Joint Informational Hearing

Implementation of the Medicaid Managed Care Rule
Tuesday, February 28, 2017 - 2:00 pm
State Capitol, Room 4202

Background

Overview

In 2016 and early 2017, the federal Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services (DHHS) finalized two Medicaid and Children's Health Insurance Program (CHIP) managed care regulations that have a significant impact on California's Medi-Cal program in several areas, including how the state pays Medi-Cal managed care plans, how the plans pay health care providers, the grievance and appeals process for Medi-Cal beneficiaries who are enrolled in plans, and access to health care providers in Medi-Cal managed care plan and county specialty mental health networks. The changes in the rules were the first update to Medicaid and CHIP managed care regulations since 2002. The key stated goals of the federal rule are:

- 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; and,
- To align key Medicaid and CHIP managed care requirements with other health coverage programs.

The rule sets forth requirements that states with Medicaid managed care must meet, options in how states meet those requirements, and gives states flexibility to establish different requirements than those contained in the federal rule. The focus of this hearing is to provide an overview of those provisions of the rule that have a significant fiscal impact on California's Medi-Cal managed care delivery system or where California has policy choices in implementing the rule.

Background

The Medi-Cal program is projected to cover 14.1 million Californians each month in 2016-17, at a cost of $100 billion in total funds ($19.6 billion General Fund). The California Department of Health Care services (DHCS) administers Medi-Cal through two types of delivery systems: managed care and fee-for-service (FFS).

DHCS contracts with 22 Medi-Cal managed care plans across California, 56 county specialty mental health plans, and two primary care case management plans (AIDS Healthcare Foundation [AHF] and Family Mosaic). Approximately 79% of the 14.1 million Medi-Cal beneficiaries (11 million Medi-Cal beneficiaries) receive care through a Medi-Cal managed care plan,[1] a significant shift from December 2011, when only approximately 45% of beneficiaries were enrolled in Medi-Cal managed care.

Medi-Cal managed care enrollment has increased as a percentage of overall Medi-Cal enrollment for several reasons, including:

- The expansion of the program as a result of the federal Patient Protection and Affordable Care Act (ACA);
- An expansion of managed care to parts of the California that were previously in FFS (the "regional" expansion to 18 small and rural counties);
- The end of the Healthy Families Program (which was previously California's CHIP program) and the shift of those children to Medi-Cal managed care;
- The requirement that seniors and persons with disabilities enroll in a Medi-Cal managed care plan; and,
- The implementation of the CalMediConnect program in seven counties, which requires individuals dually eligible for Medi-Cal and Medicare to enroll in a combined Medicare/Medi-Cal plan.

In addition to an increases in plan enrollment, the scope of Medi-Cal benefits delivered through Medi-Cal managed care plans has expanded, such as the inclusion of "mild to moderate" mental health treatment and Community-Based Adult Services (previously known as Adult Day Health Care) in the benefits provided by the plan.

Health Care Delivery in Medi-Cal

In California, there are six primary models of managed care, as follows:

- *County Organized Health Systems (COHS)* – In 22 counties, COHS plans operate, and in general, there is only one plan[2] organized by the county board of supervisors in the following counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. In December 2016, there were 2.2 million Medi-Cal beneficiaries enrolled in COHS plans.
- *Two-Plan* – Fourteen counties operate a two-plan model where there are two plans (one commercial and one county-organized local initiative in the following counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. In December 2016, there were 6.9 million Medi-Cal beneficiaries enrolled in the two-plan model plans.
- *Geographic Managed Care (GMC)* – In two counties (San Diego and Sacramento), there is a GMC model, where four or five plans participate depending on the county. In December 2016, there were 1.2 million Medi-Cal beneficiaries enrolled in the GMC model plans.
- *Regional* – In 18 more rural counties, there are two commercial plans in the following counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. In December 2016, there were 300,151 Medi-Cal beneficiaries enrolled in the regional model plans.
- *Imperial* – In Imperial county, there are two commercial plans. In December 2016, there were 75,137 Medi-Cal beneficiaries enrolled in two plans.
- *San Benito* – In San Benito county, there is one commercial plan, and beneficiaries can choose either the plan or Medi-Cal FFS (Medi-Cal FFS is not affected by the managed care rule changes in San Benito County). In December 2016, there were 83,229 Medi-Cal beneficiaries enrolled in the commercial plan.

