Missouri Foundation for Health
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Medicaid Managed Care Final Rule: Implications for Missouri

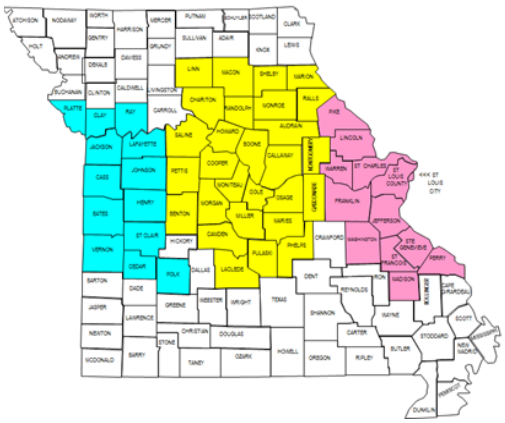
I. Background

In April 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule on managed care in both Medicaid and the Children's Health Insurance Program (CHIP). Regulations covering Medicaid managed care had not been changed since 2002, when only 58 percent of the Medicaid population was enrolled in a managed care plan. As of March 2016, 38 states and the District of Columbia have contracts with managed care organizations (MCOs) to deliver care to some portion of their state's Medicaid recipients. There are approximately 72 million beneficiaries in Medicaid across the nation, and an estimated 48 million are enrolled in a Medicaid managed care plan. The main goals of the final rule, as established by the CMS, are to:

1. Support states' efforts to advance delivery system reform and improve the quality of care for Medicaid and CHIP beneficiaries;
2. Strengthen the consumer experience of care;
3. Strengthen program integrity via accountability and transparency; and
4. Align rules across health insurance coverage programs.

The final rule outlines significant reforms to the managed care regulations that states must adhere to, but provides some flexibility as to how they are implemented. Most of the changes are left to the states to enforce on Medicaid MCOs operating within their borders. For example, provisions relating to minimum medical loss ratios, provider screenings, and network adequacy will all be left to the states to monitor. Placing the burden of administration on states may create variances between managed care requirements across state lines, establishing differing protections for consumers depending on residence.

Geography of Medicaid managed care coverage before expansion, 54 counties



Missouri initially used MCOs to deliver Medicaid benefits to children, families, and pregnant women across a specific geographic corridor. In 2015, Missouri's state budget included an allocation for statewide Medicaid managed care for that same population. In response to this legislation, Missouri began revising its request for proposals (RFP) to include the expanded geographic region. The newest RFP was released in April 2016, with awards to be given on October 1, 2016. The services reflected in the RFP contracts will begin on May 1, 2017. In addition to the geographic expansion, some major changes in the RFP include:

- Renewable five-year terms, rather than three-year terms;
- Financial penalties up to five percent of the capitation rates for failure to meet performance criteria;

- A minimum medical loss ratio (MLR) of 85 percent and rebates to the state if the MCOs exceed that threshold;
- A maximum market share of 55 percent;
- Provisions related to the ACA expansion population, should legislation allow for that in the future;
- Specific delivery reforms; and
- Delayed capitation for new geographic populations.

The following sections highlight the major revisions to the Medicaid managed care final rule but do not provide a comprehensive list of the changes. Many of these provisions have varying effective dates through July 1, 2018.

II. Standard Contract Requirements

States are required to incorporate specific provisions into the contract terms with MCOs, but all contracts will continue to be subject to CMS approval. Payments in the contracts must only be based on services covered under the state plan or services rendered in accordance with mental health parity regulations. Contracts must also explicitly include language requiring compliance with various other Medicaid regulations, including choice of provider rules and language pertaining to any relevant waiver provisions (i.e. if the contract includes prescription drug coverage, home- and community-based service waivers, or programs for dual eligibles). All contracts between states and MCOs must contain standardized non-discrimination language that outlines prohibited actions and requires compliance with other federal statutes and regulations. This includes a reference to Section 1557 of the Affordable Care Act (ACA), which prohibits health programs that receive federal funds from discriminating based on race, gender and gender identity, sexual orientation, national origin, age, disability, and color.

III. Medical Loss Ratio & Rate Development

The final rule requires that payments made to plans be based on actuarially sound estimates of care costs. States may incorporate customary MLRs to ensure that payments made to plans are used for delivery of care rather than administrative purposes. The intent of this provision is to better align Medicaid managed care MLR with that of Medicare Advantage and insurers in the small, large, and individual markets. The final rule requires Medicaid MCOs to use a standard formula for calculating and reporting their MLR; however, the rule does not mandate contracts be awarded based on the plan's ability to set a specific MLR. Rather, if states choose to set a minimum MLR, then that standard must be at least 85 percent. Even if a state forgoes mandating a MLR, rates must be set so that they could theoretically achieve the 85 percent MLR. If the MLR falls below that threshold, states should set capitation rates for future years to reflect those shortcomings. As stated above, Missouri has incorporated an MLR of 85 percent into the RFP and requires the MCO to issue a remittance to the state for failure to uphold that standard. The regulations governing MLR will be effective July 1, 2019.

