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CLIENT ADVISORY:

CMS PROPOSES SUBSTANTIAL CHANGES TO MEDICAID MANAGED CARE RULES

Modernizing Medicaid

On May 27, 2015, CMS released a proposed rule that would "modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems." The first major update to Medicaid managed care regulations in over a decade, the rule seeks to reduce the significant variability and inconsistency among the nation's many Medicaid managed care plans.

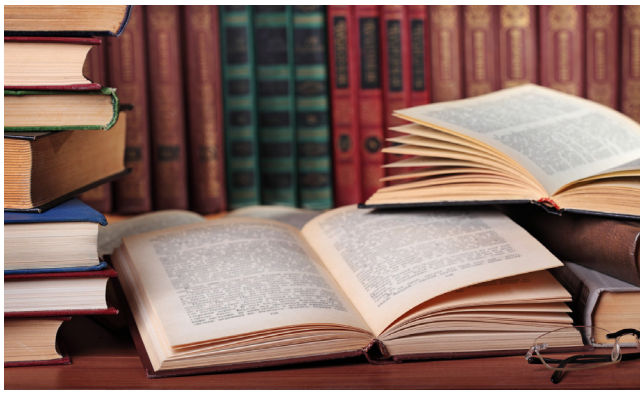
These proposed changes are both substantial and broad-reaching, covering a full 200 pages of the Federal Register. CMS categorizes its proposals into several key areas, including: beneficiary experience; state delivery system reform; quality improvement; program and fiscal integrity; managed long-term services and support programs; Children's Health Insurance Program ("CHIP") quality and access; and alignment with Medicare Advantage and Qualified Health Plans.

While each of these key areas will see meaningful changes, several proposed initiatives merit particular attention, given the impact they will have on the structure, operation, and finances of plan providers. Whether to provide comments to CMS by the July 27th deadline, or simply to capture as much of a head start as possible, plans should do all they can to understand and adjust to the sweeping changes coming their way.

Medical Loss Ratio

Perhaps the most contentious of CMS' proposals is the institution of an 85 percent Medical Loss Ratio ("MLR"). Few Medicaid managed care plans have an MLR near 85 percent, meaning that plans will have to address administrative costs across many fronts as they seek to come in line with this new requirement.

One major opportunity to impact a plan's MLR involves "activities that improve healthcare quality." Under the proposed rule, administrative costs do not include such initiatives. The rule defines these activities by reference to present CFR provisions related to Medicare Advantage and Part D plans, and includes a requirement that the activities be evidence-based or standard-of-care, capable of objective measurement and capable of producing verifiable results.



Plans presently engage in varying types of quality improvement activities. While some focus more on reducing cost and utilization, others genuinely strive to improve quality outcomes. True quality initiatives, such as those aimed at increasing the health status of high risk patients, may involve costly efforts such as data mining, identifying co-morbidities that respond to treatment interventions, and developing and overseeing care plans. Much of this activity may presently be classified as administrative cost. Going forward, however, plans should make a detailed accounting of the activities that meet the "quality" criteria, and develop a strong legal rationale for their inclusion in the numerator of the MLR calculation.

Another expense that may be moved out of the administrative category is fraud prevention. The MLR numerator may be increased by up to 0.5 percent of premium revenues for the cost of work performed by employees that directly carry out fraud prevention activities, as well as the cost of the associated data analytics and technological infrastructure that support those activities.

The proposed rule sets forth numerous characteristics of fraud prevention activities that qualify for inclusion in the MLR numerator. Thus, plans should be diligent in justifying the fraud prevention activities they seek to include in their MLR numerator.

Compliance Program Revisions

Plans can expect to make major enhancements to their program integrity and compliance programs. The proposed rule goes far beyond the standard "seven elements" of an effective compliance program, giving detailed instructions regarding both program structure and administrative procedures. As one example, Compliance Officers must now report directly to both the CEO and the board of directors. Plans must also now have Compliance Committees at both the board and the senior leadership level. Several new mandatory reporting requirements are proposed, along with obligations related to service-delivery verification, mandatory referral to program integrity and fraud control units, and suspension of payments to providers.

Data Submission and Certification

CMS' top-down emphasis on compliance is mirrored by its proposals regarding data submission and certification. Under the proposed rule, a much wider array of data must be submitted, and certification may no longer be delegated. Either the plan's CEO or CFO must be "personally responsible for the accuracy, completeness, and truthfulness of the reported data, documentation, or information." Further, the certification must be based upon a "reasonably diligent review of the data, documentation, and information specified." Previously, this "reasonably diligent" standard had only been applied to Medicare Advantage overpayments; this is the first instance of CMS applying it to the certification process itself.

