ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Medicaid Advisory Committee
Quality Care Subcommittee

May 6, 2016
10 a.m. - 12 p.m.

401 S. Clinton
1st Floor Video Conference Room
Chicago, Illinois

And

201 South Grand Avenue East
1st Floor Video Conference Room
Springfield, Illinois

Conference Call-In Number: 888-494-4032
Access Code: 5589848112

Agenda

I. Call to Order

II. Introductions

III. Approval of March 2016 Meeting Minutes

IV. New Business
   a. Managed Care Transformation Update
   b. Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes (CHICAGO) Collaboration II
   c. Diabetes Initiative Presentation
   d. Diversity in LTSS
      http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=030500050K12-4.48

V. Old Business
   a. Committee Targets for Health Disparities Project

VI. Other Business

VII. Adjournment

If you plan to participate by phone please respond in advance to Bridgett.Stone@illinois.gov for meeting materials, and so we may record your presence at the meeting accurately.

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee March 4, 2016

Members Present
Kelly Carter, IPHCA
Jennifer Cartland, Lurie Children's Hospital
Kathy Chan, CCHHS
Alap Shah for Margaret Kirkegaard, Illinois Association of Family Physicians
Alvia Siddiqi, Advocate ACE (by phone)
Jacquelyn Smith, NextLevel Health

Members Absent
Candace Clevenger, Heritage Behavioral Health Center
Joshua Evans, Illinois Association of Rehabilitation Facilities
Art Jones, Medical Home Network
Edward Pont, Illinois Chapter American Academy of Pediatrics

HFS Staff Present
Shanan Casey
Catina Latham
Paula O'Brien
Sylvia Riperton-Lewis
Bridgett Stone

Interested Parties
Ron Austin, Presence Health
Jessie Beebe, AIDS Foundation of Chicago
Judy Bowlby, Liberty Dental
Kim Burke, Lake Co. Health Dept.
Paula Dillon, Illinois Health and Hospital Association
Eric Foster, IADDA
Paul Frank, Harmony/ Wellcare
Susan Fritcher, DSCC
Kathye Gorosh, AIDS Foundation of Chicago
Jill Hayden, BCBSIL
Franchella Holland, Advocate
Greg Johnson, ISDS
Nicole Kazee, Univ. of IL Health
Robert Kitzler, FHN
Dawn Lease, Johnson&Johnson
Kate McMahon, Respiratory Health Association
Susan Oyetunde, FHN
Hetal Patel, Illinicare Health
Verletta Saxon, Centerstone
Alicia Siani, EverThrive IL
Alison Stevens, Illinois Hunger Coalition
Sally Szumlas, FHN
Brittany Ward, Primo Center
Angela Watson, NextLevel Health

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee March 4, 2016

Meeting Minutes

I. **Call to Order:** The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order March 4, 2016 at 10:07 a.m. by chair Kelly Carter. A quorum was established.

II. **Introductions:** Quality Care subcommittee members, HFS staff, and interested parties were introduced in Chicago, Springfield.

III. **Approval of December 2015 Meeting Minutes:** Kathy Chan made a motion to approve the December Minutes of the Quality Care subcommittee. Jacquelyn Smith seconded the motion which passed unanimously.

IV. **New Business:**

a. **Committee Targets for Health Disparities:** Kelly Carter introduced the topic of targeting specific areas of interest to further delve into. Shanan Casey presented on behalf of the bureau of Quality Management on targets for disparity research, and specifically what types of data are available to the department for review.

b. **Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes (CHICAGO) Collaboration II:** This presentation was postponed to the May Quality Care Subcommittee Meeting.

V. **Old Business:**

a. **Use of Quality Measures in Auto-Assignments:** Robert Mendonsa led a discussion on the department's planned use of quality measures in auto-assignments.

VI. **Other Business:**

VII. **Adjournment:** The meeting was adjourned at 12:05 p.m.

Join the Diabetes Prevention and Management Affinity Group

Project Overview

The CMS *Medicaid Prevention Learning Network* supports state Medicaid agencies in improving access to, utilization of, and quality of preventive services. As part of this initiative, CMS is creating Affinity Groups for state Medicaid agencies to learn from one another and receive technical assistance around CMS priority areas. A Tobacco Cessation group is already underway, and a Diabetes Prevention and Management group will start in February 2016.

Diabetes Prevention and Management Affinity Group

By participating in this Affinity Group you will join an interactive forum of state Medicaid agencies dedicated to improving diabetes prevention and control. Participating states will represent a range of experience in improving access to and quality of preventive services, both through managed care and fee-for-service environments. As a member, you will be able to participate in and have access to:

- **Expert moderated webinars and learning circles** that will include diabetes prevention and management strategies, tools, evaluation data and special topics identified by states.
- **One-on-one consultation with experts** in the field, to help states strengthen their own quality improvement data and measurement capacity on specific diabetes measures, and to receive tailored support to address state-identified needs.
- **Opportunity to interact with peers** and share learnings and experience.
- **Individual data analysis support** to help states plan, track, and evaluate state-level quality improvement efforts related to select diabetes measures.
- **Diabetes resources** including actionable approaches in prevention management and control, tools and strategies to working with MCOs in prevention, and performance improvement project templates tailored to Diabetes.

Join Us:

If you are interested in joining the Diabetes Prevention and Management Affinity Group, **please contact diabetes@air.org**. This group will begin in February 2016. We will schedule an initial call in January, with you and your team, to discuss your current activities, goals for this initiative and how we may help you.

Contact diabetes@air.org now to sign up for this group, or to ask any questions.

Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes Collaboration (CHICAGO II)

Kate McMahon, MPH
Stacy Ignoffo, MSW
Melissa Gutierrez, MS
Molly Martin, MD, MAPP
Jerry Krishnan, MD, PhD

May 6, 2016

Asthma Overview

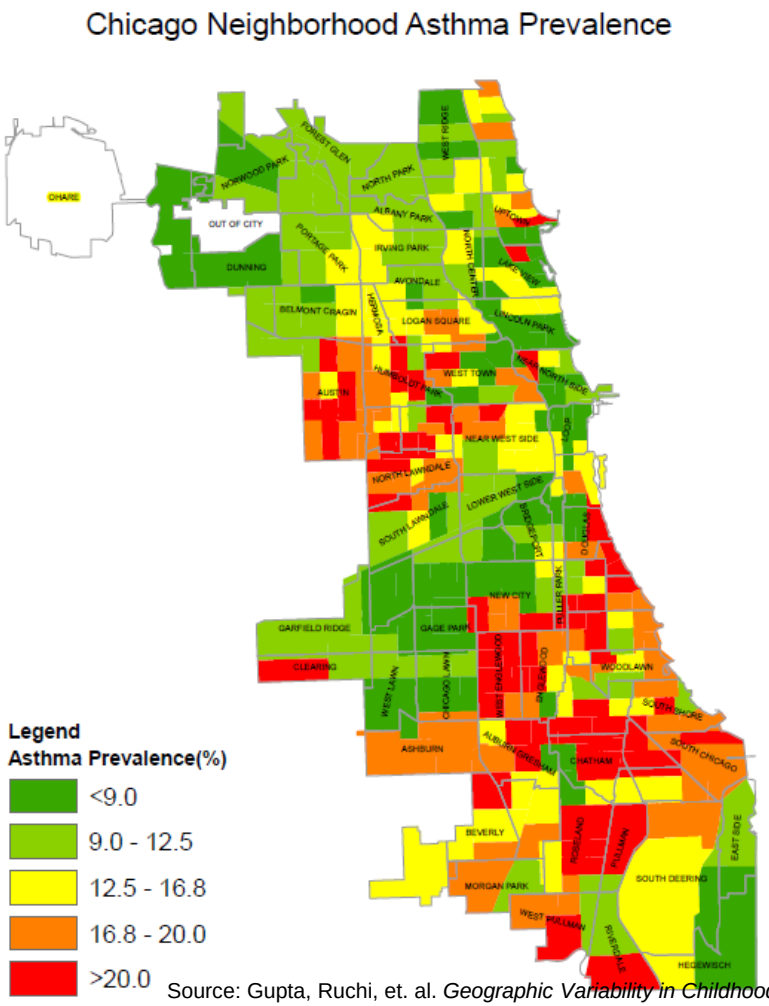
- Asthma is a lifelong illness that affects the lungs and airways
- Although the exact cause of asthma is unknown and it cannot be cured, it can be controlled with self-management education, appropriate medical care, and avoiding exposure to environmental triggers
- While some interventions have been successful in improving care of children with asthma, inconsistent application and lack of sustainability for these interventions has enabled asthma disparities to persist

Burden of Asthma in Illinois

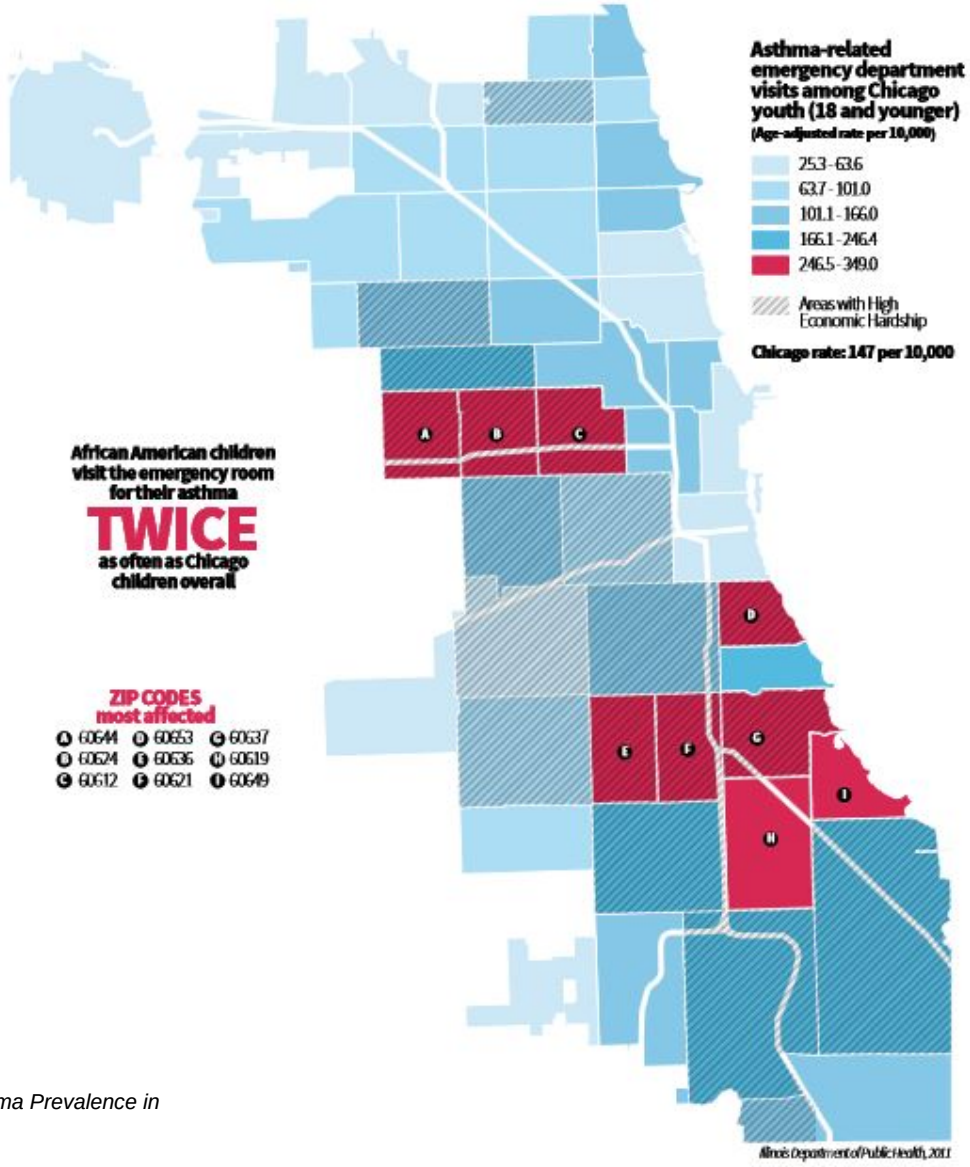
- Approximately **1.3 million Illinois residents**, or 14% of the population, have ever been diagnosed with asthma.
- Cost of treating asthma in Illinois was **$1.3 billion in 2010**
- Asthma expenditures, excluding absenteeism, are forecast to increase to **$2.2 billion by 2020**