In addition, the two primary care case management entities contracting with DHCS (AHF in Los Angeles and Family Mosaic in San Francisco) are also subject to the rule, but have limited enrollment. AHF has 726 Medi-Cal beneficiaries enrolled, while Family Mosaic had 26 Medi-Cal beneficiaries as of December 2016.

Dental services provided through Medi-Cal are known as Denti-Cal, and are primarily provided through FFS, except in two counties (Sacramento and San Diego). In Sacramento County, enrollment in a Denti-Cal managed care plan is mandatory for Medi-Cal beneficiaries. In Los Angeles County, enrollment in a Denti-Cal managed care plan is optional for beneficiaries. Denti-Cal managed care plans are also subject to the federal rule. According to a 2016 DHCS report, between the two counties, there are approximately 932,000 beneficiaries receiving care under Denti-Cal managed care.[3] The provisions of the federal rule also apply to the 56 county specialty mental health plans that provide mental health services to Medi-Cal beneficiaries with a severe mental illness (two counties are served by one plan).

Medi-Cal Managed Care Plans and Directed Payments to Providers

One of the most significant changes in the federal regulations is a prohibition (with exceptions) against states directing Medicaid managed care plans' expenditures under the contract with the state.[4] Directed payments are amounts paid to Medi-Cal managed care plans but directed by the state to certain health care providers. These payments have historically been referred to as "supplemental payments" in that they are payments from Medi-Cal plans to providers separate from specific services rendered.

California (and many other states) makes supplemental payments through Medi-Cal managed care plans in several forms. California has used supplemental payments as a way to increase federal Medicaid payments to providers using intergovernmental transfers (IGTs) from counties and other public providers as the source of funds to draw down federal Medicaid funds. These IGT funds are then matched with federal Medicaid funds and returned (through the Medi-Cal managed care plan) to those providers as supplemental payments. The state budget benefits from this arrangement for some IGTs by taking a 20% administrative fee on the amount of the IGT[5].

In addition to IGTs, most private hospitals pay a fee referred to as a quality assurance fee (QAF). The state budget benefits from this fee as 24% of the QAF revenue is used to offset General Fund expenditures for children's health coverage, with the remainder primarily used to match federal Medicaid funds to provide additional funds to hospitals, including $3.5 billion in 2015-16 paid to hospitals through Medi-Cal managed care plans. Voter approval of Proposition 52 on the November 2016 ballot, made the hospital QAF program permanent in California law and the State Constitution.

The federal rule contains exceptions to the prohibition against directed payment by allowing a phase down of "pass-through" payments from plans to hospitals over 10 years, and by allowing directed payments in the following circumstances:

- The state can require the plan to implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or,
- The state can require plans to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

Under the rule, a state can also require a plan to:

- Adopt a minimum fee schedule for network providers that provide a particular service under the contract;
- Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract; or,

- Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

Any directed payments must be developed in accordance with actuarial soundness rate requirements, generally accepted actuarial principles and practices, and have written approval prior to implementation. To obtain written approval, a state must demonstrate, in writing that the arrangement is based on the utilization and delivery of services, and meet specified criteria.

The effect of the changes in the Medicaid federal rule is to require a change in how IGT payments to providers (primarily public hospitals) and QAF payments to public and (primarily) private hospitals are made from plans to hospitals.

If the state shifts IGT and QAF pass-through payments to federally permissible directed payments, the payments has to meet the federal requirements. Specifically, the directed payment must be made to "network providers" when existing managed care payments are made to non-contracting and contracting hospitals. In addition, the directed payments must be based on the utilization and delivery of service and the federal fee schedule/uniform dollar or percentage increase requirements, as compared to existing QAF payments, which are made based on historical utilization using a sophisticated financial model to maximize the benefit of the revenue generated by the QAF and provide certainty to payors of the QAF.

For public providers who use IGTs, the rule poses similar challenges, as the current process is retrospective and based on the existence of "rate range room" (described below) for IGT payments to be made to plans. In addition, the current IGT process provides certainty to the entities making the IGT that they will receive the amount they put up and more back in federal funds in return.