Part of a Larger HHS Initiative

This emphasis on the compliance program and top-level certification comes in conjunction with a document recently published by the HHS OIG entitled "Practical Guidance for Health Care Governing Boards on Compliance Oversight." An unprecedented joint product of the OIG, the Association of Health Insurance Plans, the American Health Lawyers Association, and the Health Care Compliance Association, this guidance sets forth numerous compliance-related expectations for health care governing boards, going so far as to advise that boards expand membership to include persons with health care compliance expertise, or that they develop relationships with external compliance counsel or consultants.

This guidance also recognizes the key role of internal counsel, who may be uniquely positioned to marshal the internal and external resources needed to develop a robust compliance program, facilitate active board oversight, and give the CEO and CFO confidence when they affix their signatures in certification of the plan's data submissions.

Information Requirements

Many of CMS' proposed rules will involve significant cost, labor hours and management focus, even if outsourced. For example, plans must make significant changes relating to information shared with enrollees to ensure that all information and notices are "provided in a manner and format that may be easily understood and readily accessible by enrollees." Complex revisions and reformatting may be required to ensure that the content and format of information provided is compliant.

Among other things, plans must provide information on the basic features of managed care, covered benefits, how and where to access benefits, and cost sharing mechanisms. There are detailed instructions as to font size, tagline content, and availability of non-English language materials. Plans may provide information electronically, but only if the information is also placed on a website that is prominent and readily accessible, provided in a form that can be electronically retained and printed, and consistent with other content and language requirements.

Grievance and Appeals

To align Medicaid practices with Medicare Advantage and group health plan practices, CMS proposes significant changes to plans' grievance and appeal procedures.

Plans must acknowledge receipt of every grievance and appeal, and must provide a response to appeals within a shortened timeframe (reduced from 45 calendar days to 30 for standard appeals and from 3 working days to 72 hours for expedited appeals). Plans must also accept oral submissions of appeals and grievances, and must follow up in writing.

Adverse benefit determinations must now include the reasons for the adverse determination and the right of the enrollee, upon request and free of charge, to be provided reasonable access to copies of information relevant to the claim. Plans must give enrollees notice and a reasonable opportunity to present evidence and testimony regarding grievances and appeals, both in writing and in person.

Finally, individuals who make final decisions on grievances and appeals and their subordinates cannot be involved in any previous level of review, which could result in the need for staff realignments.

Delegation Requirements

Current standards for plans that delegate responsibilities to subcontractors under their contract with the state will be replaced with new standards modeled on the Medicare Advantage requirements related to relationships with first tier, downstream and related entities. These new standards are applicable to every contract and written arrangement that a plan has with any individual or entity that relates directly or indirectly to the performance of the plan's obligations under the contract with the state.

Delegates and subcontractors must agree to perform in accordance with the contract between the plan and the state, and agreements with delegates and subcontractors must either provide for revocation or specify other remedies in instances where the delegate or subcontractor has not performed satisfactorily. Contracts must also require delegates or subcontractors to allow audits by the state, CMS and OIG in connection with services related to contracts with the state.

Importantly, the rule makes it clear that the plan is solely accountable for complying with contracts with the state, regardless of whether services are delegated or subcontracted. Accordingly, plans must conduct a full review of all contracts and implement a sufficient delegate and subcontractor monitoring program to ensure compliance with the new standards.

Network Adequacy Requirements

While CMS defers to states the development and enforcement of network adequacy standards for Medicaid managed care plans, the proposed rule contains new standards for states to follow, based on the Medicare Advantage program. Plans may use the standards proposed by CMS to get a sense of what states may impose and the changes that may be necessary as a result.

For example, CMS proposes that states at a minimum set time and distance standards that include all geographic areas covered by the managed care program for primary care, OB/GYN, behavioral health, specialists, hospitals, pharmacy, and pediatric dental. Other factors for states to consider include anticipated enrollment, expected utilization, characteristics and needs of the population covered, the number of providers not accepting new patients, and the ability of providers to communicate with limited English-proficient enrollees.

In addition to ensuring compliance with network adequacy standards, plans must maintain and monitor their network of providers, as well as take corrective action against non-compliant providers. Plans must also coordinate with out-of-network providers for payment and ensure that the cost to the enrollee is not greater than that for services provided in-network. This could be a major operational change if plans have required enrollees to coordinate out-of-network payments in the past.

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State Monitoring

CMS recognizes the importance of strong state management and oversight of managed care and proposes to modernize state monitoring standards. Plans must be prepared for state review of almost every area of their businesses, including: administration and management; appeal and grievance systems; claims management; enrollee materials and customer services; financing, including MLR reporting; information systems, including encounter data reporting, quality improvement and program integrity, to name a few.

Unprecedented Change Ahead

This 200-page proposed rule contains the most comprehensive changes to the Medicaid managed care program in over a decade. While CMS believes that all stakeholders will benefit from these changes, there is no denying the impact they will have on managed care plans. Entities that begin to address these changes now will find themselves ahead of the pack when these proposed rules are made final by CMS.

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