Preparing Your Organization for the New Medicaid Managed Care Regulations
Impact Analysis and Implementation Tool

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Our Focus Today

• Overview of Medicaid Managed Care Regulations from the perspective of MCOs
  – Areas of major change
  – Standardization and state flexibility
  – Implementation issues

• Review of HMA’s tool to assist MCOs prepare for implementation.
Broad Implications for Health Plans

• More standardized approaches across and within states, particularly in financial management
• Specific policy standards and requirements related to MLTSS
• Substantial new reporting and oversight requirements
• Some areas of considerable state flexibility — particularly in delivery system reform
• Quality strategy still to be developed
Standardized Requirements

A driving force is standardization across states/markets. Here are a few examples:

• Medical Loss Ratio and other rate setting issues
• Appeals and grievances policies and timelines
• Provider enrollment shifted to the state level
• Encounter data and annual reports
Diversity of Approaches among States

The rule also explicitly allows states latitude to implement and/or continue down a range of pathways. For example:

- Network adequacy metrics and definitions
- IMD and “in-lieu of” options
- Delivery system and payment reforms
- The state’s managed care quality strategy
What Changed from Draft to Final

While there are few wholesale revisions, even small changes may affect plans. Here are a few differences:

• Some additional specifics in financial sections
• 14-day waiting period requirement deleted and other shifts in enrollment procedures like auto-assignment
• More substantial focus on a comprehensive beneficiary support system
• Quality strategy expectations and rating systems more detailed
State Implementation Efforts

• As states renew or revise their state managed care programs and contracts
• Contract modifications may trigger compliance requirements—and by MMC product
• This will affect different states differently
• Some lessons can be gleaned from recent states
## Final MCO Regulation: Effective Dates

<table>
<thead>
<tr>
<th>Provision</th>
<th>Effective Date</th>
<th>Provision</th>
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<tr>
<td>CHIP Provisions</td>
<td>7/1/18</td>
<td>Beneficiary Experience:</td>
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<tr>
<td>IMD</td>
<td>7/5/16 2</td>
<td>- Enrollment</td>
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<td>Approaches to Payment</td>
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<td>Network Adequacy</td>
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<td>Quality Rating System</td>
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<tr>
<td>Encounter Data</td>
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<td>- Most Provisions</td>
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<td>Appeals &amp; Grievances</td>
<td>7/1/17</td>
<td>- Increase/Decrease Limit 1.5%</td>
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<td>Quality of Care</td>
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<td>Program Integrity</td>
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<tr>
<td>- Extension to PAHPs &amp; PCCMs</td>
<td>60 days after publication</td>
<td>- Administrative &amp; Managerial</td>
<td>7/1/17</td>
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<tr>
<td>- New Health Disparities &amp; LTSS</td>
<td>7/1/18</td>
<td>- Network</td>
<td>7/1/18</td>
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<tr>
<td>- Validation: Network Adequacy</td>
<td>1 year after EQR protocol issued</td>
<td>- Recovered Overpayment</td>
<td>7/1/17</td>
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<tr>
<td>- Transparency: QAPI &amp; Accreditation</td>
<td>7/1/17</td>
<td>Medical Loss Ratio</td>
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<td>- Transparency: QS &amp; EQR</td>
<td>7/1/18</td>
<td>- Calculate &amp; Report</td>
<td>7/1/17</td>
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<tr>
<td></td>
<td></td>
<td>- Rates set to Achieve 85% MLR</td>
<td>7/1/19</td>
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1. For any rating periods for contracts starting on or after this date except as noted
2. Effective on this date; footnote number 1 does not apply
Assessing Current Status and Moving Forward

- This regulation will require adaptations in practice, policy, technology and coordination from plans, states, and providers across the spectrum.
- In some states, the current approach may be relatively close to the requirements, but change will still be needed.
- In others, they may be unlikely to achieve the end point envisioned without intermediate steps.
- Plans will need to be a part of the discussion in both environments.
Overview of HMA Developed Tool

