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Managing Partners
Mark T. Benton
Amy R. Hobbs
Shawn P. Parker
John A. Thompson

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BACKGROUND

Session Law 2015-245 (HB 372) calls for the single largest transformation and reorganization of NC's Medicaid and Health Choice programs since their implementation in 1970 and 1998, respectively. The law calls for greater budget predictability and accountability, improved quality and patient satisfaction, and increased efficiency of and sustainability for these two publicly-funded health care programs.

HB 372 shifts much of the current state-level operations for both programs to a collection of three statewide and (up to) 10 regional, capitated managed care plans that are also referred to as pre-paid health plans (PHPs). Functions to be transferred to the PHPs include:

- claims payment
- rate setting
- care management
- prior approval & utilization management
- grievance & appeals
- identification/prevention of provider fraud & abuse

In all, nearly 70+K health care providers and at least 1.5 million of 1.8 million recipients will be impacted by this reform effort. HB 372 also transfers the state-level oversight and administrative activities for Medicaid and Health Choice to a newly created Division of Health Benefits (DHB) within NCDHHS. DHB has also been directed to maintain a separate fee-for-service program for services rendered to the dual eligible population (those eligible for both Medicare *and* Medicaid) and for all dental services. That's because the reform law "carves out" these individuals and dental care from being managed by a PHP.

Additionally, HB 372 creates a new legislative supervisory body, the Joint Legislative Oversight Committee on Medicaid and Health Choice (JLOCMHC), which is expected to meet monthly and to whom a variety of updates and reports will be submitted throughout calendar years 2016-17.

NATIONWIDE MOVEMENT

Managed care has become the dominant means by which Medicaid and Health Choice services are organized, delivered and financed in the US. Until the passage of HB 372, NC was one of small handful of states (and the largest of those states) not to have embraced the managed care movement.

The US Centers for Medicare & Medicaid Services (CMS) – the federal agency that oversees all state Medicaid and Health Choice programs – reported recently that 58 percent of all program recipients across the country were enrolled in a risk-based managed care plan through which they obtained some, most or all of their health services. Some estimate that figure to increase to 70% by the end of 2015, and NC's entry in managed care will only serve to drive this rate higher.

HB 372 KEY DEADLINES

Shifting Medicaid and Health Choice from fee-for-service to managed care is not a task that can be accomplished overnight. Done correctly, it takes many months of planning, a 1-2 year period of federal review/approval, followed by months of implementation. With this in mind, HB 372 establishes the following deadlines to accomplish this task:

410 North Boylan Avenue
Raleigh NC 27603
Phone: 919-256-3982

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March 1, 2016: DHHS submits a lengthy progress report to the legislature that includes, among other things, a draft of the paperwork to be submitted to the federal government.

June 1, 2016: DHHS submits paperwork to the federal government.

January 31, 2017: DHHS submits report to the legislature on the work of an advisory committee charged with developing a strategy to serve the dual eligible under capitated PHPs.

TBD: Eighteen months following federal approval, PHP contracts shall commence. At this time, DHHS must terminate its contract with Community Care to provide primary care case management services and support this medical home model. PHPs will be responsible from that point forward with providing these functions.

TBD: Twelve months after PHP contracts begin (or sooner), the Division of Medical Assistance will be eliminated and all Medicaid & Health Choice oversight functions shall shift to the Division of Health Benefits.

COUNTY IMPACT

Now and after the transition to managed care, county departments of social services (DSSs) will have responsibility for determining a recipient's eligibility for Medicaid and Health Choice, based upon criteria set by the legislature. It is possible that the function of assigning a recipient to a primary care physician (now a county DSS function) might shift to PHPs at the time their contacts commence. And DSSs will continue their role in investigating instances of recipient fraud and abuse.

Because HB 372 does not carve out "non-emergency medical transportation" (NEMT), it is presumed that PHPs would take from county governments the responsibility for providing this service. If that presumption is correct, PHPs could contract with counties for NEMT. The reimbursements rate for that service would be set by the PHP and would be governed by any prior approval or utilization management criteria they might impose.

Local health departments (LHDs) will continue to play a critical role in providing services and maintaining the healthcare safety net. In fact, HB 372 identifies LHDs as one of four groups of "essential providers" that PHPs must include in their respective provider networks. Other essential providers include federally qualified health clinics (FQHCs), rural health clinics, free clinics and others so identified by DHHS.

Local Management Entities/Managed Care Organizations (LME/MCOs) will continue to manage behavior health services until four years from the start of the PHP contracts. It is presumed that PHPs would then take responsibility for managing these behavioral health services. If that presumption is true, PHPs could subcontract with one or more LME/MCOs to continue managing these services.

The shift to managed care should have no impact on a county's receipt of Medicaid and Health Choice revenue/reimbursement, expect for those services noted above that might be managed by a PHP and where the PHP either sets a lower reimbursement rate or opts to secure those services from another vendor.

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Summary of the Proposed Rules on Medicaid Managed Care

On June 1, 2015, CMS published 100 pages of proposed rule changes that, if adopted, would make sweeping changes to Medicaid managed care programs. This is the first, major overhaul of these rules in over a decade and – in CMS' words – strive to "modernize the regulatory structure to support delivery system reform, improve health outcomes and the beneficiary experience, while also effectively managing costs."

