  - Expects to advance at least one of the goals and objectives in the quality strategy in §438.340;
  - Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy plan
  - Does not condition network provider participation in contract arrangements under paragraphs (c)(1)(i) through (iii) of this section on the network provider entering into or adhering to intergovernmental transfer agreements; and
  - May not be renewed automatically.

Additional Criteria for Approval of VBP or Delivery System Reform

- **Contract arrangements must also demonstrate that the arrangement:**
  - Must make participation available, using the same terms of performance, to a class of providers providing services under the contract related to the reform or improvement initiative;
  - Must use a common set of performance measures across all of the payers and providers;
  - May not set the amount or frequency of the expenditures; and
  - Does not allow the State to recoup any unspent funds from the MCO, PIHP, or PAHP.
- **EHR example - DSRIP**

Pass-through Payment Transition

- **Defines "pass-through" payments as any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for:**
  - Specific service or benefit provided to a specific enrollee
  - Permitted provider payment methodology previously discussed
  - A subcapitated payment arrangement for specific set of services and enrollees
  - GME payments
  - FQHC/RHC wraparound payments

Pass-through Payment Transition: Physicians and Nursing Facilities

- **For nursing facilities and physicians:**
  - Permitted for contracts starting on or after July 1, 2017, through contracts beginning on or after July 1, 2021
  - No longer permitted for contracts beginning on or after July 1, 2022

Pass-through Payment Transition: Hospitals

- **Pass-through payments permitted, but must be phased out over a 10-year schedule beginning with contracts starting on or after July 1, 2017**
- **Maximum pass-through payment for each year equal to a percentage of a "base amount;" starts at 100% and decreases by 10% each year**
  - Base amount based on aggregate difference between the amount Medicare FFS would have paid for those inpatient/outpatient hospital services for 12-month period immediately two years prior to the rating period and the amount the plans/State would have paid without pass-through payments

Clarification on Plan Spending (§ 438.6(b))

- **Clarifies standard for incentive arrangements**
  - Must be:
    - Limited to no more than 5% above approved capitation rates and
    - (1) for a fixed period of time and for performance during that rating year; (2) not be renewed automatically; (3) available to both public and private contractors; (4) not conditioned on IGTs; and (5) necessary for specified activities, targets, performance measures or quality-based outcomes that support program initiatives specified in State's quality strategy

Clarification on Plan Spending (§ 438.6(b))

- **Standards for risk corridors and withhold arrangements**
  - Risk-sharing (reinsurance, risk corridors or stop-loss) permissible if described in contract, developed consistent with actuarial sound rule, rate development rule, and generally accepted actuarial principles and practices
  - Withhold arrangements
    - Any portion of withhold not reasonably achievable must be actuarially sound
    - Reasonable amount of withhold considering various plan-specific factors.
    - Other contractual requirements

BENEFIT FLEXIBILITY

In Lieu of Services and Institution for Mental Disease "Carve-In"

Benefit Flexibility (§ 438.3(e))

- **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

NETWORK ADEQUACY

Provider-Specific Network Adequacy Standards (new 42 C.F.R. § 438.68(b))

At a minimum, a State must develop time and distance standards for the following provider types, if covered by the MCO, PIHP, or PAHP contract:

- 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
- Additional provider types, as determined by CMS

Network Adequacy for LTSS (new 42 C.F.R. § 438.68(b)(2) and (c)(2))

- Where longterm services and supports (LTSS) are covered under the managed care contract, the State must use both time and distance standards and other types of standards for LTSS provider types that travel to the enrollee to deliver services
- With respect to network adequacy for managed care LTSS, States must take into account:
  - Elements that would support an enrollee's choice of provider
  - Strategies would ensure health and welfare and support community integration
  - Other considerations that are in the best interest of the enrollees who need LTSS

Development of Standards (new 42 C.F.R. § 438.68(c))

In developing standards, States must consider:

- Anticipated Medicaid enrollment
- Expected utilization
- Characteristics and health care needs of enrollee populations
- Number and types of network providers required to furnish services
- Number of network providers not accepting new Medicaid patients
- Geographic location of network providers and enrollees, including distance, travel time, and transportation means.
- Language abilities of network providers
- Accommodations for physical and mental disabilities, including culturally competent communications
- Use of technological and other solutions , such as triage lines, screening systems, telemedicine etc.