• Divided into sections that correspond with the subparts of the regulation, the tool format serves as a project plan.
• Part analysis and part action steps, the tool moves through the regulation in chronological order and includes:
  – Summary of Requirements
  – Potential Impact on Organization
  – Follow Up Required
  – Functional/Operation Areas
### Review of Regulation/Summary of Impact

<table>
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<th>Cite</th>
<th>Title</th>
<th>Potential Impact on Organization</th>
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</table>
| §438.700 | Basis for imposition of sanctions | **Summary:**
Provides the criteria states must use and may use to impose sanctions on plans.  

**Changes:**
Clarifies that the types of intermediate sanctions listed in §438.702 “may” be used by the state rather than stating that these “must” be the sanctions that the state establishes.  

Understand that the specific intermediate sanctions specified in §438.702 for violations (e.g., civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause etc.), may be used by the state rather than must be used.  

However, states must have intermediate sanctions in place to ensure complete understanding/knowledge of the sanctions upon contract initiation.  

To remain in full compliance, review the state’s basis for imposing sanctions and gain complete understanding/knowledge of the types of intermediate sanctions that the state will impose based on the violations that have occurred.  

Compliance Vendor Oversight
How the Tool Was Developed

• A team of HMA colleagues with managed care expertise reviewed the existing, the proposed, and the final regulations.
• Drawing on their own backgrounds in managed care, reviewers identified how changes would impact managed care plans.
• The rationale in the preamble provided insight into CMS’ intent for the changes.
• The analysis focused on both major policy changes and those changes that didn’t make headlines but have significant impacts to the plans.
How Does the Tool Apply to My Organization?

• The regulation applies to MCOs, PIHPs, PAHPs, PCCM entities, and PCCMs.
• Tailoring the tool for more than one plan type was unwieldly. Therefore, the “off-the-shelf” tool is designed for use by an MCO.
• HMA is able to customize the tool to another plan type or organization upon request.
• HMA is also able to customize the tool for specific states and programs.
## Contents

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<td>B</td>
<td>State Responsibilities</td>
<td>438.50 – 438.74</td>
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<td>C</td>
<td>Enrollee Rights and Protections</td>
<td>438.100 – 438.116</td>
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<td>D</td>
<td>MCO, PIHP and PAHP standards</td>
<td>438.206 – 438.242</td>
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<td>E</td>
<td>Quality Measurement and Improvement; External Quality Review</td>
<td>438.310 – 438.370</td>
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<td>F</td>
<td>Grievance System</td>
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<td>H</td>
<td>Additional Program Integrity Safeguards</td>
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<td>J</td>
<td>Conditions for Federal Financial Participation (FFP)</td>
<td>438.802 – 438.818</td>
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How the Tool Can Be Used

• The tool is the project plan.
• It can be used to quickly assess a plan’s readiness and potential effort required to meet new requirements.
• The tool can be used to complete a gap analysis, leading to a more targeted implementation and action plan.
• Two additional columns (Staff Lead and Status) allow users to track progress in implementing required changes.
• HMA can provide additional support by further personalizing the tool for specific plan characteristics.
• HMA can provide strategic and operational decision support as well as implementation, project management and oversight to achieve compliance.
Examples of Impacts

• Small changes with big impacts
• What to do when state-specific interpretations are yet to come
• Multi-state customizations
# Small Change with Big Impact

**Adding the Provider’s Web Address**

## Cite: §438.10

### Information Requirements

#### Summary

Addresses communications between the enrollee and the state or health plan, including how materials must be prepared, when they must be sent, and what they must contain.

#### Changes

Electronic information must be compliant with all language, formatting, and accessibility standards; be in a prominent place on the state’s and plan’s web site; and be able to be retained and printed. Additionally, all information must be made available to enrollees and potential enrollees in paper format upon request at no cost and provided within 5 calendar days.