In mandating actuarial soundness, the final rule outlines a rate development formula to help make rates consistent across plans and ensure price fairness. The factors addressed during rate formulation include a base utilization and price; trend data related to the actual Medicaid population; and a non-benefit component related to administrative costs associated with operations, taxes, licensing and regulatory fees, etc. The rule does exempt certain amounts from actuarial sound requirements, such as pass through payments, which are supplemental payments from states to MCO plans. The plans must then

distribute the payments to their contracted providers. These payments will be phased out depending on the type of provider, but all payments will be terminated by 2027. The final rule also exempts program integrity activities from rate-setting computation. CMS will have the ability to review and approve rates beginning on July 5, 2016; however, the new rate formula will not be effective until July 1, 2018.

IV. Quality, Payment, and Delivery System Reform

The final rule allows states to mandate Medicaid MCO plans to participate in reform efforts and to enroll in specific payment schedules, including value-based purchasing models, pay-for-performance, and other alternative payment methodologies. Missouri's RFP includes some quality and delivery reforms relating to local community care coordination programs, which can include subcontracting with medical homes and Accountable Care Organizations (ACO). It also requires that MCO plans have a strategy for implementing healthy behavior incentives for enrollees, as well as incentives for providers to deliver care in a more cost-efficient and medically appropriate manner.

The proposed rules would have required states to employ a Medicaid quality improvement strategy; however, CMS amended this provision after seeing countless comments from states on the financial and administrative burden of maintaining such broad conditions. Despite this revision, the final rule does require that states have a managed care quality strategy that includes both adequacy and availability standards, as well as state-specific goals for quality improvement, performance improvement projects, and independent external reviews of such projects. This is to ensure that states monitor plan outcomes on health status and equity. Missouri's quality strategy must be effective by July 1, 2018.

To comply with the provisions regarding independent external reviews, all MCO plans must have reviews completed on an annual basis to validate network adequacy and performance improvement projects. States should incorporate certain measures to be assessed from these reviews, such as whether a plan effectively meets state criteria. Each state is also encouraged to directly test network adequacy and the accuracy of MCO information given to enrollees. Plans may be exempt if they have a current Medicare Advantage contract or if there are alternative reviews from either Medicare or private accreditation entities. The findings from the independent evaluations must be published by the state for consumer review and comparison.

CMS also requires states to implement a five-star rating system for MCOs participating in Medicaid. The agency will establish measures and methodologies for the rating system to mimic the scheme used to rate qualified health plans in the marketplaces. States will have no later than three years to implement, once CMS publishes the regulations pertaining to the rating systems. In addition, MCOs must establish their own specific quality assessment and improvement programs for contracts beginning on July 1, 2017. To ensure that the various quality improvement programs have the intended effect, states must systematically monitor plans on a range of issues. These issues include but are not limited to: administrative processes, enrollee appeals, marketing, and the availability and accessibility of services. All data collected from the state must be used to improve the overall performance of MCOs in the Medicaid program to ensure beneficiaries get the best possible care.

Missouri must work diligently to ensure that the geographic expansion of managed care does not create negative quality or cost outcomes. Recent studies illustrate that managed care plans achieve shorter lengths of stay but more readmissions after discharge and more emergency room visits. Moreover, the same studies found that MCOs fared worse on 10 out of 18 quality metrics when compared to traditional fee-for-service. Missouri's RFP includes the obligation for the state to contract with independent evaluators for external quality review for MCOs. In 2015, Missouri's MO HealthNet Division contracted

with a private entity to conduct a "secret shopper" survey for Medicaid MCO plans. Although not required, the RFP includes provisions continuing the use of this method to test adequacy and availability. Missouri also has existing requirements on quality improvement and assessment and will continue to implement them through the next bidding cycle. Although the RFP includes some language on monitoring, the state does not currently employ a comprehensive system to be fully compliant with federal regulations.

V. Enrollment & Disenrollment

Federal law and regulations require that states allow certain populations to choose a managed care plan, such as dual eligibles, Native Americans, and children receiving Supplemental Security Income, or in special placements related to disability, foster care, or adoption. There must also be at least two managed care plans for beneficiaries to choose from. To further protect beneficiary choice, the final rule establishes parameters around passive and default enrollment in managed care plans. The rule permits states to use passive enrollment, where individuals are assigned to a plan but also have the opportunity to choose a different plan option for a period of up to 90 days. This is allowable so long as beneficiaries understand the right to make an active choice. The rule also identifies a multitude of factors that states should consider when setting passive enrollment systems, such as previous plan assignment, quality performance, existing provider relationships, accessibility for people with disabilities, and family preference. States must develop rules around default enrollment to ensure that an individual's failure to choose does not create gaps in coverage. Default rules, however, do not require the same level of scrutiny and should only be based on capacity to enroll individuals.

