Agenda

• Overview of Managed Care Final Rule, 42 CFR 438
• Impact to Behavioral Health LME-MCO’s
• Timeline and Next Steps
• Questions
Managed Care Final Rule - Overview


- First Update to the Medicaid Managed Care regulations since 2002.

- Seeks to modernize the Medicaid managed care regulations to reflect changes in managed care delivery systems.

- Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017.
Goals of the Final Rule

• To support State efforts to advance delivery system reform and improve the quality of care

• To strengthen the beneficiary experience of care and key beneficiary protections

• To strengthen program integrity by improving accountability and transparency

• To align key Medicaid and CHIP managed care requirements with other health coverage programs.
In Lieu of Services

• Contracts must specify the approved in lieu of services
• In lieu of services are medically appropriate and cost effective alternatives to state plan services or settings.
• Enrollees are not required to use the in lieu of service
• Approved in lieu of services are authorized and identified in the LME-MCO contract.
• The utilization and cost is taken into account in developing the capitation rates.
Institution for Mental Disease (IMD)

- In lieu of option of the State to address access issues for short term acute psychiatric and substance use disorder needs.
- The IMD is an alternative setting to the hospital setting for covered services under the State plan.
- Permits state to make monthly capitation payment to the LME-MCO for an enrollee, aged 21-64, that has a short term stay in an IMD
  - Short term stay: no more than 15 days within the month
Screening of Network Providers

• The State must screen and enroll, and periodically revalidate, all network providers of LME-MCOs.

• Effective July 1, 2017, new Behavioral Health providers will be required to enroll in NCTracks
  – Current Provider Upload process will cease by July 1, 2017.
Screening of Network Providers

• Two changes for these new providers:
  – $100 application fee will be for all enrollments, re-enrollments, reverifications, and additions of site locations. An enrollment fee of $554 may be charged to some providers.
  – Providers in some categorical risk categories will be required to complete screening activities.

• Effective July 1, 2018, Behavioral Health providers currently enrolled in NCTracks will be required to reverify/recredential.
Provider Integrity Requirements

• Designation of a compliance officer who reports directly to CEO and Board of Directors

• Establishment of a Regulatory Compliance Committee on Board of Directors and at the Senior Management level.

• Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks
Provider Integrity Requirements

• Each plan that receives annual payments under the contract of at least $5 million must have policies and procedures written for all employees and any contractor or agent, that provide detailed information about the false claims act including employees rights as whistleblowers.

• Prompt reporting of all overpayments identified or recovered, specifying the overpayment due to potential fraud to the State.

• Contracts must specify:
  - The retention of recoveries of all overpayments from the LME-MCO to a provider.
  - Includes timeframes, process required for reporting the recovery of all overpayments.
Right to Audit

• The subcontractor must agree that the state, CMS, Health and Human Services (HHS) Inspector General, and Comptroller General have the right to audit, evaluate and inspect any books, records, contracts or electronic systems of the subcontractor that pertain to any aspect of services and activities performed or determination of amounts payable.

• The subcontractor will make available for an audit, evaluation or inspection its premises, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.

• The right to audit will exist through ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
External Quality Review (EQR)

• Current EQR activities
  – Assessment of Compliance with Medicaid Managed Care Regulations
  – Validation and Calculation of Performance Measures
  – Validation of Performance Improvement Projects
  – Validation of Encounter Data
  – Validation of Consumer and Provider Surveys
  – Information Systems Capabilities Assessment

• Two new EQR activities
  – Validation of network adequacy
  – Develop the quality rating for LME-MCOs

• States must post on website:
  – Accreditation status of each managed care plan
  – State managed care quality strategy
  – Annual external quality review reports
Continuation of Benefits

• The enrollee must request continuation of benefits before the expiration of the original authorization

• Benefits must continue for the duration of the appeal or State Fair Hearing rather than the current requirement of continued benefits for the length of the original authorization period

• Because enrollees may be held financially liable for continued services if the final decision is adverse to the enrollee, States must create consistent rules for beneficiary financial liability for services in FFS and managed care
Mental Health Parity

• The rule ensures that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP will have access to mental health and substance use disorder benefits regardless of whether services are provided through the managed care organization or another service delivery system. It also prevents inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market (including the state and federal marketplace) and Medicaid and CHIP, and helps promote greater consistency for these beneficiaries.
Mental Health Parity

• The Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans to ensure that the financial requirements and treatment limitations that are applicable to mental health or substance use benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

• States will be required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements, including prepaid inpatient health plans or prepaid ambulatory health plans.
Encounter Data

- Collect and submit encounter data sufficient to identify the provider rendering the service
- LME-MCOs must meet the 95% threshold for acceptance of encounter data through NC Tracks
- Encounter data is required for the following:
  - Rate setting
  - Performance measure reporting
  - Medical record reviews
Encounter Data Validation

• Periodic audits. The State must periodically, but no less frequently than once every 3 years, conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each LME-MCO.

• The reconciliation determines the completeness of encounter data in comparison to the related financial payments and recoupments the LME-MCO made to providers in a period.

• Final encounter data validation is generated after the onside EQR review.
Medical Loss Ratio

• 85% - Minimum MLR

• Actuarially sound rates are set to achieve a MLR of at least 85%

• LME-MCOs calculate and report their MLR experience for each contract year and attest to the accuracy

• Numerator = incurred claims + activities that improve health care quality + fraud reduction activities

• Denominator = premium revenue MINUS taxes, fees, assessments

• The state must perform an periodic audit of the MLR reports at least every three years.

• Annual audited financial reports specific to the Medicaid contract
Next Steps/ Timeline

• Current LME-MCO contracts comply with the majority of the final rule requirements

• DMA is revising LME-MCO contracts to comply with July 1, 2017 requirements

• Draft contracts to LME-MCOs by mid-November 2016

• Final contracts sent to CMS April 1, 2017 with an effective date of July 1, 2017

• Subsequent amendments to comply with provisions with an effective date after July 1, 2017
Contact Information

• Trey Sutten, (919)855-4214, Trey.Sutten@dhhs.nc.gov
• Christal Kelly, (919)814-0056, Christal.Kelly@dhhs.nc.gov
CMS Final Rule 42 CFR 438

Questions?