Medicaid Hot Topics

August 10, 2023

Speakers

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Agenda

- Access Provisions of the May 3, 2023, Proposed Rule on Managed Care
- State Directed Payment Provisions of the May 3, 2023, Proposed Rule on Managed Care
- Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review Provisions of the May 3, 2023, Proposed Rule on Managed Care
- Medical Loss Ratio Changes and Considerations Related to the May 3, 2023, Proposed Rule on Managed Care
- Disproportionate Share Hospital Third Party Payer Provisions of the February 24, 2023, Proposed Rule.

Mercer

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Proposed Rules Part I: Medicaid & CHIP Managed Care

Proposals and Considerations

August 10, 2023

A business of Marsh McLennan

Medicaid Managed Care Proposed Rule

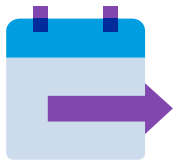
Overview

Access and Rate Transparency

Directed Payments, In Lieu Of Services, and Medical Loss Ratio

Quality Ratings for Plans

External Quality Review and Quality Strategies



Implementation Timeline

Managed Care NPRM

Access and Rate Transparency Proposals (§§438.66 and 438.68)

Maximum Appointment Wait Times + Network Adequacy Standards

- 90% compliance with maximum routine appointment wait times:
  - 10 days for mental health and SUD
  - 15 days for OB/GYN and primary care
  - Additional state-chosen service
- States must continue to maintain quantitative network adequacy standards outside of appointment wait times

Reactions

- **Mixed:** Telehealth can count towards wait time standards, but only if the provider also offers in-person visits. Should there be exceptions for rural health and BH?

Annual Enrollee Experience Surveys

- Mandatory surveys
- Must inform MCO operational improvements
- Results must be reported as part of annual MCPAR report

Reactions

- **Good:** EQROs can administer or validate the enrollee experience
- Do states want CMS to mandate the use of specific surveys?

Secret Shopper Surveys

- Provider directory oversight, focused on primary care, OB/GYN, mental health, SUD + state-selected service
- Conducted by an independent entity
- Survey results included in the annual network certification results report to CMS

Reactions

- Oversight tool for the MCO provider directory and wait time standards
- **Good:** EQROs can administer surveys

Network Exceptions

- If exceptions are made to network adequacy standards, **provider payment rates** must be considered in the state's decision to allow an exception

Reactions

- CMS provides limited details on how states must consider provider payment rates in an exception process

Managed Care NPRM

Access and Rate Transparency Proposals: Annual Network Certification (§438.207)

Annual Payment Analysis

- Benchmarks primary care, OB/GYN, mental health, and SUD to Medicare
- Analyze adult and pediatric separately

Reactions

- Separate by adult and child if the benchmarking is noticeably different
- Will paid claims data be complete enough to submit a report 180 days after end of rating period with the annual network certification?
- Concerns about comparison to Medicare as services and benefits don't align
- How are APMs handled?

HCBS Annual Payment Analysis

- Benchmarks homemaker, home health aide, and personal care services to Medicaid FFS
- Analyze adult and pediatric separately

Reactions

- FFS will be an outdated or nonexistent benchmark in some states. Do states have to update or create fee schedules solely for this purpose?
- Assume it applies regardless of operating authority (state plan or waiver)
- Would creating regional comparisons by service be more useful?

Annual Network Certification

- Adds secret shopper and payment analysis results to the CMS template; annual reports due 180 days after rating period

Reactions

- CMS reporting template becomes mandatory
- Unclear how the template will be updated to reflect secret shopper survey results and payment analysis

Remedy Plans

- Plans due to CMS within 90 days of an access issue; 12–24 months to improve access in measurable and sustainable ways; quarterly reporting
- CMS can defer FFP if access issues not addressed

Reactions

- CMS staff resources
- States must consider payment levels and other options, like licensing requirements, as potential remedies
- Unclear if the Remedy Plans or progress reports are public
- Unclear if EQRO has a role
- Access issues affecting all payers

State Directed Payments: The Good, the Bad, the Ugly

The Good (§§438.3 and 438.6)

Streamlining

- No preprint if 100% of Medicare (Comment: CMS should offer a range [e.g., 95%–105%])
- States are encouraged, but not required, to involve the actuary in the development of SDP

VBP

- Removes rules that prohibit states from setting the amount or frequency of the plan's expenditures
- Allows condition- or population-based VBP
- States will be allowed to recoup unspent funds from MCOs
- Allows states to implement stronger and more flexible VBP incentives