Sources: BRFSS and Illinois Department of Public Health

Local Childhood Asthma Disparities



Source: Gupta, Ruchi, et. al. *Geographic Variability in Childhood Asthma Prevalence in Chicago. 2007*



Factors that Contribute to Childhood Asthma Disparities

Barriers to the implementation of guidelines-based asthma care

- **Medical care factors**
  - Limited access to quality health care and asthm self-management education that is patient-centered and culturally sensitive.
  - Episodic and fragmented care, as a result of the type of care available and the affordability of care. This factor is also influenced by cultural norms regarding health care seeking behaviors.
  - Low levels of health literacy.
  - Barriers (including costs) to adherence to prescribed medications and to measures to control environmental exposures.
- **Physical and psychosocial environmental factors**
  - Environmental exposures to allergens and pollutants in the home and school settings which exacerbate asthma.
  - Lack of family resources and community support for appropriate asthma self-management behaviors.
  - Higher levels of chronic stress and acute exposures to violence, which exacerbates asthma and impedes adherence to therapy.
  - Competing family priorities, such as access to food or secure housing, that impact a family's ability to address asthma.

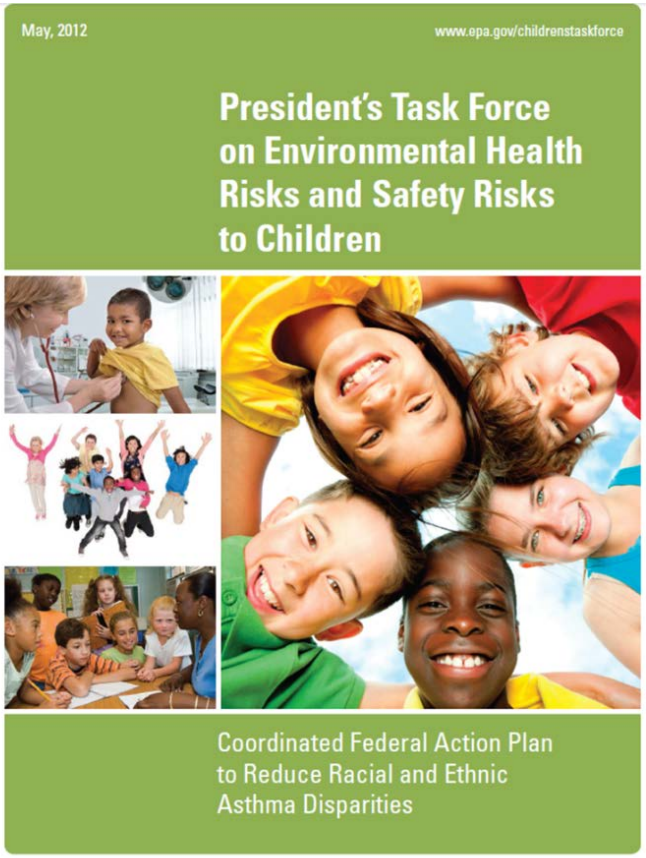
Lack of local capacity to deliver community-based, integrated, comprehensive asthma care

- Lack of coordination across service delivery agents.
- Limited community-level activities to reduce outdoor air pollution.
- Limited models and cost benefit analyses for integrated community partnerships.

Gaps in capacity to identify and reach children most at risk

- Variability in the data collected at local, state and national levels.
- Limited use of innovative technologies to identify populations at highest risk for poor outcomes.

Federal Action to Reduce Childhood Asthma Disparities



***Enhance capacity to deliver integrated, comprehensive asthma care to children in communities with racial and ethnic asthma disparities.**

Conduct **research to evaluate models** of partnerships that empower communities to identify and target disparate populations and provide comprehensive, integrated care at the community level.

Examine the relative contribution and **cost-effectiveness of different components** of a system-wide partnership program.