The directed payment provisions apply to rating periods for contracts starting on or after July 1, 2017.

"Rate Range" Change

The May 2016 rule effectively prohibits the use of "rate ranges" when states set Medicaid managed care plan rates. The rule requires states to certify the final capitation rate paid per rate category of aid (COA) (an example of a COA rate category would be the rate for a child, an adult and aged/disabled individuals) under each risk contract and document the underlying data, assumptions and methodologies supporting that specific capitation rate.[6] CMS must review and approve the capitation rates as actuarially sound.[7] This effectively requires that the Medi-Cal rate-setting process to be a prospective specific rate (and not a range), and limits the ability of states to use rate range room to fund additional federal fund payment through plans.

DHCS' Medi-Cal managed care rates for full service plans are developed in conjunction with Mercer (a consulting firm) using COA group-specific rate ranges. The state publishes three rates, but typically pays rates at the lower bound of the rate range, as shown below for a child in 2014 paid to a county organized health system plan in a particular county:

Category of Aid	Lower Bound	Midpoint	Upper Bound
Child Rate	$99.86	$104.21	$108.56

If funds can be located to fund the non-federal share of the rate through an IGT (i.e. from county hospitals, the University of California, or fire departments), a rate increase may be granted up to the upper bound of the rate range. The use of rate ranges has enabled DHCS to limit General Fund spending and to draw down additional federal funds to support safety net and public providers while using local IGT funds as the required federal match. States utilize rate ranges for multiple reasons in paying different managed care plans varying capitation rates, including as a method to stabilize the safety net delivery system by directing payments to safety net providers.

Time and Distance Standards

The May 2016 rule requires states to develop time and distance standards for the following provider types[8], if covered under the contract:

- Primary care, adult and pediatric;
- OB/GYN;
- Behavioral health (mental health and substance use disorder), adult and pediatric;
- Specialist, adult and pediatric;
- Hospital;
- Pharmacy;
- Pediatric dental;
- Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards;
- Long-term services and supports (LTSS) (for plans with contracts which cover LTSS), for LTSS provider types in which an enrollee must travel to the provider to receive services; and,
- Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

States are allowed to have varying standards for the same provider type based on geographic areas. In developing the network adequacy standards, states must consider, at a minimum, the following elements:

- The anticipated Medicaid enrollment;
- The expected utilization of services;
- The characteristics and health care needs of specific Medicaid populations covered in the plan contract;
- The numbers and types (in terms of training, experience, and specialization) 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, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees;
- The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
- The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities; and,
- The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

States developing standards for LTSS providers must also consider the following:

- Elements that would support an enrollee's choice of provider;
- Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee; and,
- Other considerations that are in the best interest of the enrollees that need LTSS.

If states allow an exception to any of the provider-specific network standards developed, the standard by which the exception will be evaluated and approved must be specified in the plan contract and based, at a minimum, on the number of providers in that specialty practicing in the plan service area. States that grant an exception to a plan must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under federal rules. States must publish the standards on their Website, and the information must be made available at no cost to enrollees and available for people with disabilities in alternate formats or through the provision of auxiliary aids and services upon request.

California has time and distance standards in statute, regulation and contract for Medi-Cal managed care plans for primary care physicians and hospitals but not specialists. Medi-Cal

requires in its managed care contracts that a primary care physician be within 10 miles or 30 minutes of the beneficiary's residence, and that a hospital be available within 15 miles or 30 minutes. In addition, California has appointment time elapsed standards for physicians, as follows:

Urgent Appointments	Wait Time
For services not needing prior approval	48 hours
For services needing prior approval	96 hours
Non-Urgent Appointments	
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

On February 2, 2017, DHCS released its proposed "Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal" for public comment. The DHCS policy proposal uses existing standards in Knox-Keene Act (the state law that managed care plans must be in compliance with) or Medi-Cal contract or regulation where those standards are available, and establishes different time and distance standards for new provider categories based on county size. Public comments on the DHCS proposal are due to DHCS on February 28, 2017.

