

# A Review of the New Medicaid Managed Care Final Rules and Implications

**Manatt on Medicaid Webinar Series**

July 20, 2016, 1:00-2:00 pm ET

# Agenda

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## Background



## Key Issues Overview and Implications

- Medical Loss Ratio
- Actuarial Soundness
- Pass-Through Payments
- Value Based Purchasing
- Beneficiary Support and Enrollment
- Consumer Transparency
- Long Term Services and Supports



## Questions

# Agenda

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## ○ Questions

# Medicaid's Growing Influence in Health Care

Medicaid is the single largest source of coverage nationwide, and growing...

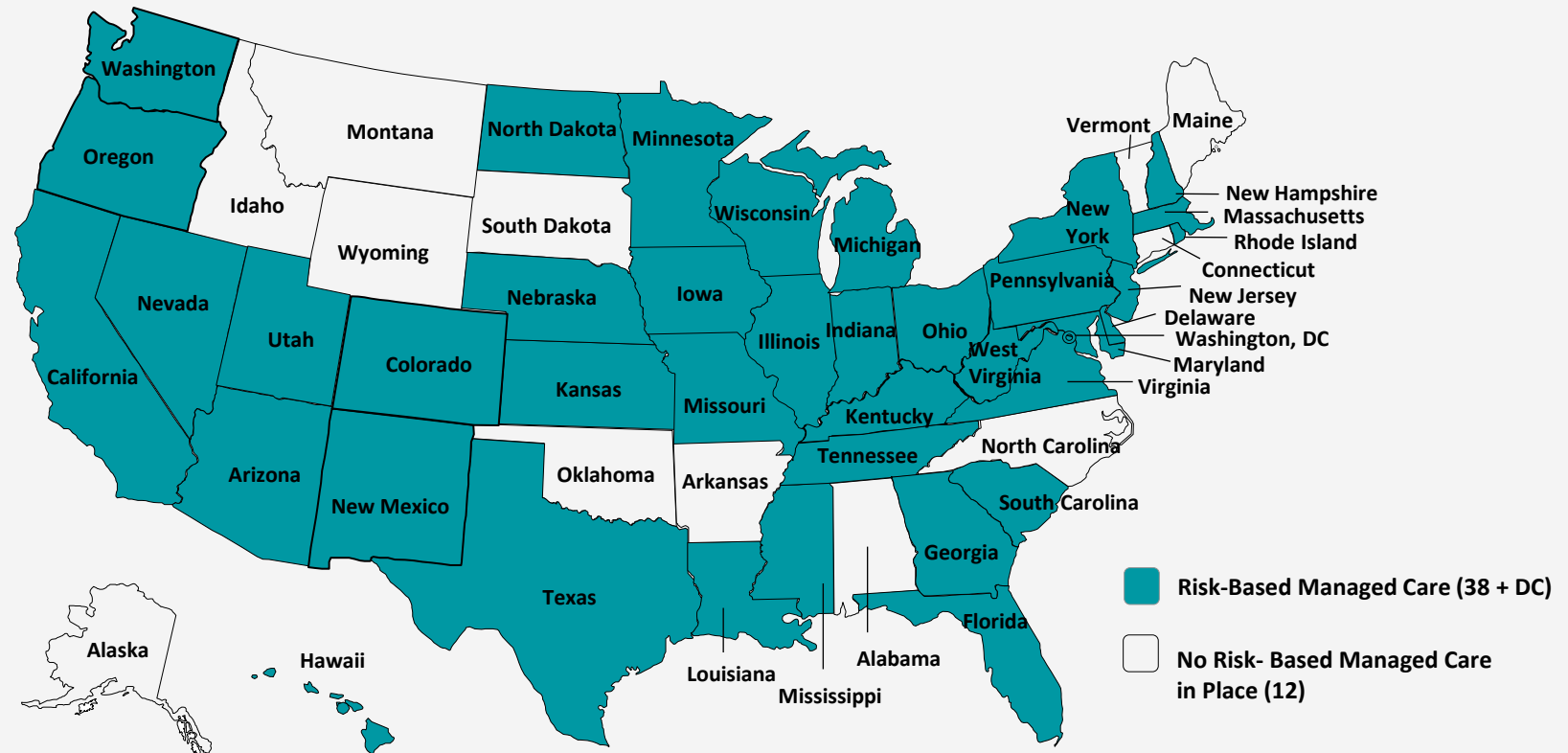
- ✓ Covers 70 million people annually, 22% of total U.S. population
- ✓ With the ACA, enrollment grew by 13.8% nationally in FY 2015
  - Expansion state enrollment grew by 18% on average
  - Non expansion state enrollment grew by 5% on average
- ✓ \$475 billion in total spending annually



Sources: Centers for Medicare & Medicaid Services (CMS). "National Health Expenditures". [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html); CMS. "Medicaid & CHIP December 2015 Enrollment Report". Dec 2015. [www.medicare.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf](http://www.medicare.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf); Kaiser State Health Facts; Kaiser Family Foundation. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid". Jan 2016. <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicare-an-update/>.