The final rule also tackles the process of disenrollment from managed care plans. States are prohibited from permitting disenrollment when a request to do so is based on a change in health status, use of services, diminished mental capacity, or uncooperative or disruptive behavior related to special needs. Disenrollment for the latter is allowable if continued enrollment would "seriously impair" the ability to furnish services to the individual or other enrollees. Disenrollment can be done for specific reasons, such as moving out of a service area; a need for services not available through a plan's network; or exclusion of covered services by the plan on religious or moral ground. The rule also requires states to utilize a transitional care policy in case a plan contract is terminated for those individuals who would otherwise be harmed by the lack of continuity of coverage. States are required to notify beneficiaries of specific deadlines relating to disenrollment to ensure compliance with notice and the appeals process. These disenrollment provisions will become effective almost immediately on July 5, 2016.

Missouri already requires most of the stated provisions on beneficiary enrollment; therefore, not many modifications are necessary to maintain compliance. Missouri would have to adjust its auto-enrollment process, since the current formula does not take into account existing provider-patient relationships. Moreover, the state will likely have to modify timelines used in the RFP to match those laid out in the final rule.

VI. Network Adequacy

One of the most central parts of the final rule revolves around network adequacy, specifically as it relates to specialized services. The proposed rule would have required network adequacy to be measured through time and distance standards as well as patient-to-provider ratios. Nevertheless, the final rule only requires states to develop time and distance criteria for specific services and providers. These include primary care, obstetrical and gynecology services, behavioral health, specialty care,

hospital care, pharmacy services, dental services, and long-term services and supports. A separate provision requires MCO plans to ensure that their networks include sufficient access to family planning services and to explicitly notify beneficiaries that they do not need a referral to see a provider to access such services. The separate provisions for family planning were justified by CMS, since access to family planning is already specifically protected by allowing for free choice of providers regardless of network. All MCOs or organizations offering Medicaid managed care plans must have up-to-date provider directories that are easily accessible online and in paper form by request. These directories must include not only details about the provider, but also other factors that affect network adequacy, such as expected utilization of services; the number of network providers accepting new patients; geographic location and transportation; the ability of providers to ensure access to accommodations for patients with physical and mental health needs; and availability of culturally competent providers able to appropriately communicate with beneficiaries. In protecting network adequacy, states must receive documentation from managed care plans illustrating the plan's ability to take on enrollees and provide an adequate amount of care. CMS also suggests that states should attempt to use nontraditional methods to improve access to providers, such as telemedicine. The provisions relating to network adequacy will go into effect on or after July 1, 2018.

Plans serving individuals with specialty needs are required to provide evidence of care coordination and continuity of care, with a particular focus on discharge planning and regular sources of primary and specialty care. They must also identify enrollees who would benefit from long-term services and supports and provide expanded access to services for these enrollees. Further, all covered services must be accessible around the clock if medically necessary, and states must monitor such accessibility through effective tracking systems.

In Missouri, access standards for all MCO plans are established by the Department of Insurance. Additionally, Missouri's RFP includes network adequacy standards such as travel distance metrics and appointment wait-time measures. It does not, however, include travel-time standards. CMS guidance on network adequacy for Medicare Advantage plans refers to time standards as travel time only and does not reference appointment times. That being said, the final rule gives states the authority and flexibility to set their standards. Therefore, Missouri is likely compliant until further guidance from CMS says otherwise. CMS did not mandate that states directly test provider networks but allows them to use testing as a means of external quality review. The state already utilizes secret shopper surveys to test network adequacy and availability and will continue to do so as outlined in the most recent RFP.

VII. Enrollee Rights

The final rule requires states to create an independent beneficiary support system to help existing or future beneficiaries understand the enrollment process and their plan options. To promote this function, states should establish standardized forms and booklets to be shared with enrollees to foster better understanding. States must also ensure that MCOs have written policies in place relating to beneficiary rights. Certain rights have been qualified as "specific rights" and require enhanced protection from states. These rights include the right to receive information on treatment and options and for such options to be presented in an appropriate and comprehensible manner. The enrollee also has the right to request and review their medical records free of charge and maintains the ability to request revisions or corrections to their record. The final rule aims to promote patient engagement by allowing for a right to a second opinion from a qualified health care provider. It also places more emphasis on enhancing the provider-patient relationship by safeguarding meaningful communications. MCOs may no longer restrict providers from advising or advocating on behalf of a patient on several issues related to care planning, enrollee rights, and preferences. The final rule also requires MCOs to

contract with providers that are able to communicate in a culturally competent manner and ensure enrollees with differing or special needs are able to have effective communication with the entire care team. The RFP includes some protections for Missouri beneficiaries but not to the extent of the final rules.

VIII. Other Miscellaneous Changes

In addition to the aforementioned revisions to the Medicaid managed care regulations, there are numerous other provisions related to a wide variety of topics. Other areas affected by the final rule include: marketing strategies; medical necessity guidelines; transparency for consumers; information systems; grievances and appeal; choice counseling, and program integrity.

More information on the final rule can be found by visiting here.