Medical Loss Ratio

The May 2016 rule requires states to ensure that each managed care plan calculate and report a medical loss ratio (MLR).[9] In general terms, an MLR is the percentage of each dollar the plan receives in premiums that the plan spends on health care services, as defined, versus administration, sales, marketing and profit. In addition to requiring plans to calculate and report an MLR, states must develop plan rates in a way that the plan would reasonably achieve a MLR standard of at least 85% for the rate year.[10] The MLR requirement applies to contracts starting on or after July 1, 2017.

The federal rule permits states to require Medi-Cal managed care plans to meet a minimum MLR, provided the minimum MLR is equal to or higher than 85% (the standard used for projecting soundness) and the MLR must be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan that is consistent with this federal rule. In addition, the rule gives states the option of requiring a rebate if plans do not meet the MLR.

The ACA required states to establish an MLR[11] for health plans serving commercial populations. Dental plans are exempt for the ACA-required MLR. For plans in the large group market, the ACA-required MLR is 85% or a higher percentage determined by the state through regulation. For individual and small group plans, the MLR is 80% or higher percentage determined by the state through regulation. The federal DHHS Secretary can adjust small group and individual

market MLR if he or she determines that the 80% requirement may destabilize the individual market in a state. If a plan fails to meet the federal MLR requirements, rebates are required to be issued to the plans' customers. California does not impose a MLR on full-service Medi-Cal managed care plans, except for a federally required MLR for the Medicaid optional expansion population. California has a contractually required dental "minimum" loss ratio for dental managed care plans of 70%.[12] Federal rebates from the ACA-required MLR (reported to the Department of Managed Health Care [DMHC]), which regulates commercial and most Medi-Cal managed care plans) indicate, from reporting year 2011 through 2015, 10 plans have issued rebates in the following dollar amounts:

- Individual market: $64 million;
- Small group market: total $138.2 million; and,
- Large group market: total $3.3 million.

Grievance and Appeals

The May 2016 rule requires Medicaid managed care plans to have a grievance and appeal system[13] in place for enrollees. The rule restricts plans to only having one level of appeal for enrollees. The rule also contains a new restriction on the ability of beneficiaries enrolled in a managed care plan to directly file an appeal through a state fair hearing. Instead, the rule allows a beneficiary to request a state fair hearing only after receiving notice that the plan upholds the adverse benefit determination, or if the plan fails to adhere to notice and timing requirements in federal rules related to the grievance.[14]

A beneficiary has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan, and a grievance can be filed either orally or in writing. Following the plan grievance process (or if it has been exhausted due to the plan's failure to meet grievance timeframes), the beneficiary must request a state fair hearing no later than 120 calendar days from the date of the plan's notice of resolution. These provisions apply to rating periods for contracts starting on or after July 1, 2017.

External Medical Review Option

The May 2016 rule permits states to offer and arrange for an external medical review[15] if the following conditions are met.

- The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the state fair hearing;
- The review must be independent of both the state and the plan;
- The review must be offered without any cost to the enrollee; and,

- The review must not extend any of the appeal timeframes and must not disrupt the continuation of benefits requirement in the federal rule.

California law requires health plans regulated by DMHC and health insurers regulated by the California Department of Insurance (CDI) to offer enrollees an independent medical review[16] and experimental and investigational therapy independent review.[17] Both of these reviews are provided to enrollees at no charge.

Because the Knox-Keene Act already requires an external medical review, the new federal option in the rule effectively only applies to Medi-Cal beneficiaries enrolled in plans that are exempt from Knox-Keene Act licensure in California. COHS plans are exempt from licensure under the Knox-Keene Act for their Medi-Cal line of business.[18] In addition, county specialty mental health plans are allowed to be exempt from the Knox-Keene Act upon the request of the director of DHCS.[19]

SB 260 (Monning) of the 2015-16 Session would have required COHS licensure of Knox-Keene plans (one of the COHS, San Mateo Health Plan, is already Knox-Keene licensed for its Medi-Cal line of business). That measure failed passage on the Assembly Floor.