Out-of-Network Providers

- Will be allowed, but not required
- Addresses a barrier states raised to CMS
- CMS seeks comments on unintended consequences

State Appeal Rights

- CMS can disapprove an SDP, but states can appeal to the Department of Appeals Board review, similar to the process for financial disallowances

State Directed Payments: The Good, the Bad, the Ugly

The Bad (§§ 438.6 and 438.7)

Certification Reports

- Calculate SDP cost percentages
- Two-year retro report
- Actuarially certified

No Post-Payment Reconciliation

- Payment can only be made on current claims and encounters
- Impact on cash flow
- **Better:** Target larger payments or certain provider types

More Rigorous Evaluation

- Written evaluation plan for CMS prior approval, updated with amendments and renewals
- Many more metrics and measures
- SDPs and evaluations must be posted on state website

VBP Administration

- No payment unless improvement
- Do the benefits of the VBP flexibility outweigh the administrative burden?
- Will states want to create this level of work for unproven models?

State Directed Payments: The Good, the Bad, the Ugly

The Ugly (§ 438.6(c))

Average Commercial Rate

- Total Payment Rate for facility IP, facility OP, NF, or practitioner services at an academic medical center cannot be paid more than ACR
- Targeting services that are usually funded by taxes and IGTs
- Upward pressure on total health system cost
- **Better:** Reconsider NF, because Medicaid is the primary payor, like BH (excluded in NPRM)

SDP Limit?

- CMS floated a proposal to develop a "State directed payment cost percentage" and limit SDP expenditures to 10%–25%
- This is NOT in the regulation text now, but we expect it in the final

"States assert that using a separate payment term offers administrative simplicity to the State agency in administering the SDPs because distributing a pre-determined amount of funding among the plans is much easier than relying on actuarial projections."

Financing & Redistribution

- Concern is with taxes and IGTs that are funding SDPs and redistribution agreements among providers that are not directed by states
- SDP preprint approval would be contingent upon state documentation that the financing is allowable
- **Caution:** Backdoor enforcement of the canceled MFAR rule

Medical Loss Ratio Changes and Considerations

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Consulting Actuary

AUGUST 10, 2023

Milliman

Proposed changes to medical loss ratio calculations

Provider Incentive Arrangements

- Some arrangements would be prohibited from inclusion in the numerator
- State will need to modify MCO contracts

Reporting of Overpayments

- Clarifies definition of “prompt” reporting to State
- Requires inclusion of “identified” and “recovered” overpayments in numerator

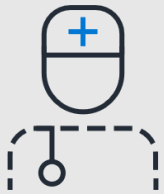
State Directed Payments

- Numerator and denominator of MCO MLR reports must include separate lines for SDP

Other Minor changes

- Prohibits MCOs from allocating overhead (indirect) costs to HQI expenses
- Clarifies when MLR needs restated

Provider incentive arrangements



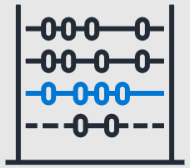
MCO provider incentives must be established with a documented arrangement prior to the effective date of the measurement period and that arrangement must require the provider to meet clearly-defined, measurable, and well-documented improvement standards to receive the incentive payments

States must modify MCO contracts to include new provisions related to the MCO's provider incentive contracts

Reporting of overpayments

CMS intends to clarify "prompt" reporting of overpayments by the MCOs. The proposed rule seeks comment on whether "within 10 business days" is a reasonable definition. Expecting significant push back from all stakeholders regarding this proposal.

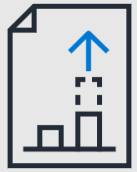
MCOs to report "identified and recovered" overpayments to State. The proposed rule does not define "identified." Expecting push back from stakeholders regarding this definition due to common provider payment issues resulting in appeals and reconciliations.



Overpayments must be excluded from capitation rate development and the numerator of the medical loss ratio. States must also modify MCO contracts to comply with these timeframes.

State directed payments (SDP)

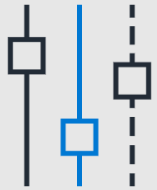
MLR calculation must include lines in the numerator and denominator for the SDP in the reports submitted to CMS.



States may need to consider whether SDPs should be included in MLR remittance calculations. Including SDPs artificially inflates the loss ratio of the plans. States could also consider higher MLR thresholds for remittance.