Exceptions Process (new 42 C.F.R. § 438.68(d))

- States may choose to grant exceptions to the provider-specific network standards
- Standard why which the exception will be evaluated and approved must be
  - Specified in the MCO contract
  - Based on the number of providers in that specialty practicing in the area
- States that grant exceptions must monitor enrollee access to that provider type on an ongoing basis

Publication of Network Adequacy Standards (new 42 C.F.R. § 438.68(e))

- States must publish network adequacy standards on the Medicaid agency website
- Standards must be made available at no cost to enrollees with disabilities in auxiliary formats

Availability of Services; Assurance of Adequate Capacity and Services 42 C.F.R. §§ 438.206 and 438.207

Availability of services (438.206)

- Few significant changes to existing regulation
- Contract must provide for out-of-network care (at cost to enrollee no greater than if services were furnished in-network)
    - where necessary for the enrollee to have access to a second opinion
    - where covered services are not available to the enrollee through a network provider

Assurance of Adequate Capacity and Services (438.207)

- Requires submission of network documentation at the time the MCE enters into a contract with the State, **on an annual basis**, and at any time there has been a significant change in operations that would affect the adequacy of capacity and services

Access to Out-of-Network Services

Where out-of-network is required other than as described in 42 C.F.R. § 438.206:

1. State contracts with managed care entities must require the entity to pay for covered services provided by **Indian Health Care Providers** (whether in-network or not) to Indian enrollees (42 C.F.R. § 438.14(b))
2. State contracts with MCOs, PIHPs, and PAHPs must require those entities to pay for out-of-network
   - **emergency services**, where the enrollee has an emergency medical condition or a representative of the managed care entity has advised the enrollee to seek emergency services (42 C.F.R. § 438.114(c)
   - **post-stabilization services**, where out-of-network coverage would be required under the Medicare Advantage rules at 42 C.F.R. § 422.113(c) (42 C.F.R. § 438.114(e))

Access to Out-of-Network Services (Continued)

3. When a State chooses to contract with **only one MCO, PIHP, or PAHP in a rural area**, rather than offering a choice of at least two plans, the State must make out-of-network services available in some circumstances (42 C.F.R. § 438.52(b))
4. Temporary out-of-network services may be required as part of a **"transition of care policy"** (42 C.F.R. § 438.62(b)(1)(i))
5. State must make out-of-network care available if immediately required due to **unforeseen illness, injury, or condition** (SSA § 1903(m)(2)(A)(vii))

PROVIDER SCREENING AND ENROLLMENT

Provider Screening and Enrollment (new 42 C.F.R. § 438.602(b))

- PPACA § 6401(b) required State Medicaid agencies to require all ordering or referring physicians or other professionals to be enrolled as participating providers
- In its February 2011 regulation implementing the provider screening and enrollment rules, CMS refrained from applying the requirement in the managed care context
- CMS now implements this requirement: "The State must screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, and PAHPS, in accordance with the requirements of part 455"
- Compliance required for managed care contracts starting on or after July 1, 2018

Provider Screening and Enrollment (new 42 C.F.R. § 438.602 (b))

- Requirement does not obligate network providers to render services to FFS beneficiaries

- MCE's credentialing process operates independently from enrollment

Provider Screening and Enrollment (new 42 C.F.R. § 438.602(b))

Screening and Enrollment Process

1. Provider completes enrollment application
2. Providers required to make various disclosures set forth in 42 C.F.R. Part 455, Subpart B
3. State verifies provider's licensure
4. Intensity of provider screening process varies based on categorical risk levels of "limited," "moderate," or "high"

Successful completion of this process results in the Medicaid provider being "enrolled" with the State Medicaid agency

Per 42 C.F.R. § 455.414, States must revalidate the enrollment of providers at least every five years

Provider Screening and Enrollment (new 42 C.F.R. § 438.602(b)(2))

- Managed care entity may execute network provider agreements pending screening and enrollment
- MCE must terminate agreement in the following circumstances:
  - Immediately, upon notification from the State that the network provider cannot be enrolled
  - Upon expiration of the 120 days, if enrollment not complete

OTHER PROGRAM INTEGRITY SAFEGUARDS

Fraud and Abuse: Plan Compliance Program

- **Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing**
- **Verification whether services that have been represented to have been delivered were received**
- **Referral of potential fraud, waste or abuse identified by plan to State Medicaid program integrity unit and any potential fraud to State Medicaid Fraud Control Unit**
- **Suspension of payments to a network provider for which State determines credible allegation of fraud**

Fraud and Abuse (§ 438.602(f))

- **State must investigate whistleblower information relating to:**
  - Medicaid Plans
  - Subcontractors
  - Network Providers

Network Provider Overpayments (§ 438.608(d))

- **By July 2017, Medicaid plans will be contractually obligated to**
  - Require network providers to report and return overpayments within 60 days of identification
  - Establish a mechanism for receiving overpayment reports and returns
- **Defines an "overpayment" as "any payment made to a network provider . . . to which the network provider is not entitled to under title XIX of the Act."**

GRIEVANCES AND APPEALS

Simplification and Consistency with Medicare Advantage

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
  - 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

- **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

- **CMS changes course to continue to require providers to obtain patient consent to file appeal; concern about enrollee financial liability**
- **Precludes individual who made initial determination or his/her subordinate from making grievance and appeal decisions**

BEST PRACTICES FOR COMPLIANCE

Tips for Plans and Providers for the Implementation of the Final Rule

Questions?

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