This summary provides a brief description of the existing managed care rules as well as a high-level overview of the proposed rules. The opportunity to offer input on the latter ended on July 27th. CMS was expectantly deluged with comments, so a revised set of final rules aren't expected to be issued until 2016.

Existing Rules for Medicaid Managed Care

States currently design, administer and oversee their own Medicaid managed care programs within a relatively minimal federal regulatory framework. Last updated in 2002, the current federal rules set forth responsibilities and requirements in areas such as beneficiary rights and protections, quality assessment, provider access, grievances and appeals, program integrity and sanctions. Some of the more notable existing federal rules include:

- States must ensure that network plans are adequate and enrollees have timely access to services
- States can require that recipients have the choice of at least two plans (except in rural/underserved areas)
- Recipients can change plans within the initial 90-day enrollment period and annually thereafter
- Recipients who do not pick a plan can be "auto-assigned" to a plan
- Plans must assist the State in its efforts to make information available/accessible to non-English-speaking and the disabled populations
- Plans must have quality improvement plans; States have wide latitude in assessing/monitoring that quality and establishing performance improvement requirements
- Plans are required to submit encounter data – the format and timing of which are determined by the State
- Plans are required to have in place a compliance plan to guard against fraud, waste and abuse; however, States are NOT required to audit payments to and by the plans
- Capitated rates paid to plans are required to be actuarially sound; there is no current federal cap on what's spent by a plan on administrative costs.

High-Level Summary of Proposed Rules

CMS stated that it had four objectives in mind when developing their proposed rules for Medicaid managed care plans. Those objectives were: (1) achieve better alignment with other insurers, particularly Medicare Advantage plans; (2) promote delivery system reform; (3) improve beneficiary protections and the quality of care provided by managed care plans; and (4) foster improvements in payment and accountability.

Key provisions of the proposed rules are:

Medical Loss Ratio: A MLR measures how money is spent on direct patient care versus administration (e.g., a higher MLR % = more spending on patient care). As of 2017, managed care plans would be required to calculate/report a yearly medical loss ratio (MLR) with a minimum floor of 85%. States have the options of establishing a higher MLR higher and requiring a remittance payment from plans failing to meet the MLR.

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Network Access and Adequacy: States would be required to develop specific "time and distance standards," with an emphasis on the following provider types: primary care, OB/GYN, hospital, pharmacy, pediatric dental, behavioral health and long-term services and supports (LTSS). In setting these minimum standards, States would have the ability to account for the number of existing providers practicing in a given geographic area. On a related note, the proposed rules also identify a series of elements that States must consider in defining/calculating what would constitute an adequate supply of providers.

Plan Choice: Provides Medicaid recipients with at least 14 calendar days to choose a managed care plan during which time any expenses would be covered under a traditional Medicaid fee-for-service (FFS) system.

Beneficiary Support: Requires States and plans to establish a support system that provides services to beneficiaries both before and after enrollment in a managed care plan.

Quality of Care: Requires States to develop/adopt a rating system for their participating managed care plans and also requires plans to be accredited as a prerequisite to contracting with a State.

IMD Exclusion: Since 1965, CMS has prohibited Medicaid payments for individuals aged 21-64 years old that receive care in an "Institute for Mental Disease" or IMD. An institute is defined as a "hospital, nursing home or other facility with more than 16 beds that is primarily engaged in the diagnosis, treatment and care of persons with a mental disease." The proposed rules would allow for payments made to a managed care plan to include care for patients receiving treatment in an IMD for 15 days or less.

Payment: Permits States to set minimum fee schedules that must be adhered by all Medicaid managed care plans. Also allows States to require plans to engage in "value-based purchasing" initiatives and/or align their payment methods with multi-payer initiatives. The proposed rules also appear to allow States to require plans to participate in patient-centered medical home and other prevention efforts and to connect to a health information exchange (HIE).

Prescription Drugs: Requires Medicaid managed care plans (that offer drug coverage) to respond to prior authorization (PA) requests for drugs within 24 hours and to provide a 72-hour emergency supply of drugs that require PA. And unless mandated by a State, the proposed rules do not require plans to cover all prescription drugs covered under Section 1927 of the Social Security Act. That particular section of the law requires State Medicaid programs to cover all drugs whose manufacturer has signed a drug rebate agreement with the federal government. Drugs not covered by a managed care plan (but whose manufacturer has a signed a rebate agreement) would have to be made available by and paid for by the State.

Provider Enrollment: Requires States to screen and enroll all Medicaid providers that participate in a Medicaid managed care plan.

Program Integrity: Expands and strengthens existing requirements on plans to submit encounter data to the state and federal government; also beefs-up minimum fraud and abuse detection activities to be undertaken by all managed care/pre-paid plans.

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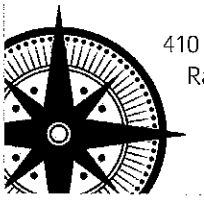
Public Policy Consulting

Mark T. Benton
Managing Partner

Ph: 919-256-3982
M: 919-985-6444

Benton@theparatumgroup.com
www.TheParatumGroup.com



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