NIH Funding to Reduce Childhood Asthma Disparities

RFA-HL-15-028: Creating Asthma Empowerment Collaborations to Reduce Childhood Asthma Disparities (U34)

- 12 month planning grant to conduct a community needs assessment; develop an asthma care implementation plan (ACIP) that integrates care where children live, learn, play and receive medical care; and design a clinical trial to improve care of children living with asthma at high risk of poor outcomes
- **CHICAGO II is one of 9 funded collaborations nationwide**

RFA-HL-17-001: Asthma Empowerment Collaborations to Reduce Childhood Asthma Disparities (U01)

- Applications due 11/16/16; earliest start date 7/1/17
- Up to 4 awards; 6 year award; sustainability and dissemination included in addition to active intervention phase

CHICAGO II Project Overview

Goal: Improve quality of care and reduce disparities in outcomes

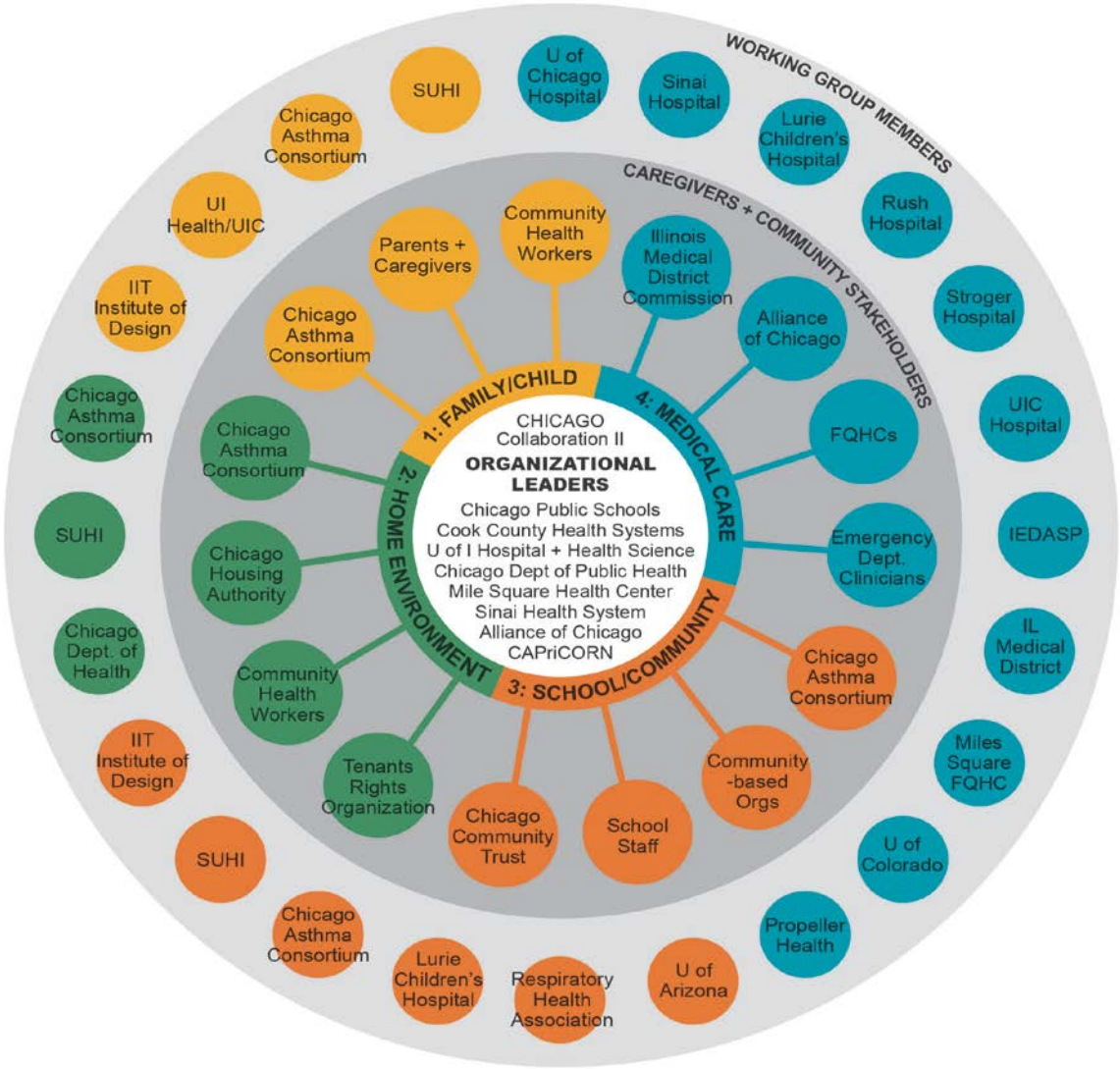
Aim 1: Actively engage a diverse group of stakeholders to align study activities outlined in Aims 2, 3, and 4 with the **needs of communities disproportionately affected by asthma**.

Aim 2: Conduct a community-based needs assessment (CNA) to refine the design of the CHICAGO II ACIP.