<table>
<thead>
<tr>
<th>Potential Impact on Organization:</th>
<th>Action/Follow Up Required</th>
<th>Functional/Operational Area</th>
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</thead>
<tbody>
<tr>
<td>Some required data elements for the provider directory, such as the provider’s web site URL may not be collected and stored by the plan currently. Gathering and adding that data could be a large workload.</td>
<td>If not already available electronically to enrollees and potential enrollees, include provider directory on the plan web site.</td>
<td>IT Provider Network</td>
</tr>
<tr>
<td>Identify any required data elements for the online provider directory that are not currently collected and stored. If there are gaps, develop a plan to collect the information on both a one time and ongoing basis. Modify the database to store the information and feed it to the online directory.</td>
<td>IT Provider Network Credentialing</td>
<td></td>
</tr>
</tbody>
</table>
## Multi-state Customizations:
Plan Monitoring

### Cite: §438.66
State Monitoring Requirements

### Summary
Details state monitoring and oversight requirements for all managed care programs, and minimum system aspects that the state’s system must address.

### Changes
Annually, the state must submit a report no later than 150 days after the end of the contract year on each managed care program operated by the state. The report must include:

1. Financial performance of each plan
2. Encounter data reporting by plan
3. Enrollment and service area expansion, if applicable, of each plan
4. Modifications to, and implementation of, covered benefits
5. Grievance, appeal, and fair hearings for the program
6. Availability and accessibility of covered services within the contracts
7. Evaluation of plan performance (quality measures, report cards, surveys)
8. Sanctions and corrective action plans as well as formal and informal interventions to improve performance
9. Any factors related to MLTSS not covered above

The report must be posted to the website, shared with the Medical Care Advisory Committee, and provided to the stakeholder consultation group if MLTSS.

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</table>
| In some states where the Medicaid program currently monitors the required areas, the impact to the plan will be minimal. In other states, however, the new monitoring requirements could result in substantial changes to reporting requirements and additional administrative tasks to enable the state to meet its monitoring responsibility. | Plans should compare previous monitoring tools and reports to the proposed regulation to identify new requirements that must be addressed. | Compliance  
Government Relations  
Affected departments |
| Work with the Medicaid agency to determine how monitoring and reporting requirements will change. | Identify opportunities for input on how monitoring will be conducted and potential efficiencies. | Government Relations |

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**Getting out in front:**
Getting Ahead of the Rating System

### Cite: §438.334
Medicaid Managed Care Quality Rating System

**Summary**
New section that requires states to adopt the Medicaid managed care quality rating system developed by CMS; or adopt an alternative Medicaid managed care rating system. States must implement such Medicaid managed care rating system within 3 years of the date of final rule.

CMS, in consultation with States and other stakeholders, will identify performance measures and a methodology for a Medicaid managed care rating system that aligns with the summary indicators of the qualified health plan quality rating system developed per 45 CFR 156.1120 that is standardized across plans and provides transparency in reporting plan performance.

States may request approval to use an alternate quality rating system.

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</tr>
</thead>
<tbody>
<tr>
<td>CMS will develop a rating system that states can use if they choose.</td>
<td>Plans may consider working with CMS around the development of a rating system.</td>
<td>Quality Improvement Plan Leadership</td>
</tr>
<tr>
<td>With quality ratings publicly reported in comparison to competitors, the importance of high performance is emphasized.</td>
<td>If not already known, the plan should determine how its performance compares to competitors in each market.</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>In states that opt to develop their own rating system, plans will need to adapt their quality metrics systems to accommodate data collection requirements and reporting.</td>
<td>Provide input to the state on how the quality ratings are calculated if the state elects to adopt an alternative Medicaid managed care quality rating system.</td>
<td>Plan Leadership Government Relations Quality Improvement</td>
</tr>
</tbody>
</table>
Next Steps

• The tools will be available this week to help plans develop and implement their strategy for state advocacy and compliance

• HMA is available to do custom webinars for your organization that is specific to your state or states
Q&A

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