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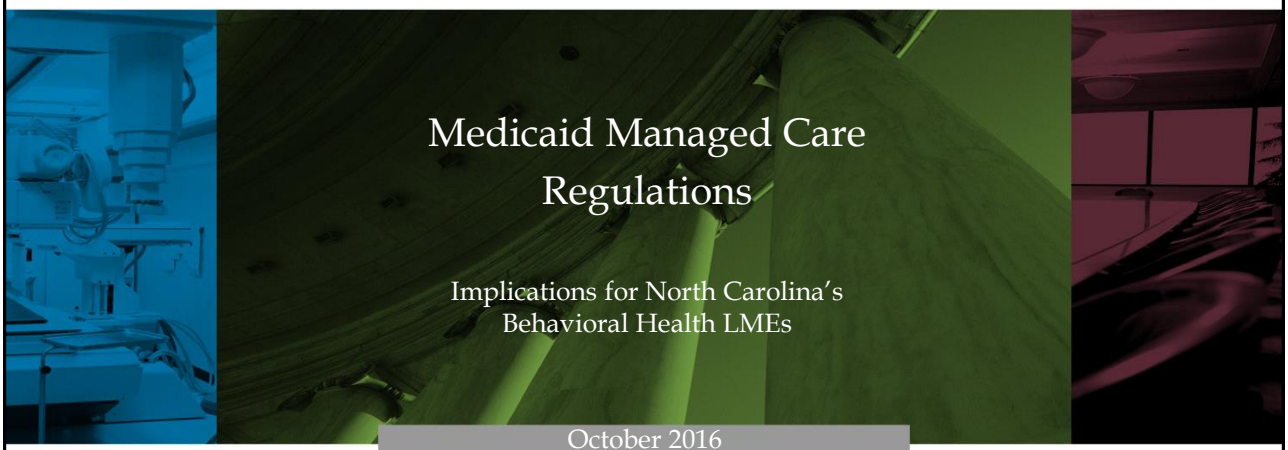

Medicaid Managed Care Regulations

Implications for North Carolina's Behavioral Health LMEs

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Agenda for today

- Provide you with a basic knowledge of the Medicaid Managed Care Rule released earlier this year.
- Offer a solid foundational understanding of the quality sections in the regulation.
- Discuss the timeline and next steps for preparing and implementing the necessary changes.

Broad Implications

- More standardized approaches across and within states, particularly in financial management.
- Substantial new reporting and oversight requirements.
- New requirements applied to PIHPs and PAHPs
- Considerable state flexibility—particularly in delivery system reform arenas.
- Quality strategy still to be developed.

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Standardized Requirements

A driving force is standardization across states/markets. Here are a few examples:

- Medical Loss Ratio and other rate setting issues. (Sec 438.5-438.8)
- Appeals and grievances policies and timelines. (Sec 438.400 et seq.)
- Provider enrollment requirements shifting. (Sec 438.602)
- Encounter data and annual reports. (Sec 438.604 and 438.66)

Important Requirements Less Standardized

The rule also explicitly allows states latitude to implement and/or continue down a range of pathways. For example:

- Network adequacy metrics and definitions (Sec 438.68)
- IMD and "in-lieu of" options (Sec 438.6 and 438.3)
- Delivery system and payment reforms (scatter throughout rates and quality sections)
- The state's managed care quality strategy (Sec 438.340)

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What Happens Now

There is no state roadmap. Will take considerable time to parse out the pathway.

- States will need to revise their contracts to comply with the regulation.
- States (and plans) will need to decide how they will respond to different flexibilities
- The timeline for adoption is also complex.

So let's dive into each of these areas.

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Network Management and Consumer Supports

- Assuring access and reporting to the state
- Provider enrollment

- Consumer communications regulated
- Grievance and appeals systems detailed
- Parity and evidence-based requirements

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Quality Measurement and Rate Setting

- Encounter data penalties.
- Performance improvement programs
- EQR activities

- Medical loss ratio and care management/supports
- Data for rate setting

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Innovations at "State Option"

- IMDs can be used and billed if stays of less than 15 days
- Articulates an "in lieu of" policy
- Pass through payments more restricted
- Plan rating system
- Others…

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Final MCO Regulation: Effective Dates

Provision	Effective Date [1]	Provision	Effective Date [1]
CHIP Provisions	7/1/18 [2]	**Beneficiary Experience:**	
IMD	7/5/16 [2]	- Enrollment	7/1/17
Approaches to Payment	7/1/17	- Supports	7/1/18
Network Adequacy	7/1/18	- LTSS: Most Provisions	7/1/17
Information Requirements	7/1/17	- LTSS: Transition Plan	7/1/18
Quality Rating System	No later than 3 years after final notice in Federal Register	**Actuarially Sound Capitation Rates**	
Encounter Data	7/1/17	- Most Provisions	7/1/17
Appeals & Grievances	7/1/17	- Increase/Decrease Limit 1.5%	7/1/18
Quality of Care		**Program Integrity**	
- Extension to PAHPs & PCCMs	60 days after publication	- Administrative & Managerial	7/1/17
- New Health Disparities & LTSS	7/1/18	- Network	7/1/18
- Validation: Network Adequacy	1 year after EQR protocol issued	- Recovered Overpayment	7/1/17
- Transparency: QAPI & Accreditation	7/1/17	**Medical Loss Ratio**	
- Transparency: QS & EQR	7/1/18	- Calculate & Report	7/1/17
		- Rates set to Achieve 85% MLR	7/1/19

1. For any rating periods for contracts starting on or after this date except as noted
2. Effective on this date; footnote number 1 does not apply

Assessing Current Status and Moving Forward

Near Term:

- Work with the state to figure out where in the contracting cycle these effective dates apply.
- Review your current contracts and assess how they match the major regulatory provisions.
- Where there are gaps or differences in your capacity or practices, identify needed resources, information, and action plan.
- Figure out a timeline for changes and work with the state where compliance may be a challenge.

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Moving Forward, continued

Over time:

- Be part of the quality strategy discussions.
- Beef up your reporting and oversight structures.
- Work with the state and health plans on parity
- Explore payment innovations, current and future.