The CMS Medicaid Managed Care Final Rule

An Overview for
Behavioral Health Directors

Linnea Koopmans
Senior Policy Analyst
December 14, 2016

Presentation Outline

- CMS Background
- Medicaid Managed Care (MMC) Final Rule Context and Goals
- How the Rule applies to county behavioral health systems
- Sections of Impact
- Process for Analysis and Implementation

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

CMS BACKGROUND

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

CMS Background

- Center for Medicare and Medicaid Services (CMS) is one of 11 operating divisions within the U.S. Department of Health and Human Services[1]
  - Total HHS budget exceeds $1 trillion
- CMS administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)
  - CMS programs are anticipated to serve 125 million Americans in FY 2017[2]

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

CMS Background

- Mission: As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at a lower cost.

MMC FINAL RULE CONTEXT AND GOALS

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

MMC Final Rule Context

- The MMC Final Rule is the first major update to Medicaid managed care regulations since 2002
  - Enrollment in managed care has increased
  - Currently, nearly 2/3 of Medicaid beneficiaries are enrolled in managed care[3]
- The Rule advances CMS efforts to achieve the Triple Aim of better care, smarter spending, and healthier people

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

MMC Final Rule Context

- Updates Part 438 of title 42 Code of Federal Regulations
- Regulations are published in the Federal Register:
  - Proposed regulations – June 2015
  - Final regulations – May 6, 2016 with effective date of July 5, 2016
- Implementation varies by section over the next three years

CMS Goals for the MMC Final Rule

1) Support state efforts to advance delivery system reform and improve quality of care
2) Strengthen beneficiary experience of care and beneficiary protections
3) Strengthen program integrity by improving accountability and transparency
4) Align Medicaid and CHIP managed care requirements with other health coverage programs[4]

HOW THE RULE APPLIES TO COUNTY BEHAVIORAL HEALTH

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

How the Rule Applies to County BH

- The MMC Final Rule applies to:
  - Managed Care Organizations (MCOs)
  - Prepaid Inpatient Health Plans (PIHPs)
  - Prepaid Ambulatory Health Plans (PAHPs)
  - Primary Care Case Managers (PCCMs)

How the Rule Applies to County BH

- Under California's 1915(b) waiver, county mental health plans are designated as non-risk PIHPs for mental health services[5]
- Counties that opt in to the DMC-ODS waiver are designated as non-risk PIHPs for substance use disorder services[6]

How the Rule Applies to County BH

- A PIHP is an entity that:
  1) Provides medical services to enrollees under contract with the State agency, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
  2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees
  3) Does not have a comprehensive risk contract[7]

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

How the Rule Applies to County BH

- Not every section of the regulations apply to county MHPs and DMC-ODS waiver counties
- Rules that generally **do not** apply include:
  - Sections that do not pertain to PIHPs
  - Sections that only pertain to capitated systems
  - Sections that only pertain to risk-based contracts

SECTIONS OF IMPACT

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Sections of Impact: Network Adequacy

- Network adequacy (Section 438.68):
  - Nine elements states must consider to measure network adequacy
  - State must certify networks and EQRO validates
  - States must develop time and distance standards for behavioral health

Sections of Impact: Network Adequacy

- Network Adequacy Con't:
  - States are permitted to have varying standards for the same provider type based on geographic areas
  - Exceptions are permitted but must be stated in the contract and the state must monitor beneficiary access and report findings to CMS
  - *Implementation date: July 1, 2018*

Medicaid Managed Care (MMC) Final Rule

Network Adequacy

CMS Overview of Network Adequacy Provisions in MMC Final Rule

"In order to strengthen access to services in a managed care network, the final rule requires states to establish network adequacy standards in Medicaid and CHIP managed care for key types of providers, while leaving states the flexibility to set the actual standards to better reflect local market and geographic conditions."[1]

Network Adequacy Requirements – Summary of 42 CFR §438.68[2]

- States must develop **time and distance standards** for specified provider types, including behavioral health.
- Network adequacy standards must **cover all geographic areas.**
  - States are permitted to have **varying standards** for the same provider type based on geographic areas.
- Network adequacy standards must consider nine elements, including:

Required Elements of Network Adequacy Standards (42 CFR §438.68)	Existing MHP Network Adequacy Requirement[3]	New Requirement
Anticipated Medicaid enrollment	✓	
Expected utilization of services	✓	
Characteristics and healthcare needs of specific Medicaid populations covered in PIHP contract	✓	
The numbers and types of network providers required to furnish the contracted Medicaid services	✓	
The numbers of network providers who are not accepting new Medicaid patients	✓	
The geographic location of network providers and Medicaid enrollees	✓	
The ability of network providers to communicate with limited English proficient enrollees in their preferred language		✓
Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities		✓
Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions		✓