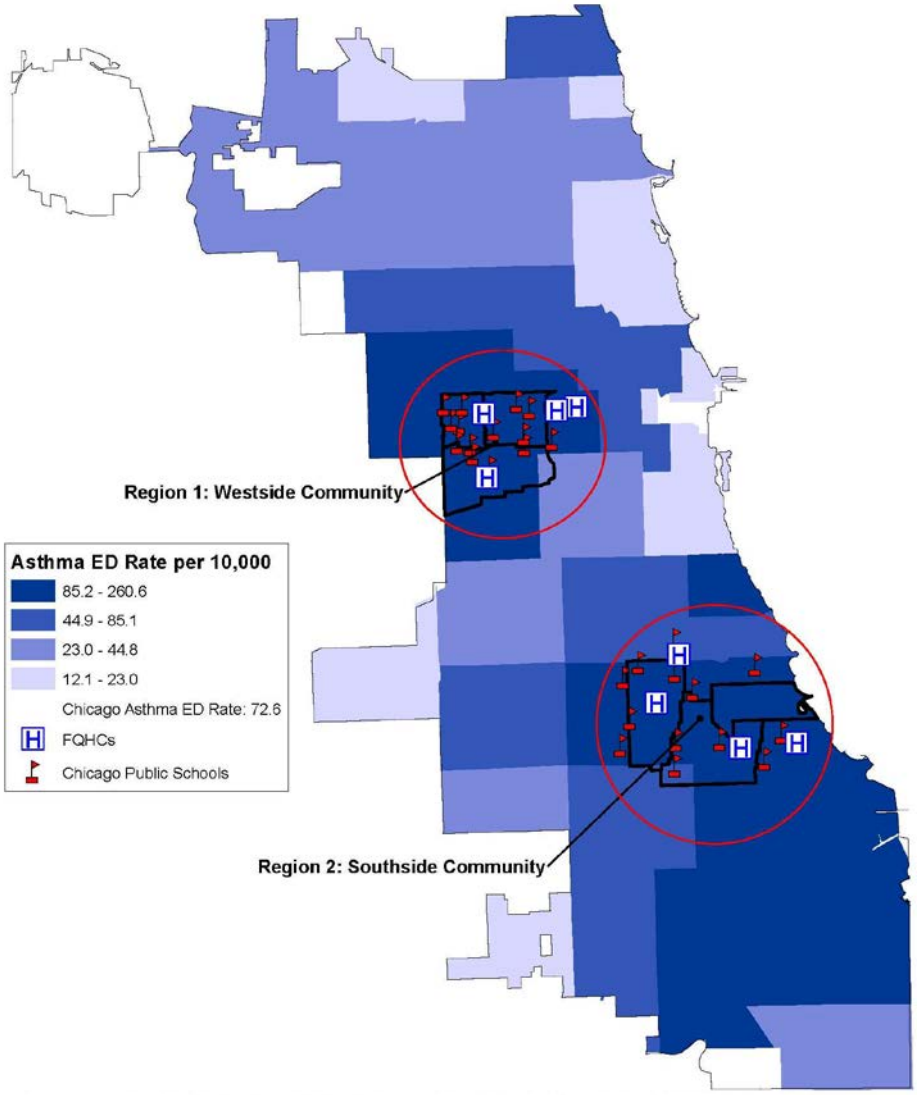
Aim 3: Update and finalize the four-sector CHICAGO II ACIP.

Aim 4: Update and finalize the design of a clinical trial to evaluate the four-sector CHICAGO II ACIP.

CHICAGO II Team and Stakeholders



CHICAGO II Target Population



Map Source: Sinai Health System, 2015. Data Source: Illinois Hospital Association, COMPdata 2008-2010

CHICAGO II Provisional Asthma Care Implementation Program (ACIP)

1. Medical care

- EDs and ambulatory practice providers complete CAPE during encounter (decision support and patient education tool).
- Clinicians review rescue and controller medication use via Propeller Health dashboard, providing audit and feedback to clinicians about need for treatment intensification
- CHWs serve as supports in medical settings, and review use of CAPE with caregivers/children during and after encounters

2. Family and child

- Audit (self-monitoring)/ feedback support on medications and triggers via Propeller
- Home CHW intervention using CAPE developed in medical sector

3. Home

•Audit (self-monitoring)/feedback support on medications and triggers via Propeller
•Home CHW multi-trigger, multi-level intervention using CAPE developed in medical sector; Chicago DPH and/or MTO assistance for severe cases.

4. Community

•Audit(self-monitoring)/feedback support on medications and triggers via Propeller
•Self-management education using RHA Fight Asthma Now (FAN) intervention
•Direct observed therapy of ICS and albuterol
•Use of school-based health centers, where available

CHICAGO II

possible interventions

Propeller Health sensor

A tool for real-time tracking of inhaler usage

Propeller Health is a sensor that fits onto a patient's inhaler. It keeps track of every time the inhaler is used. For patients, the sensor works with a mobile app to show how often the inhaler is used and to identify patterns. Doctors can also see patient data through a HIPAA-compliant website.

A new way to learn asthma management

Tracking asthma symptoms, triggers and inhaler-use is the best way to manage asthma. However, collecting data about these elements manually is difficult and time consuming. Finding a way to accurately track medication usage with minimal effort can ultimately lead to better care.

Who is this for?

- Asthma patients
- Caregivers
- Primary care doctors and asthma specialists

Outcomes

- Better symptom management
- Better understanding of asthma triggers and inhaler use
- Fewer emergency department visits
- Reduced medical costs

Fight Asthma Now® (FAN)

Asthma curriculum designed for students

FAN was created by Respiratory Health Association. It is based on asthma care guidelines with input from doctors, nurses, community educators, and parents of children with asthma. Engaging lessons give students the information and tools they need to better manage their asthma. FAN has been used in participating Chicago Public Schools since 2007.

Who is this for?

- Youth with asthma (2nd–6th graders)
- Teens with asthma (7th–12th graders)

Outcomes

Research shows FAN gives students a better understanding of:

- how to recognize asthma symptoms
- how to take asthma medicine correctly and use a spacer
- how to identify and avoid asthma triggers
- how to use an asthma action plan

Community Health Workers

Asthma educators who come to you

CHWs are public health workers who work in underserved communities. They are trained professionals who perform education, counseling, social support and advocacy. For children with asthma, CHWs work one-on-one with their families to:

- identify and avoid asthma triggers
- manage asthma episodes
- help families use asthma medications correctly
- control asthma on a long-term basis
- connect families with the right medical care

Who is this for?

- Families of children with asthma
- Schools with students with asthma

Outcomes

- Fewer emergency room visits and hospitalizations
- Fewer days and nights with asthma symptoms, especially among vulnerable, low-income populations
- Demonstrated costs savings to Illinois Medicaid

Asthma Discharge Plan

A family-friendly education tool

This new asthma education tool is designed for parents and children with asthma when they are discharged from the Emergency Room for asthma-related care.