# Managed Care is the Dominant Medicaid Delivery System

38 states and DC contract with comprehensive managed care organizations;  
90% of all U.S. Medicaid beneficiaries live in these states



# MCOs Increasingly Enrolling Complex Populations

States are increasingly using managed care as a vehicle to cover comprehensive benefits for complex populations



## Complex Populations Drive Majority of Costs

- 83% of Medicaid's costliest beneficiaries have at least three chronic conditions
  - ✓ Severe mental illness
  - ✓ Dual-eligibles
  - ✓ HIV/AIDS
  - ✓ Developmentally disabled



## State Goals

- Addressing physical health, behavioral health, and long-term care silos
- Improving quality and consumer experience mechanisms and oversight capacity
- Transitioning to population health - focusing on the person, not their diagnosis
- Bending the cost curve

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# Medical Loss Ratio (MLR)



# MLR Requirements in Rate Setting

## Plan Responsibilities

- Calculate and report Medicaid MLR for purposes of rate setting beginning in plan year 2017 on an annual basis
  - *CMS declined to allow calculation based on 3-year rolling average as done under ACA*
- File MLR reports within 12 months of end of reporting period

- ✓ Total incurred claims
- ✓ Expenditures on quality improving activities
- ✓ Expenditures on program integrity activities
- ✓ Non-claims costs
- ✓ Premium revenues
- ✓ Taxes, licensing and regulatory fees
- ✓ Expenditure allocation methodology
- ✓ Credibility adjustment, if applicable
- ✓ Calculated MLR
- ✓ Remittance owed to State, if applicable
- ✓ Comparison with audited financial report
- ✓ Data aggregation method
- ✓ Number of member months/

## State Rate-Setting

- Use past MLR data in setting future rates
- Design managed care rates to anticipate minimum MLR of at least 85%



State options:

- **Minimum Standard.** May adopt minimum MLR standard, which must be at least 85%. May set > 85% MLR so long as leaving room for “reasonable administrative expenses.”
- **Rebate.** May require plans return capitation amounts if not satisfying minimum MLR.

# Calculation Largely Tracks Medicare and Commercial

Methodology modeled after Medicare and commercial plan MLRs,  
with Medicaid-specific adjustments

- Includes payments to third-party vendors
- Does not include expenses for network development, utilization management, claims processing, and administrative fees

Includes risk sharing programs with a state, such as stop-loss

MLR =  $\frac{\text{Incurred Claims} + \text{Quality Improvement Expenses}}{\text{Revenue}}$

Includes "kick" payments for enrollee pregnancies and other life events

Revenue

"Credibility adjustments" to plans with small enrollment, compensating for higher probability of irregular claims experience

# Actuarial Soundness

# New Rate Setting Transparency

New and more extensive requirements on states to assure that the rate development process is transparent and rates are sufficient to cover plan responsibilities

Collect or develop a base rate from past three years of utilization data

Apply appropriate trend adjustments


Apply appropriate non-benefit costs

Make reasonable adjustments as necessary

Consider historical and projected MLR

Apply risk adjustment methodology, if used



 If unavailable, states may request an exemption and propose a plan to develop utilization data within two years.

- ✓ Capitation rates must be developed using rate cells and reflect provider payment rates built into contracts
- ✓ States must certify actual rates, rather than rate ranges with only de minimis changes not triggering new CMS review

# Pass-Through Payments

# New Limits And Potential for New Payments

## New limits on amount and duration of pass through payments

- Pass-through payments are **supplemental payments that states direct managed care plans to provide to specific providers**; not directly linked to services under the contract or outcomes
- CMS has had **longstanding concerns with pass-through payments**, including their potential to limit plans' ability to effectively implement value-based purchasing
- In long run, final rule **phases out states' ability to use pass-through payments**
- In short run, final rule **opens door for new stream of supplemental payments**

### Phase-down Approach

- Calculate base amount of allowable pass-through payments by comparing what Medicare would have paid to what Medicaid paid for services.
- Re-base annually.
- Reduce the pass-through payment limit annually.