Quality Rating System

Each state contracting with a Medicaid managed care plan must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the plan.[20] In addition, each state contracting with plans to furnish services to Medicaid beneficiaries must adopt the Medicaid managed care quality rating system developed by CMS or adopt an alternative Medicaid managed care quality rating system.[21] The state option for an alternative quality rating system must be submitted to CMS for approval and receive prior approval prior to implementation, and the state must obtain input from the state's Medical Care Advisory Committee and provide an opportunity for public comment of at least 30 days on the proposed alternative Medicaid managed care quality rating system or modification. The Medicaid managed care quality rating system must be implemented within three years of the date of a final notice published in the Federal Register.

Beneficiary Support System

The May 2016 rule requires states to develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a managed care plan. The beneficiary support system must include at a minimum:

- Choice counseling for all beneficiaries;
- Assistance for enrollees in understanding managed care;

- For enrollees who use or express a desire to receive LTSS, the following:
    - An access point for complaints and concerns about plan enrollment, access to covered services, and other related matters;
    - Education on enrollees' grievance and appeal rights within the plan, the state fair hearing process, enrollee rights and responsibilities, and additional resources outside of the plan;
    - Assistance, upon request, in navigating the grievance and appeal process within the plan, as well as appealing adverse benefit determinations by the plan to a state fair hearing; and
    - Review and oversight of LTSS program data to provide guidance to the state Medicaid Agency on identification, remediation and resolution of systemic issues.

The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. The system may not provide representation to the enrollee at a state fair hearing but may refer enrollees to sources of legal representation.

DHCS has an enrollment broker (Maximus) it uses when enrollees select a Medi-Cal managed care plan, an ombudsman office in DHCS to assist with consumer issues involving plans, and a non-profit health consumer group that assists dual eligibles with CalMediConnect plans but it is unclear if these existing entities will meet the beneficiary support system requirement of the rule.

Conclusion

More than a third of Californians are enrolled in Medi-Cal and nearly 80% of these beneficiaries are enrolled in a Medi-Cal managed care plan. The federal Medicaid managed care rules were promulgated to improve quality, performance and accountability. SB 171 (Hernandez) and AB 205 (Wood) are companion bills which have been introduced to implement statutory changes resulting from the Medicaid managed care rule. As introduced, both bills would implement one provision of the rule which allows Medi-Cal beneficiaries up to 120 days after the date of notice to file a fair hearing (an appeal), instead of 90 days in existing law. In addition, SB 171 and AB 205 state legislative intent to implement the revisions in the federal regulations governing Medicaid managed care. Given the enormity of the Medi-Cal program in California and the fundamental changes in the rule made to existing financing arrangements and the existing access to care requirements, this hearing is intended to provide a public forum for discussion of the options and requirements under the federal needed to achieve the fundamental policy goal of meeting the care needs of the Medi-Cal beneficiaries.

[1] Department of Health Care Services November 2016 Medi-Cal Estimate, "Estimated Average Monthly Eligibles November 2016 Estimate."

[2] COHS plans subcontract with other plans in the counties they serve but those entities contract with the COHS and enrollment is considered COHS enrollment.
[3] Department of Health Care Services 2015 Activities Relating to Medi-Cal Dental Managed Care Report to the Legislature May 2016.
[4] Title 42 of the CFR, Section 438.6.
[5] Welfare and Institutions Code Section 14301.4.
[6] Title 42 of the CFR, Section 438.7
[7] Title 42 of the CFR, Section 438.4.
[8] Title 42 of the CFR, Section 438.68.
[9] Title 42 of the CFF, Section 438.8.
[10] Title 42 of the CFR, Section 438.4.
[11] Section 2718 of the Patient Protection and Affordable Care Act.
[12] Medi-Cal Dental GMC Program Contract, Exhibit A, Attachment 3, Financial Information.
[13] Title 42 of the CFR, Section 438.402.
[14] Title 42 of the CFR, Section 438.408.
[15] Title 42 of the Code of Federal Regulations, Section 438.402.
[16] Health and Safety Code Article 5.5, commencing with Section 1374.30 and Insurance Code
[17] Health and Safety Code Article 5, commencing with Section 1370.4 and Insurance Code .
[18] Welfare and Institutions Code Section 14087.95.
[19] Welfare and Institutions Code 14714.
[20] Title 42, Section 438.340.
[21] Title 42, Section 438.334.