States will need to modify MCO contracts for any reporting changes in the CMS and remittance versions of the MLR calculations.

Other minor changes



Overhead and indirect costs that do not directly improve health care quality will be unallowable in healthcare quality improvement expenses in the numerator.

Expense allocation methodologies must be described in detail related to how it was allocated to Medicaid, how expenses met quality criteria and methods used to allocate.

Resubmissions of MLR reports will only be required when State's make a retroactive change to the capitation rates, rather than any time capitation payments change

MEDICAID "HOT TOPICS" (continued)

JUDY HATFIELD, CPA

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May 3, 2023 Medicaid Program; Medicaid and CHIP Managed Care Access, Finance and Quality Rule (Proposed)

- Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review

  (42 CFR §§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

- Medicaid & CHIP Managed Care Quality Rating System

  (42 CFR §§ 438.334 and 457.1240)

https://myersandstauffer.com/cms-proposed-rules-2023/

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Managed Care State Quality Strategies

- *Increase opportunity interested parties have to provide input.*
- *Require states make their quality strategy available for public comment at the 3-year renewal and post on their websites the full results of the 3-year review regarding the effectiveness of their quality strategies.*
- *Quality strategy must be submitted to CMS, prior to finalizing a revised or renewed strategy, at a minimum every 3 years, following the review and evaluation of the strategy, in addition to when significant changes are made to allow CMS to provide feedback to help strengthen strategies before they are finalized.*
- *Compliance required no later than one year from the effective date of the final rule.*

External Quality Review

1) *Removal of primary care case management (PCCM) entities from mandatory external quality review.*
2) *Defined 12-month EQR review period as beginning on the first day of the most recently concluded contract year or calendar year, whichever is the nearest to the EQR-related activity. This applies to all activities except for the activity requiring a 3-year period (438.58(b)(1)(iii)).*
3) *New optional EQR activities to support proposed managed care evaluation requirements related to quality strategies, state directed payments, and in lieu of services.*
4) *Removal of requirement that private, national accreditation organizations (PAOs) must apply for authority from CMS in order for States to rely on PAO accreditation reviews in lieu of EQR activities to assist in the non-duplication of mandatory EQR activities with Medicare or accreditation reviews.*
5) *Revisions to communication and due date for finalization of external quality review results.*
   - *Finalization of technical reports revised from April 30 to the following December 31 to align with HEDIS measures.*
   - *Requirement to maintain at least the previous 5 years of EQR technical reports on States' websites*
   - *Expansion of information required to be reported in EQR technical reports.*
   - *Compliance not later than December 31, 2025.*

Medicaid & CHIP Managed Care Quality Rating System

- Envisioned as a one-stop shop where beneficiaries can access information regarding:
  1) Medicaid and CHIP eligibility and managed care.
  2) Compare health plans based on quality, performance, and other key factors to beneficiary decision making.
- CMS notes the proposed rule reflects extensive stakeholder engagement.
- CMS emphasizes the desire to leverage existing systems and processes in the development of the QRS.

Medicaid & CHIP Managed Care Quality Rating System

- Timeline
  1) CMS proposes implementation requirement no later than the end of the fourth year following the effective date of the final rule.
  2) Annual updates would be required after the initial implementation.
  3) States would be given at least two calendar years from the start of the measurement year to display health plan results and ratings.

Quality Rating System

• Measures & Data Collection

- 18 proposed mandatory measures. Many of which are already being reported. List of measures may be updated annually.
- States may include additional measures without approval.
- Data must include date for all members who receive coverage from the managed care plan.

• Website Display

- Information must be clear and understandable.
- Website must have interactive features allowing users to tailor for specific information such as formulary, provider directory, etc.
- Display must be standardized so users can compare among health plans.

• Annual State Reporting

- Supporting documentation for quality measures.
- The date on which the state publishes its quality ratings
- Attestation required that all displayed measures were calculated and issued in compliance with CSM codified requirements.
- CMS plans to create a portal for submission and give States a minimum of 90 days' notice to submit.

February 24, 2023 Medicaid Program; Disproportionate Share Hospital Third Party Payer Rule (Proposed)

- Purpose of the Proposed Rule:
  1) Update the regulatory requirements of the disproportionate share hospital (DSH) program in response to the Consolidated Appropriations Act (CAA), 2021
  2) Further improve the DSH program.

https://myersandstauffer.com/consappropact-2021/

Hospital-Specific Disproportionate Share Payment Limit (42 CFR § 447.295)

- Effective October 1, 2021 CAA revised methodology for calculating the Medicaid shortfall component of the DSH payment limit
  1) Only Medicaid costs and payments for services provided to beneficiaries for whom Medicaid is the **primary** payer will be considered in the calculation of the Medicaid shortfall.
  2) Exception exists for 97th percentile hospitals if the hospital-specific DSH limit is higher under the methodology in effect January 1, 2020.
  3) October 1, 2021 effective date of CAA will be applied based on fiscal years beginning on or after October 1, 2021.

97th Percentile Exception

• Qualifying Hospitals

- Applies to hospitals at or above 97th percentile of all hospitals nationwide with respect to the number of Medicare supplemental security income (SSI) days or the percentage of Medicare SSI days to total inpatient days.

• Data Sources

- Healthcare Cost Report Information System (HCRIS), Medicare Provider Analysis and Review (MEDPAR) and SSI data from Social Security Administration.
- Data available as of March 31 (prior to October 1) will be used. Regardless of audit status.

• Notification

- CMS to publish a list annually prior to October 1 each year.
- List published October 1 will be used prospectively for subsequent year's DSH payment calculation.

Reporting Requirements (42 CFR § 447.299)

- Calculating Medicaid Shortfall
  1) Revise reporting in DSH audit to incorporate CAA requirements allowing inclusion of only Medicaid primary inpatient and outpatient hospital services.
  2) Applicable to SPRY beginning on or after October 1, 2021.
- Reporting DSH Overpayments
  1) Proposed rule adds an additional reporting requirement to the annual DSH audit reporting components.
  2) New data element would require auditors to quantify the financial impact of any finding, including those resulting from incomplete or missing data, lack of documentation, non-compliance with regulation, or other deficiencies identified in the independent certified audit.

Questions Regarding New Data Element

- Is it CMS' intention to incorporate the estimated impacts into DSH overpayment calculations?
- If so, how will caveats where a range is reported for the impact be included?
- Many of the auditors' disclosures require legal interpretation or further guidance to determine whether there would be any financial impact on DSH overpayments. Would CMS allow an exemption for calculating an estimated impact for those items?

Discovery of DSH Overpayment and Its Significance (42 CFR § 433.136)

- Proposed rule specifies overpayments identified through the DSH independent audit will be considered discovered the earliest of:
  1) The date the State submits the DSH certified audit report to CMS, or any of the following:
  2) The date which any Medicaid official first notifies a provider in writing of an overpayments,
  3) The date a provider initially acknowledges a specific overpayment amount in writing to the Medicaid agency,
  4) The date any State official initiates a formal action to recoup a specific overpaid amount from a provider.

Reporting DSH Overpayments (CFR 42 § 447.299)

- Codifies existing policy on overpayments identified through the annual independent DSH audit.
  1) Federal share must be returned to the Federal Government, or
  2) Redistributed by the State to other qualifying hospitals if redistribution is allowed under the State Plan.
  3) Overpayments must be separately reported on the CMS-64 as a decreasing adjustment reflecting the return of the overpayments in fiscal year corresponding to the original DSH allotment and expenditure claimed by the State.
  4) For redistributions, States would be required to report any overpayment redistribution amounts on the CMS-64 within 2 year from the date of the discovery that a hospital-specific limit has been exceeded. A increasing adjustment would be required on the CMS-64 representing the DSH redistribution in the fiscal year corresponding to the original DSH allotment and expenditure.

Limitations on Aggregate Payments for DSHs Beginning October 1, 1992 (CFR § 447.297)

- Proposed rule eliminates requirement to publish annual DSH allotments in the Federal Register.
- Alternatively the Secretary will post preliminary and final national expenditure targets and state DSH allotments in the Medicaid Budget and Expenditure System/State Children's Heath Insurance Program System (MBES/CBES).
  1) CMS notes publishing in the Federal Register.
  2) Rather than publishing by April 1 as currently required, the proposal revises the date to as soon as practicable.

DSH Health Reform Reduction Methodology (42 CFR § 447.294)

- Proposed rule eliminates provision that DSH allotments included in budget neutrality calculations for coverage expansion under section 1115 as of July 31, 2009 be excluded in the DSH allotment reduction calculation.
  1) All section 1115 waivers approved as of or before July 31, 2009 have expired.
  2) Average high uninsured and high Medicaid factor reduction percentages would be applied to DSH allotments diverted under section 1115 demonstrations.

Questions

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