*Physician and nursing facility payments sunset in 2022. Hospital payments sunset in 2027.*



# Value Based Purchasing

# Driving Payment and Delivery System Reform

Framework for states to leverage Medicaid managed care systems to advance payment and delivery system reforms

## State Payments to Plans

States must tie incentive and withhold arrangements to meaningful quality goals and performance outcome measures

- **Incentive arrangement:** Plan may receive additional funds over and above the capitation rate for meeting a specified target
- **Withhold arrangement:** A portion of plan capitation is “withheld” pending achievement of particular outcomes

## Plan Payments to Providers

State may direct plans to use particular payment methodologies to promote access, quality and delivery system reform

- Implement value based purchasing models
- Participate in multi-payer delivery system reform or performance improvement initiative
- Set higher payment standards for particular provider types or services

## Alternative/Additional Services

- **“In lieu of” services:** State may determine alternative services/settings to state plan services that are medically appropriate and cost-effective substitutes
- **Value-add services:** Plan may determine to purchase and provide services not included in state plan or plan contract as a way to improve health and reduce costs



# **Beneficiary Support and Enrollment**

# Required Consumer Supports

Requires states to provide outreach and support to consumers before and after plan enrollment

**Choice counseling for all beneficiaries.** Choice counseling entities will be considered enrollment brokers and must meet independence and conflict of interest standards, including not having a financial interest in a plan.

**Assistance in understanding managed care.**

**Targeted assistance with LTSS.** Required LTSS functions include:

- Access point for complaints and concerns
- Education: (1) enrollees' grievance and appeals rights within the State fair hearing process; and (2) enrollees' rights and responsibilities; and (3) additional resources outside the managed care entity
- Assistance in navigating the grievance and appeals process, including referrals to legal representation
- Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues

- ✓ Managed care plans may not provide any beneficiary support system activities
- ✓ States are encouraged to leverage existing services and resources; new system is not required if services are already being provided
- ✓ States may use different entities for different services



The system must be accessible by phone, in-person, and online

# Stronger Protections in Plan Enrollment

## Choice Period

- States must provide enrollees an opportunity to make an active and informed decision
- **Voluntary managed care programs** must either: 1) provide an enrollment choice period during which enrollees may exercise an informed decision; or 2) employ a passive enrollment process in which the state enrolls the individual into managed care while simultaneously providing a period of time for the enrollee to make an active choice
- **Mandatory managed care programs:**
  - With passive enrollment, individuals are enrolled in a plan selected by the State; enrollees can accept or make an active choice
  - With no passive enrollment, individuals are given a chance to make an active choice; if no choice is made, they are enrolled into a plan based on the default process
- States must provide appropriate notice to enrollees including contact information for the beneficiary support system, length of enrollment period, implications of options available, and process for making a selection

## Plan Assignment

- Prioritize “existing provider-beneficiary relationship” and relationships with providers that have “traditionally served Medicaid beneficiaries”
- Ascertain relationship through plan enrollment or fee-for-service records, encounter data, or by contacting beneficiaries

# Consumer Transparency

# Enabling and Empowering Consumer Decision-making

Improves transparency and supports informed decision-making by Medicaid beneficiaries

## Content and Format of Information

- Enrollee handbooks better aligned with private market summary of benefits and coverage
- Materials must be available in alternative languages and formats for people with limited English proficiency and with disabilities

## Access to Information

- Provider directories must be available on plan websites
- Enrollee handbooks and formularies may be distributed electronically
- If posted on website, provider directories and enrollee handbooks must be available in machine readable formats

## New Quality Ratings

- New quality rating system for Medicaid managed care plans focused on clinical quality management, member experience and plan efficiency, and affordability.
- Plan ratings will be posted online by states

## **Long Term Services and Supports**

# New Transparency and Protections

Significant transparency in LTSS-related information, stakeholder input on program design and implementation, and special beneficiary supports and protections

## Required Elements of MLTSS

1. Adequate planning
2. Stakeholder engagement
3. Enhanced provision of HCBS
4. Alignment of payment structures and goals
5. Support for beneficiaries
6. Person-centered processes
7. Comprehensive, integrated service package
8. Qualified providers
9. Participant protections
10. Quality

- ✓ Specific choice counseling, grievance and appeals assistance, and disenrollment protections for MLTSS enrollees
- ✓ Assessment of care needs and development of coordinated treatment plan
- ✓ Time and distance standards for LTSS providers accounting for providers traveling to beneficiaries
- ✓ LTSS-focused quality assessment, performance improvement program, and quality strategy

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**Questions?**

**THANK YOU!**

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