[1] Medicaid and CHIP Managed Care Final Rule (CMS 2390-F). *Strengthening the Consumer Experience*. April 25, 2016. Accessed via: https://www.medicaid.gov/medicaid/managed-care/downloads/strengthening-the-consumer-experience-fact-sheet.pdf
[2] Medicaid Managed Care Final Rule (CMS 2390-F). Accessed via the Federal Register: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] MHP Contract Boilerplate, Exhibit A Attachment I. http://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf

- The section allows for a **process for states to permit exceptions** for any of the provider-specific network standards.
  - Exception must be specified in the MHP contract and be based on the number of specialty providers practicing in the service area.
  - Where exceptions are granted, states must monitor enrollee "on an ongoing basis" and report findings to CMS.
- States must **publish network adequacy standards on their website**.

Network Adequacy and Medi-Cal Managed Care Plans

- Medi-Cal managed care plans (MCPs) currently have time and distance standards for primary care, OB/GYN providers, and hospital services[4].
  - Knox Keene Act requirement is 30 minutes or 15 miles.
  - DHCS requirement is 30 minutes or 10 miles.
- Time and distance standards are not currently applied to other MCP specialists that would be comparable to county MHP specialty mental health service providers.
- MCPs are also required to comply with provider-to-enrollee ratios for specified providers.
  - For example, the ratio for primary care physicians and total physicians is 1: 1,200.
- While provider ratios are not specified in the MMC Final Rule, DHCS may look to apply ratios to certain MHP provider types.

Other Sections Related to Network Adequacy[5]

- Definition of network provider: 42 CFR §438.2
- Availability of services: 42 CFR §438.206
  - All services covered under State Plan shall be "available and accessible" to enrollees in a timely manner.
- Information Requirements: 42 CFR §438.10
  - Describes provider directory requirements and specifies frequency for updates.
- Assurances: 42 CFR §438.207
  - MHPs are required to provide assurances and documentation to the State that demonstrates their network adequacy. Documentation to be submitted annually or upon significant change in operations.
- EQR Activities: 42 CFR §438.358
  - Requires validation of MHP network adequacy during the preceding 12 months.
- State Responsibilities: 42 CFR §438.602
  - State to post on its website documentation that demonstrates MHP's compliance with requirements for availability and accessibility of services, including network adequacy.

[4] Kaiser Family Foundation. *Medi-Cal Managed Care: An Overview and Key Issues*. March 2, 2016. Accessed via: http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues
[5] Medicaid Managed Care Regulations: Network Adequacy. DHCS Presentation to CBHDA Final Rule Workgroup. October 31, 2016.

Sections of Impact: Beneficiary Supports & Protections

- Grievance and Appeals Requirements (Section 438.408):
  - Shortens timeframe for PIHPs to make decisions about beneficiary appeals
  - 30 calendar days for standard resolution (from 45 days) and 72 hours for expedited resolution (from 3 business days)
  - *Implementation date – July 1, 2017*

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Sections of Impact: Data Quality

- Data Quality (Sections 438.242 and 438.818):
  - Increased data reporting
  - Encounter data standards incorporated into PIHP contracts
  - Connection with managed care section and Medicaid Statistical Information System (MSIS)

Sections of Impact: Data Quality

- Data Quality Con't:
  - State must report to CMS
  - CMS may disallow FFP if out of compliance
  - *Implementation date – July 1, 2017 (encounter data)*
  - *Implementation date – July 1, 2018 (compliance/FFP)*

Sections of Impact: Quality Measurement & Improvement

- Quality Assessment (Section 438.330)
  - Gives authority to CMS to specify performance measures and topics for performance improvement projects (PIPs)
  - CMS to consult with state and stakeholders
  - *Implementation date: July 1, 2017*

Sections of Impact: Quality Measurement & Improvement

- Additional provisions related to quality:
  - Quality strategy (Section 438.340)
    - *Implementation date: July 1, 2018*
  - Quality rating system (Section 438.334)
    - *Implementation date: 3 years after publication*

Sections of Impact: State Monitoring Requirements

- Increased role for state monitoring (Section 438.66):
  - Requires submission Annual Program Assessment Report (APAR) to CMS
  - Ten distinct areas of reporting
  - *Implementation date: July 1, 2017*

Sections of Impact: State Monitoring Requirements

- Increased role for state monitoring (Section 438.602):
  - State enrollment of providers
  - New provider screening elements
  - Additional state oversight requirements
  - *Implementation date: July 1, 2017 or July 1, 2018 depending on subsection*

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Sections of Impact: External Quality Review

