MACPAC

Managed Care Oversight

Medicaid and CHIP Payment and Access Commission

Moira Forbes

Presentation overview

- Background and context
- Purpose and framework for oversight
- Oversight approach in key areas
- Policy questions

Background and context

- Commissioners have raised questions about the adequacy of managed care oversight
- State oversight processes and accountability mechanisms are receiving media scrutiny
- Centers for Medicare & Medicaid Services (CMS) is continuing to issue guidance to states on implementing the 2016 rule and has indicated that it may propose changes

Purpose and framework for oversight

- Medicaid enrollees in MCOs are entitled to receive covered services and to protections specific to managed care coverage
- Oversight framework addresses multiple goals
  - Ensure that the federal government holds states accountable
  - Ensure that states hold MCOs accountable
  - Establish minimum standards for MCO performance
- CMS and states use a variety of accountability tools (e.g., standards, contracts, reviews)

Oversight approach: Appeals and grievances

- Managed care has its own procedures to authorize services
- Consequently, enrollees must follow separate procedures to appeal coverage issues within the MCO before they access state fair hearings
- Grievances and appeals are potential indicators of quality and access problems
- Federal rules require MCOs to establish specific processes and states to provide oversight

Appeals and grievances, con't

- Considerable variation among states in how grievance and appeals data are used for oversight
  - Routine monitoring
  - Focused quality studies
  - Compliance with federal regulations
  - Public reporting
- Little is known about how states use data to identify concerns or follow up with MCOs
- Future reporting on state quality strategies may provide more information on feedback loops

Oversight approach: Network adequacy

- MCOs are required to provide access comparable to that in fee for service
- States must have standards and MCOs must document that they have adequate networks
  - Capacity to serve expected number of enrollees
  - Appropriate range of services
  - Sufficient number/mix/geographic distribution of providers; time-and-distance standards for some specific provider types
- Detailed rules went into effect July 1, 2018

Network adequacy, continued

- A variety of data and reports can be used to monitor compliance and access to care
  - Geomapping, encounter data analysis, provider participation reports, enrollee surveys, enrollee and provider complaint data analysis, secret shopper studies, authorization and referral data, etc.
- Many of these approaches are costly and time-intensive, little is known about which are most effective
- States also try to balance MCO compliance with responding to specific access complaints

Oversight approach: Readiness

- CMS and states conduct pre-implementation MCO readiness reviews
  - Assess the ability and capacity of MCO to perform satisfactorily in major operational areas
  - Prepared to comply with program and contract requirements
  - Ready to deliver services to enrollees
- Before 2016, readiness reviews typically required as a waiver condition; since 2017 has been required by regulation

Readiness, continued

- Readiness reviews are part of both state and CMS oversight
  - State processes must include both desk and on-site reviews
  - Reviews must be started at least three months before effective date
  - Findings must be submitted to CMS
  - CMS can delay program implementation date based on readiness findings
- Regulation focuses on MCO readiness and not other aspects of program readiness

Oversight approach: Beneficiary protections for vulnerable populations

- Individuals with significant or complex health care needs require additional protections in managed care
  - MCOs have additional responsibilities regarding access to care and coordination of care
  - MCOs can limit provider networks and have incentives to contain costs
- Federal rules address access to care, continuity of care, timely referral, and service authorizations

Beneficiary protections, con't

- Federal rules specify beneficiary protections but say little about how states should monitor or respond to MCO failures to comply
- Limited review of state data shows variation in the extent to which states collect data to support specific oversight
  - Broken out by population, risk/acuity, diagnosis
  - Showing use of care management, out-of-network referrals, etc.

Policy questions

- How do we balance between flexibility and control? Where are national standards appropriate and where is state variation OK?
- How do we assess performance vs. compliance? Where is process review sufficient? Where is outcomes monitoring valuable?
- What data are needed for oversight? What metrics are appropriate?
- When is self-attestation sufficient? When are external audits appropriate?

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September 14, 2018