Collaboratively designed to teach self-management

This tool was designed with input from caregivers, emergency room staff, asthma specialists, and clinic doctors. This tool is currently being tested at six Chicago-area Emergency Rooms. The tool shows:

- how to take your medications
- how to manage symptoms
- how to manage asthma at home
- how to use an inhaler with spacer

Who is this for?

- Children with asthma and their families
- Emergency Room doctors
- Primary care clinic physicians

Outcomes

- Strongly preferred over current discharge documents by caregivers and clinicians
- Selected by caregivers as the preferred tool to share with family and schools

Daily medications at school

Schools dispense asthma medication during the week

Research shows that when children use their medicine to control their asthma every day, they experience dramatically fewer asthma attacks. For this intervention, schools would give asthmatic children their prescribed controller medicine every day that school is in session and their rescue medicine when needed. To do this, we would need to think about:

- Who in the school will give the medication?
- Will students need separate inhalers for school and home? Or will students carry their inhaler with them?

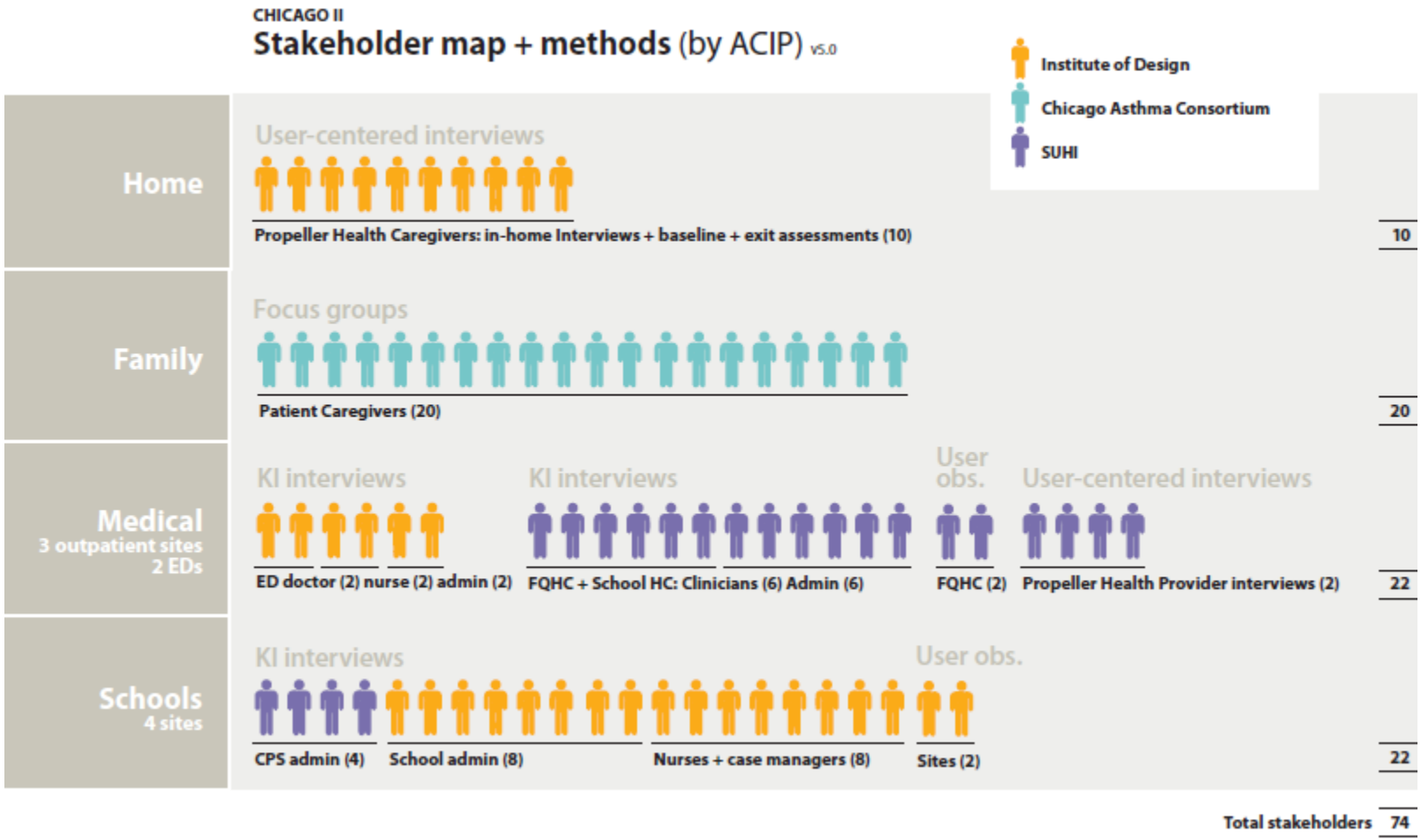
Who is this for?

- Students with asthma

Outcomes

- Better school attendance because of better asthma control

Stakeholder Engagement by Sector



3 lenses for data analysis

1 Theme analysis

Looks at *contextual issues* across the ACIP—the anxieties, ambitions, activities and needs —at work in schools, EDs and FQHCs.

Examples:

Primary care docs don't know what happens in the ED;

Asthma symptoms seen as normal;

Parent engagement is a barrier;

2 Intervention fit + feasibility

Looks broadly at *stakeholder perceptions* of the fit and feasibility of each intervention based on their experience with the target population (perceptions tracked by sector, site + role)

1 RE-AIM analysis

Assesses the *potential* for each intervention to succeed in its:

Reach
Effectiveness
Adoption
Implementation
Maintenance

…and includes participant suggestions for how each intervention could be implemented to score better in these areas.