- Increased role of EQR:
  - Decrease in FFP match rate for state EQR activities (Section 438.370)
    - *Implementation date: Rule effective date*
  - Validation of network adequacy (Section 438.358)
    - *Implementation date: July 1, 2018*
  - Annual posting of technical report (Section 438.364)
    - *Implementation date: July 1, 2018*

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Sections of Impact: Additional Analysis

- Additional sections of impact under analysis by DHCS and CBHDA
- Other sections of impact in areas such as:
  - Program integrity
  - Program standards to prevent fraud, waste, and abuse

The Final Rule and the IMD Exclusion

- Payments to MCOs and PIHPs for specified IMD stays (Section 438.6(e)):
  - "Allows states to receive FFP and make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD[8]" if certain conditions are met
  - Not applicable to California under current system
    - Mental health PIHPs (MHPs) are non-capitated and non-risk

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Connection with 1915(b) Waiver

- California's 1915(b) waiver special terms and conditions (STCs) will help prepare MHPs for some of the additional requirements in the MMC Final Rule
- Key STC requirements[9]:
  - MHP performance dashboard measuring quality, access, timeliness, translation/interpretation to be posted on DHCS website

Connection with 1915(b) Waiver

- Key STC requirements con't:
  - Tracking requirements related to timeliness and possible timeliness PIP
  - Additional posting requirements to DHCS website including:
    - QI plans
    - Plans of correction
    - Grievance and appeals reports

PROCESS FOR ANALYSIS AND IMPLEMENTATION

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Process for Analysis and Implementation

- DHCS implementation led by Director Jennifer Kent
- Impacts across DHCS divisions, including Mental Health & Substance Use Disorder Services (MHSUDS)
- DHCS implementation strategy includes internal research, external stakeholder input, and provision of guidance to MCOs and PIHPs[10]

Process for Analysis and Implementation

- MHSUDS review process includes all three branches:
  - Mental Health Services
  - Substance Use Disorder Compliance
  - SUD Program, Policy & Fiscal Division
- 11 internal workgroups

Process for Analysis and Implementation

- DHCS-CBHDA Workgroup
  - A subgroup of the Medi-Cal Policy Committee
  - Includes Medi-Cal Policy Chairs, county experts, CBHDA staff, and DHCS leadership and regulatory experts
- Goal of workgroup:
  - Assess impact
  - Build plan for implementation

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Process for Analysis and Implementation

- CBHDA Approach:
  - Encourage flexibility where granted by CMS
  - Utilize county and state expertise
  - Understand existing Medi-Cal managed care requirements
  - When applicable, research requirements of behavioral health or comparable specialty services in other states

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Process for Analysis and Implementation

- MMC Final Rule will require MHP contract amendments
  - Expect in 2017
- Changes to state regulations
- DHCS to develop implementation plans
  - Collaboration with CBHDA Final Rule Workgroup

Process for Analysis and Implementation

- Resources:
  - Eight fact sheets and webinar presentations on CMS website: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html
  - DHCS to report on progress in public stakeholder forums
    - Stakeholder Advisory Committee
    - Managed Care Advisory Group
  - Regular updates in CBHDA Medi-Cal Policy Committee

References

1) HHS – About Us. U.S. Department of Health and Human Services website. Accessed via: http://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html
2) Department of Health and Human Services FY 2017 Justification of Estimates for Appropriations Committees. Accessed via: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf
3) HHS issues major rule modernizing Medicaid managed care. U.S. Department of Health and Human Services website. Accessed via: http://www.hhs.gov/about/news/2016/04/25/hhs-issues-major-rule-modernizing-medicaid-managed-care.html
4) Final Rule Overview. Center for Medicare and Medicaid Services. Accessed via: https://www.medicaid.gov/medicaid/managed-care/downloads/final-rule-overview.pdf
5) California1915(b) Waiver. Delivery Systems. Accessed via: http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf
6) California's 1115 Waiver. CMS Special Terms and Conditions, Drug Medi-Cal Definitions. Accessed via: http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs11-22-16.pdf
7) Medicaid Managed Care Regulations. 438.2 Definitions. Access via: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
8) "Institutions for Mental Disease (IMD) as an 'in lieu of' service." Milliman. Accessed via: http://us.milliman.com/insight/2016/Institution-for-Mental-Disease-IMD-as-an-in-lieu-of-service/
9) 1915(b) Waiver Special Terms and Conditions. Accessed via: http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf
10) DHCS Updates: Managed Care Mega Rule and Other Changes in California. DHCS Presentation at CPCA Annual Conference. October 28, 2016.

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

Contact Info

Linnea Koopmans

Senior Policy Analyst

lkoopmans@cbhda.org

Michele Bennyhoff

Deputy Executive Director

mbennyhoff@cbhda.org

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA