The Managed Care 'Mega Reg': Impacts and Intersection with Health First Colorado Behavioral Health Program

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Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Discussion

- Lay of the land - Changing regulatory framework coupled with payment reform
- Overview of the managed care MEGA Regulations
- Select Behavioral Health Program Impacts
- The Future! What to expect and why everything is going to be OK.

Worlds Collide – Managed Care Regulations and Payment Reform

You signed up for a presentation on the managed care regulations, so why am I bringing up payment reform?

Federal Regulatory Changes

- Several impactful federal regulatory updates in recent years
  - HCBS Wavier Rule
  - Access to Care Rule
  - Managed Care Rule

National Drive to Value-Based Purchasing and Integrate Care

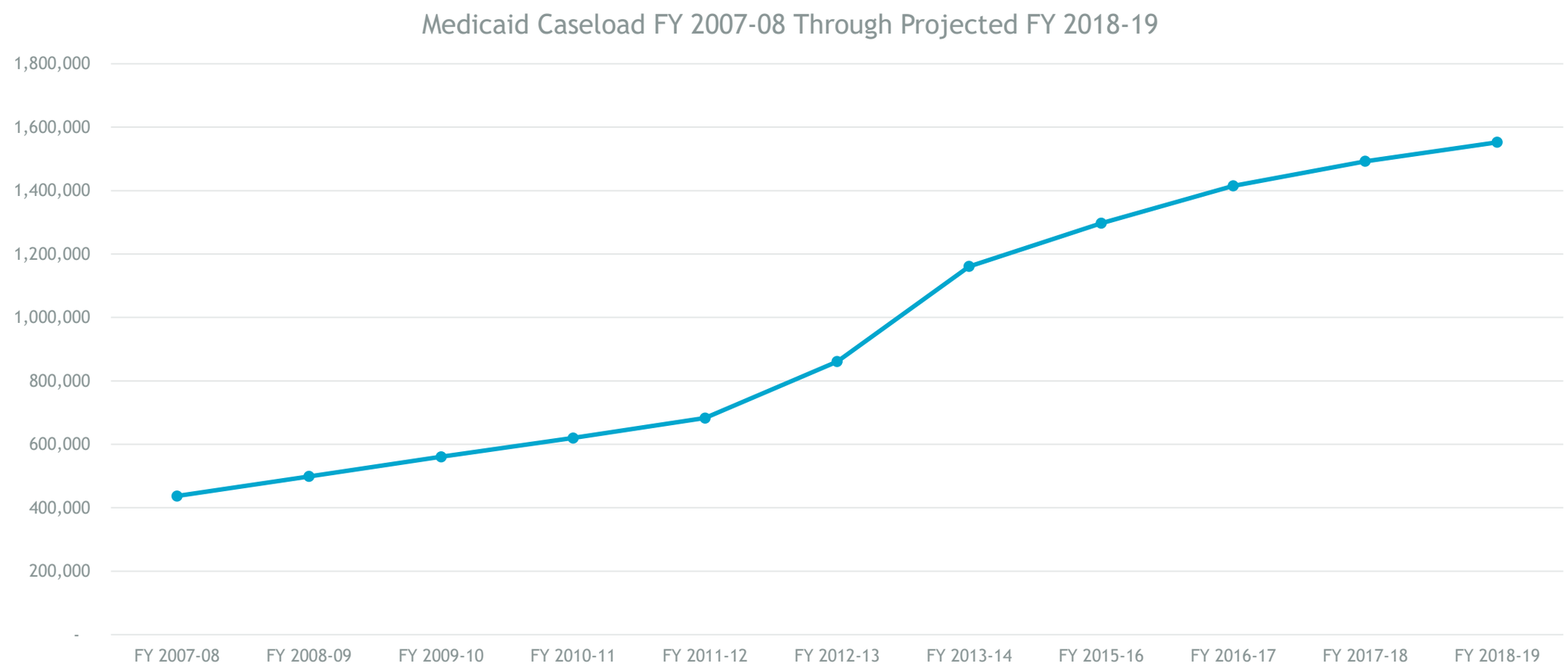
- Health Care Policy Learning Action Network Framework
  - How you pay matters, not just how much
  - Public commitment from CMS and Colorado
- MACRA - Medicare primary care payment reform
- CPCi/CPC+/TCPi – multipayer primary and specialty care reforms
- State Innovation Model – large investment in integrated care nationally
- PAMA Section 223 Demo - Certified Community Behavioral Health Centers

Colorado Payment Reform

- Time of change for all providers
  - The Accountable Care Collaborative
  - Community Mental Health Center Reforms
  - Integrated Care – SIM
  - CPCi/CPC+ and TCPi
  - Managed Care Reforms
  - Hospital Reforms – DSRIP
  - FQHC reforms

Connecting the Dots

There is a national push for increased value, quality, transparency and accountability in Medicaid and Medicare. It probably has something to do with this:



Overview of the Managed Care Regulation

- Timeline
- Regulation Focus Areas
  - Beneficiary Support and Information
  - Enrollment and Disenrollment
  - Provider Network Adequacy
  - Managed Long-Term Services and Supports
  - Appeals
  - Capitation Rate-Setting
  - Quality of Care
  - State Monitoring
  - Program Integrity
- Hundreds of pages of specific requirements – high level today

Timeline

- Phased in Requirements
  - Immediate at time of passage
  - 60 days post publication
  - Contracts starting on or after 7/1/17
  - Contracts starting on or after 7/1/18
  - No later than 7/1/18
  - No later than contracts starting 7/1/19
  - No later than 3 years from the date of a final notice published in the Federal Register

Beneficiary Support and Information

- Choice counseling related to enrollment decisions
- Additional specific criteria for what information must be communicated to enrollees, and in what format
  - When you can provide them electronically, and when you cannot.
- Provider directories – additional specification added to requirements
- Clear focus on informed decision making and accessibility of information for enrollees

Enrollment and Disenrollment

- Additional specificity regarding enrollment and disenrollment with an emphasis on client choice.
- Clients entering and exiting managed care programs may require transition plans to ensure access to services during the transition between delivery systems

Provider Network Adequacy

- Time and distance standards established by the state that can vary by population and region.
- States do have a degree of flexibility, but states will have to demonstrate the standards meet the needs of the population and that plans are compliant.
- This is a great opportunity to work together and think differently about how we meet the service needs of our clients.

Managed Long-Term Services and Supports

- Mostly not applicable in Colorado
- Colorado has a statutory prohibition on having LTSS under managed care with the exception of the Program of All-inclusive Care for the Elderly (PACE)
- PACE is a program based on a three-way agreement between Medicare, Medicaid, and PACE organizations and is governed under different regulations – not impacted by the Mega Reg

Appeals

- The final rule creates greater alignment with marketplace and Medicare Advantage processes
- Specific timelines for state and plan responses
- The rule clarifies standards for enrollee access to records and benefits while under appeal.

Capitation Rate-Setting

- I assume no one wants me to talk about this section
  - We'll just skip it

Capitation Rate-Setting

- Multiple significant changes
- Office of the Actuary/ Centers for Medicare and Medicaid Services oversight
- Changes to actuarially soundness standards
  - Specific rate cells are certified, not the aggregate expenditure (expansion issue)
  - Rate ranges narrowed
- Minimum Medical Loss Ratio (MLR)
- Documentation requirements increased
- Ability for states to mandate provider level payment reform and direct provider payments

Quality of Care

- States must develop a comprehensive quality strategy and managed care programs must be incorporated in the strategy.
  - When states mandate participation in reforms and direct provider payments, it must be tied to this plan.
- States must evaluate the performance of managed care plans and publish the results. Guidance not yet issues regarding the standards to be applied, but it seems as though states have some latitude in how they rate plans.

State Monitoring

- New level of accountability for states
- States will be responsible for many different aspects of managed care program performance and will have to report to CMS annually
- States cannot delegate accountability for ensuring access to efficient, quality care.

Program Integrity

- Major point – managed care plan encounter data must be complete and accurate or the state is at significant risk of losing federal funds.
- CMS's enforcement mechanism is no longer nuclear and is now more likely to be applied.
- This is currently a weak area in our state for many plans and providers. Greater emphasis and accountability on quality data is coming!

Mega Reg Takeaways

- Fundamental overhaul of accountability in Medicaid managed care programs both at the state and plan level.
- Emphasis on fiscal responsibility, client choice and protection of rights, and quality.
- There is a long runway for implementation, but there is a lot of work to be done.
- The state will post a requirement by requirement listing with effective dates (A link will be shared through CBHC once it is available)

Worlds Collide Part 2: Regulatory Framework and Payment Reform

- The MEGA regulation increases accountability and transparency, but in some cases, reduces flexibility and is administratively burdensome.
- Payment reform can help mitigate the loss of flexibility.
- Payment reform can be the catalyst for quality improvement emphasized in the MEGA regulation.

Example 1: Payment Reform as a Solution to Lost Flexibility

- Under the MEGA regulation, lowered rates due to new rate process
- The higher rates allowed a greater degree of flexibility in providing services to clients
- The state is investigating making quality payment above and beyond the capitation payment to reward performance and build back in additional flexibility in the behavioral health program.

Example 2: Payment Reform as a Solution for Compliance

- In some cases, the regulations and payment reforms work together.
- Access standards established under the regulations will need a policy solution because there are very real workforce and provider capacity shortages.
- Two pieces of payment reform work together to help address the issue
  - Primary care reforms that promote integrated care
  - Restructuring of the BH risk arrangement

Takeaways

- Expect a major push for greater transparency and accountability to improve outcomes for clients and to demonstrate sound fiscal stewardship of public funds
- Payment reform coupled with regulatory reform can be a powerful driver for improved quality and access.
- Navigating the changing regulatory framework and implementing reforms that improve the quality of life of the people we serve requires strong partnerships; we have to walk this path together.

Questions or Concerns?

Contact Information

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Thank You!