Considerations in Developing the Research Project (U01)

- How will children at high risk of poor outcomes in asthma be identified within the community?
- What are the sizes of the communities to be studied?
- Who is the comparator group and why is it appropriate?
- What is the potential for interactions between the ACIP participants and the control group?
- **What is the treatment assignment and duration?**
- **What is the plan for integrating interventions into a program of care around the child?**
- **What are the outcomes?**

Medicaid Advisory Committee
Quality Care Subcommittee Perspective

- What interventions do you prefer across sectors?
- What quality measures and performance measures are you using for pediatric asthma?
- What measures or long term outcomes would you like to see?
  - (i.e. reduction in hospitalizations; cost savings of interventions)

Recommendations for Medicaid Advisory Committee Quality Care Subcommittee

- Formalize collaboration between Medicaid Advisory Committee Quality Care Subcommittee and CHICAGO II team
- Participate in analysis of the community needs assessment, help refine the asthma care implementation program (ACIP) and design the clinical trial
- Share data and information on quality and performance measures for pediatric asthma as well as data on CHICAGO II children (as appropriate)

Thank you!

Contact us:
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Senior Director of Programs & Policy
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www.lungchicago.org/research-chicagocollaboration2/

Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

Overview of the Final Rule

Center for Medicaid and CHIP Services

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Today, the predominant form of service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children's Health Insurance Program Reauthorization Act of 2009 adopted key Medicaid managed care provisions for CHIP
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- 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**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

- Publication of Final Rule
  - On display at the **Federal Register** on April 25th
  - Will publish in the **Federal Register** May 6th
- Dates of Importance
  - Effective Date is July 5th
  - Provisions with implementation date as of July 5th
  - Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017
  - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
  - Applicability dates/Relevance of some 2002 provisions

- Medicaid.gov – Landing and Managed Care Pages
  - Link to the Final Rule
  - 8 fact sheets and implementation timeframe table
  - Link to the CMS Administrator's "Medicaid Moving Forward" blog
- ManagedCareRule@cms.hhs.gov

To further support state and federal delivery system reforms, the final rule:

- Provides flexibility for states to have value-based purchasing models, delivery system reform initiatives, or provider reimbursement requirements in the managed care contract
- Strengthens existing quality improvement approaches with respect to managed care plans

<u>Examples</u>

- Capitation Payments for Enrollees with a Short-Term Stay in an Institution for Mental Disease
- Value-Based Purchasing

- Permits state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-64, that has a short term stay in an Institution of Mental Disease (IMD)
  - Short term stay: no more than 15 days within the month
  - Establishes rate setting requirements for utilization and price of covered services rendered in alternative setting of the IMD
- "In lieu of services" (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings
  - Establishes contractual requirements for ILOS
  - Establishes rate setting requirements for ILOS

These provisions apply as of the effective date of the final rule

- Clarifies state payment-related tools for managed care plan performance
  - Establishes requirements for withhold arrangements
  - Retains requirements for incentive arrangements
- Acknowledges that states may require managed care plans to engage in value-based purchasing initiatives
- Permits states to set min/max network provider reimbursement levels for network providers that provide a particular service
- Transition period for pass-through payments to hospitals, physicians and nursing facilities "supplemental"- still must phase these out

These provisions apply to rating periods for contracts starting on or after July 1, 2017

Goal: Modernization and Improving Quality of Care

Recognizes advancements in State and managed care plan practices and federal oversight interests

Examples

- Network Adequacy
- Information Standards
- Quality of Care

Modernization: Network Adequacy

- States will develop and implement time and distance standards for:
  - primary care – adult and pediatric;
  - specialty care – adult and pediatric;
  - behavioral health (mental health and substance use disorder) – adult and pediatric ;
  - OB/GYN; hospital; pharmacy; and
  - pediatric dental
- States will develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- Managed care plans will certify the adequacy of the networks at least annually

Provisions apply to any rating period for contracts starting on or after July 1, 2018

Modernization: Information Requirements

- States will operate a website that provides specific managed care information including each managed care plan's handbook, provider directory, and formulary
- States will develop definitions for key terms and model handbook and notice templates for use by the managed care plans
- States and managed care plans may provide required information electronically if the information is available in paper form upon request and free of charge

These provisions apply to any rating period for contracts starting on or after July 1, 2017

Improving Quality: Quality Rating System

- States must implement a quality rating system (QRS) for Medicaid and CHIP managed care plans and to report plan performance for MCOs, PIHPs, and PAHPs
- CMS expects to implement the QRS over 5 years including:
  - A public engagement process to develop a proposed QRS framework and methodology using summary indicators adopted by the Marketplace QRS
  - Publication of the proposed QRS in the *Federal Register* with comment period, followed by notice of the final Medicaid and CHIP QRS
- States will have flexibility to adopt alternative QRS, with CMS approval

States must implement a QRS no later than 3 years from the date of a final notice published in the Federal Register

Quality of Care

- Extends managed care quality strategy, QAPI, and external quality review (EQR) to PAHPs and to PCCM entities whose contracts include financial incentives
  - *Applies 60 days after publication; see QS, QAPI and EQR applicability below*
- Adds two new elements to states' managed care quality strategies related to health disparities and long term services and supports
  - *Applies July 1, 2018*
- Adds new mandatory EQR activity to validate network adequacy
  - *Applies no later than one year from the issuance of the EQR protocol*
- Improves transparency of quality information
  - *Applies no later than the rating period for contracts starting July 1, 2017 for QAPI and posting of accreditation status; applies July 1, 2018 for QS and EQR*

Goal: Strengthen Beneficiary Experience

Strengthens the beneficiary experience of care and key beneficiary protections

Examples

- Enrollment Process
- Beneficiary Support System, Including Choice Counseling
- Managed Long-Term Services and Supports (MLTSS)

Beneficiary Experience: Enrollment and Supports

Enrollment

- States retain flexibility to design their enrollment processes to best meet population needs and programmatic goals
- States will be required to provide notices to explain implications of enrollees' choices as well as all disenrollment opportunities
- Improved information content and distribution methods
  - *Applies to rating periods for contracts starting on or after July 1, 2017*

Supports

- Establishment of a beneficiary support system - An independent system to provide choice counseling and assist enrollees post-enrollment
  - *Applies to rating periods for contracts starting on or after July 1, 2018*

Beneficiary Experience: Managed Long Term Services & Supports

Rule implements elements of CMS' May 2013 MLTSS guidance, such as

- Requires States to establish and maintain a structure for stakeholder engagement in planning and oversight of MLTSS programs
- Requires that enrollees with LTSS needs are involved in person-centered treatment and service planning
- Creates for cause disenrollment reason to another plan if institutional, employment, or residential provider leaves enrollee's plan
- Ensures there is more accurate and timely data gathering and sharing among managed care plans and providers
  - *Above apply to any rating period for contracts starting on or after July 1, 2017*
- Requires transition plans when a beneficiary moves from FFS to managed care or into a new managed care plan
  - *Applies to any rating period for contracts starting on or after July 1, 2018*

Improvements

The final rule retains state flexibility to meet state goals and reflect local market characteristics while:

- Ensuring rigor and transparency in the rate setting process
- Clarifying and enhancing state and managed care plan expectations for program integrity

- <u>Examples</u>
  - Better defining Actuarial Soundness
  - Transparency in the Rate Setting Process and Approval
  - Program Integrity
  - Encounter Data

Payment and Accountability: Actuarially Sound Capitation Rates

- Establishes standards for the documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification
  - *Applies to any rating period for contracts starting on or after July 1, 2017*
- Permits states to increase or decrease the certified capitation rate by 1.5% (overall 3% range) without submission of a new rate certification
  - *Applies to any rating period for contracts starting on or after July 1, 2018*
- Requires that differences among capitation rates for covered populations must be based on valid rate development standards
  - *Applies to any rating period for contracts starting on or after July 1, 2017*
- Permits certain mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval
  - *Applies to any rating period for contracts starting on or after July 1, 2017*

Payment and Accountability: Program Integrity

- Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse
  - *Applies to rating periods for contracts starting on or after July 1, 2017*
- Network providers will be screened, enrolled and revalidated as done in FFS
  - Network providers are not required to participate in the FFS program.
  - States can require managed care plans or a third party to conduct the screening process
  - *Applies to rating periods for contracts starting on or after July 1, 2018*
- Requires managed care contracts to address treatment of recovered overpayments by managed care plans and to take these amounts into account in the rate setting process
  - *Applies to rating periods for contracts starting on or after July 1, 2017*

Payment and Accountability: Encounter Data

- The Affordable Care Act and this rule condition payment of FFP on timely, accurate, and complete reporting of encounter data
- For contracts starting on or after July 1, 2017, States must require that managed care plans:
  - Collect and submit encounter data sufficient to identify the provider rendering the service;
  - Submit all encounter data necessary for the State to meet its reporting obligation to CMS; and
  - Submit encounter data in appropriate industry standard formats (i.e., ASC X12N 837, ASC X12N 835, NCPDP)

Goal: Alignment with Other Insurers

Aligns Medicaid and CHIP managed care requirements with the private market or Medicare Advantage requirements to:

- Smooth beneficiary coverage transitions
- Ease administrative burdens of managed care plans that participate across publicly-funded programs and the commercial market

<u>Examples</u>

- Medical Loss Ratio (MLR)
- Appeals and Grievances

Alignment: Medical Loss Ratio

- Managed care plans are required to calculate and report their MLR experience for each contract year
  - *Applies to rating periods for contracts starting on or after July 1, 2017*
- Actuarially sound rates are set to achieve a MLR of at least 85%
  - *Applies to rating periods for contracts starting on or after July 1, 2019*
- States have the flexibility to set a standard higher than 85% and/or impose a remittance requirement
- Expenditures for program integrity activities in the MLR calculation will align with a future standard adopted in the private market rules

Alignment: Appeals and Grievances

- Definitions and timeframes for resolution of appeals are generally consistent with the private market and Medicare Advantage
- Extends managed care appeals and grievance requirements to Pre-paid Ambulatory Health Plans (PAHPs)
- Managed care plans will perform one level of internal appeal for enrollees to use before proceeding to a State Fair Hearing
- States have the option to offer enrollees an external review so long as that process does not extend overall timeframes for the appeals process

These provisions apply to rating periods for contracts starting on or after July 1, 2017

Aligning CHIP with Medicaid

CHIP substantially aligns with Medicaid provisions related to:

- Medical loss ratio
- Information requirements
- Disenrollment
- Conflict of interest
- Continued services to enrollees
- Network adequacy
- Enrollee rights & protections
- MCO, PIHP, and PAHP standards
- Quality measurement and improvement
- External quality review
- Grievance system
- Program integrity
- Sanctions

Note: CHIP adopts the changes Medicaid finalized in these sections

Non-Aligned CHIP Provisions

Medicaid standards not applied:

- Prior approval of plan contracts
- Enrollment protections related to choice of plans (which is not required in CHIP)
- Rate-setting standards and certification
- Managed long-term services and supports

Questions

Future Presentations

In the coming weeks, we will host in depth presentations on the following topics:

- All Times are 12:00-1:30 EST
- May 12 - Beneficiary Experience/MLTSS
- May 19 - Quality
- May 26 - Program Integrity
- June 2 - Rate Setting, DSR, and MLR
- June 9 - CHIP

Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations