Medicaid Managed Care Final Rule: Impact to DHCS and Medi-Cal Managed Care Plans

December 2016
Final Rule Overview

**Background**
First major overhaul of the managed care regulations since 2002
- Response to the major shift to the managed care delivery system nationwide
- Directed at states to ensure compliance with Medicaid managed care plans (MCPs) and downstream effects to beneficiaries

**Recurring Themes**
Aligns the Medicaid managed care program with other health insurance coverage programs (i.e., Marketplace, Medicare Advantage)
- Adds many consumer protections to improve the quality of care and beneficiary experience
- Improves State accountability and transparency
- Inclusion of Long Term Services and Supports (LTSS) needs

**Implementation Dates**
Effective July 5, 2016
- IMD and in-lieu-of-services provisions effective July 5, 2016
- Phased implementation over three years, starting with the July 1, 2017 contract rating period
Major Provisions at a Glance

- **Beneficiary Information Requirements**
- **Grievances and Appeals**
- **Cultural Competency**
- **Care Coordination**
- **Quality Assessment and Performance Improvement**
- **Prescription Drugs Utilization Review**
- **Program Integrity**
- **State Monitoring & Oversight Requirements**
  (with Annual Managed Care Program Report due in 2018)

**Managed Care Quality Strategy**

- **Network Adequacy Provider Screening and Enrollment**
- **Annual Network Certification**
- **Beneficiary Support System**

**EQRO Validation of Network Adequacy Quality Rating System**

- **2019 and beyond**

**July 1, 2017 contract rating year**

**No later than July 1, 2018 contract rating year**
Key Provisions: 2017

**Beneficiary Information Requirements**
- Beneficiary communication via email and text
- State operated website with plan specific information (e.g. Provider Directories, drug formularies)
- Model handbook and template notices
- Non English taglines in beneficiary materials

**Grievances and Appeals**
- Timeframes for resolution of appeals shortened to 72 hours
- Requires gender identity be included as a component of culturally appropriate care
- Requires that appeals are exhausted at the plan level before proceeding to a State Fair Hearing

**Access and Cultural Competency**
- Requires gender identity be included as a component of culturally appropriate care

**Care Coordination**
- Apply to all appropriate settings including behavioral health settings and LTSS

**Quality Assessment and Performance Improvement**
- MCP Performance Improvement Projects (PIPs) must include mechanisms to assess beneficiaries using LTSS and/or with special health care needs
Drug Utilization Review (DUR)

Drug Utilization Review requirements as defined in 42 CFR 456, Subpart K and annual reporting requirement

Program Integrity

Data certification
- Overpayments policy for plan recoveries due to fraud, waste, and abuse
- Ownership and control disclosures
- 10 year records retention period and right to audit
- Increased sanctions limit

State Monitoring & Oversight

Public posting of MCP compliance and performance

Health Information Systems

MCP encounter data submissions to the State must be per CMS specifications

MCP Accreditation Status

Public posting of each MCP’s accreditation status
# Key Provisions: 2018

<table>
<thead>
<tr>
<th>Quality Strategy</th>
<th>Network Adequacy</th>
<th>Encounter Data</th>
<th>Provider Enrollment and Screening</th>
<th>Beneficiary Support System</th>
<th>Annual MCP Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>New elements include plan to identify and reduce health disparities, transition of care policy, and a plan to identify individuals needing LTSS or with special health care needs.</td>
<td>Time and distance standards for specialized provider types.</td>
<td>Federal Financial Participation (FFP) is contingent on encounter data submission per CMS specifications.</td>
<td>All Medi-Cal providers must be screened and enrolled by the State.</td>
<td>Choice counseling and assistance to beneficiaries post-enrollment, including LTSS.</td>
<td>Annual Program Assessment Report due to CMS.</td>
</tr>
</tbody>
</table>
Key Provisions: 2019 and Beyond

Network Adequacy
New mandatory EQRO activity to validate network adequacy

Quality Rating System
Plan rating system based on a common set of performance measures
Implementation Components

- Deliverables Review and Approval
- Workgroups
- Statutes and Regulations
- All Plan Letters
- Contract Amendments
### Implementation Strategy

<table>
<thead>
<tr>
<th>Internal research</th>
<th>External Stakeholder Input</th>
<th>Plan Guidance</th>
</tr>
</thead>
</table>
| • Conducted gap analysis of Final Rule provisions in contrast with current requirements to identify impact  
• Consulted with areas across the Department for input on policy and operational considerations | • Engage the Medi-Cal managed care health plans (MCPs) and stakeholder groups including the DHCS Stakeholder Advisory Committee, Managed Care Advisory Group, topic-specific workgroups, and external partners such as the Department of Managed Health Care (DMHC)  
• Collaborate on development of materials, deliverables, and/or processes prior to implementation | • Provide guidance to assist MCPs with implementation on each of the activities via All Plan Letters and contract amendments  
• Provide deliverables requirements to the MCPs on a flow basis throughout the implementation phases  
• Roll out contract amendments per implementation year |