Managed Care Oversight

Medicaid and CHIP Payment and Access Commission

Moira Forbes

Overview

- Background
- Key oversight areas
- Policy questions

Background

- MACPAC is examining several aspects of the federal-state relationship, including the balance between expanding flexibility and ensuring accountability
- CMS is reviewing opportunities to improve federal-state collaboration in Medicaid administration, including managed care
- Review of managed care requirements provides an opportunity to discuss oversight expectations and opportunities for flexibility

Key Oversight Areas

Medicaid managed care

- Comprehensive risk-based managed care is the primary Medicaid delivery system
  - 29 states deliver most services through managed care
  - Accounts for nearly half of Medicaid spending
  - About 60 percent of Medicaid enrollees are in managed care
- Differences between fee-for-service and managed care delivery systems require different approaches to program management and oversight

Elements of oversight

- Structural requirements
  - E.g., beneficiary support system, excluded provider prohibition
- Ongoing processes and activities
  - E.g., ongoing monitoring system, initial enrollee health screening
- Reporting requirements
  - E.g., post recent external quality review organization (EQRO) report, annually measure and report findings using state-defined metrics

Payment

- Key aspect of federal oversight is ensuring that state payments to managed care organizations (MCOs) are sufficient and actuarially sound
- 2016 rule adds to existing standards
  - Specifies standards and procedures for developing and documenting capitation rates
  - Adds more specificity to actuarial soundness requirements
  - Requires states to develop rates so that MCOs can reasonably achieve a medical loss ratio of 85%
  - Put “in lieu of” and “pass through” guidance into rule

Payment

- Some provisions have not yet gone into effect
  - Pass-through provisions being phased in over 5-10 years
  - Medical loss ratio reporting required in 2018, rate-setting component in 2019
- States and MCOs have raised concerns
  - Changes could increase time needed to review proposed capitation rates and increase uncertainty
  - Medicaid covered populations and services are significantly different from other insurance programs
- Some provider groups support the changes

Network adequacy

- Medicaid managed care restricts patient freedom of choice; consequently; Medicaid MCOs must assure access to:
  - an appropriate range of services
  - preventive and primary care services
  - a sufficient number, mix, and geographic distribution of providers
- 2016 rule requires states to develop certain network adequacy standards and conduct additional monitoring

Network adequacy

- By July 1, 2018 states must develop time and distance network adequacy standards and make the standards and monitoring public
  - Primary care (adult and pediatric), ob/gyn, behavioral health, adult and pediatric specialists, hospital, pharmacy, and pediatric dental providers
- Plans must certify their networks annually
- Consumer advocates support the use of state quantitative time and distance standards although some supported a federal standard

Quality

- Statute requires that state Medicaid managed care programs have a quality assessment and improvement strategy
- 2016 rule requires states to:
  - develop a more comprehensive quality strategy
  - implement a quality rating system (QRS) for MCOs
  - create opportunities for stakeholder and public engagement
  - improve transparency

Quality

- Some portions of the rule have already gone into effect
- Effort associated with many provisions is anticipated to be significant and states have been given several years to comply with state quality strategy and QRS provisions
  - Initial effort to design strategy and reporting system
  - Annual effort to collect and report data
- Changes are supported by consumer advocates

Reporting

- CMS has few direct oversight and monitoring obligations in statute
  - Has generally focused on reviews of waivers and MCO contracts
- 2016 rule establishes new provisions focused on CMS oversight of state operations
  - Pre-enrollment
  - Ongoing operations
  - Periodic and retrospective
- Requires more frequent and detail state reports

Reporting

- State reporting requirements incorporate—but may duplicate—some existing efforts
- States have raised concerns about the balance between burden and transparency; also the adequacy of CMS resources to review increased amount of data
- Advocates have noted that transparency requirements will allow stakeholders to more easily monitor program performance

Policy Questions

Status of final rule

- CMS, states, MCOs are implementing the rule
- Although many provisions went into effect immediately, some provisions did not into effect until 7/1/2017
  - Allowed states and MCOs time to develop appropriate rates and contract terms
  - CMS can use enforcement discretion if states are moving toward compliance
- A few provisions will not go into effect until later contract years or after other decisions are made

Rule review

- Intent of rule is to provide appropriate balance among state flexibility, national minimum standards, and alignment across programs
- Some have raised concerns that requirements create excessive burdens on states and plans
- CMS is conducting a review of the rule
  - Seeking to "prioritize beneficiary outcomes and state priorities"
  - May change enforcement or propose a new rule

Policy questions

- Do these elements achieve an appropriate balance between flexibility and accountability?
- What changes could be made to meet program goals while reducing burden or program constraints?
- Are there alternative approaches to implement value-based payment methodologies and measure outcomes?

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