PIHP / Managed Care Requirements

Balanced Budget Act of 1997 (BBA)
In 1998, Michigan Medicaid Specialty Services moved to a managed care model including capitated payments and financial risk for Prepaid Inpatient Health Plans (PIHPs).

PIHP is a federal designation by the Centers for Medicare & Medicaid. PIHPs are similar to Medicaid health plans but are not at full risk for funding. Under a managed care service arrangement healthcare financing is linked to population health improvements and service delivery with the goals of providing a high quality, efficient, effective services in the most cost effective manner possible. These are known as the “Triple Aim”: Better Health, Better Care, Better Value.

Contract Requirement with Michigan Department of Health and Human Services:

Balanced Budget Act of 1997 (BBA) final rule 42 CFR Part 438 effective June 14, 2002 and all other applicable pertinent Federal, State and local Statutes, Rules and Regulations
Managed Care Core Functions

PART 438—MANAGED CARE

- Subpart A—General Provisions
- Subpart B—State Responsibilities
- Subpart C—Enrollee Rights and Protections
- Subpart D—Quality Assessment and Performance Improvement
- Subpart F—Grievance System
- Subpart H—Certifications and Program Integrity
- Subpart I—Sanctions
- Subpart J—Conditions for Federal Financial Participation
Core Managed Care Functions: CUSTOMER SERVICES (Information Requirements - 438.10)

- **Information Services**: Includes activities directed to the general population of the service area as well as to consumers of treatment and support services.
  - General orientation of new and potential consumers
  - Provisions of a Member Handbook
  - Development and dissemination of informational brochures
  - Coordinating community and stakeholder input and disseminating of specialized information about benefit plans
  - Operation of a telephone line and web site(s)
  - Marketing and Public Relations activities

- **Customer Complaint, Grievance and Appeals Processes**. Both formal and informal grievance and appeal mechanisms are coordinated as part of the Customer Services function.

- **Community Benefit**. Including activities directed at the population of the entire service area, or sub-groups of that population, rather than at identified individuals. It focuses on activities designed to promote wellness and healthy Communities.
Core Managed Care Functions: CUSTOMER SERVICES (Enrollee Rights & Protections - 438.100)

- Written policies regarding enrollee rights
- Right to:
  - Receive information as contained in 438.10
  - Right to be treated with respect and due consideration of his or her dignity and privacy
  - Receive information about available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand
  - Participate in the decisions regarding his or her healthcare, including the right to refuse treatment
  - Be free from any form of coercion, discipline, convenience or retaliation
  - Exercise their rights in a manner that does not adversely affect their services
Core Managed Care Functions: QUALITY MANAGEMENT
(Quality Assessment and Performance Improvement - 438.200)

The BBA has multiple sections under this scope, including:

- Access Standards
- Assurances of adequate capacity and services,
- Coordination and continuity of care
- Coverage and authorization of services
- Provider Selection
- Enrollee Information
- Confidentiality
- Enrollment and disenrollment
- Grievance Systems
- Subcontractual relationships and delegation
- Practice Guidelines
- Quality assessment and performance improvement program
- Health information systems
MDHHS and CMS contract and regulations require PIHPs to develop an overall Quality Assessment and Performance Improvement Program (QAPIP) for its organization and its provider network. Specifications for the QAPIP are detailed both in federal regulation and the MDHHS contract. The QAPIP includes the development of an annual QI Plan that includes specific developmental and improvement activities to improve the overall effectiveness of clinical and administrative practices.

- **Components of Quality Management include:**
  - Standards Setting
  - Performance Assessment
  - Regulatory Management/Corporate Compliance
  - Managing Review Processes
  - Quality Process Facilitation
  - Research
  - Provider Education and Training
Core Managed Care Functions: UTILIZATION MANAGEMENT

Utilization Management (UM) is a set of administrative functions that pertain to the assurance of appropriate clinical service delivery.

- That only eligible beneficiaries receive specialty plan benefits
- That all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires
- That beneficiaries are linked to other Medicaid, Health Plan or other services when necessary
- **Access** - Determination of eligibility
- **Authorization** - Assessment of Medical Necessity for services including determination of scope of service, duration of treatment, and intensity or frequency of interventions
- **Utilization Review** - must have practices and procedures in place to monitor treatment access is assured in accordance with a regionally defined benefit; and that eligible consumers receive appropriate care with emphasis on ensuring proper use of clinical and financial resources, including addressing over/under-utilization of services.
Core Managed Care Functions: PROVIDER NETWORK MANAGEMENT (Structure and Operation Standards, 438.214-230)

- Ensuring qualified providers in sufficient number and variety are available to allow consumer choice and assure the provider network is in compliance with regulatory requirements and performance expectations.

- Providers include both organizations and individual professional practitioners providing clinical services or paraprofessionals providing supports to consumers.

- Specific functions included under the provider network roles are:
  - Network Development (including annual assessment of network adequacy)
  - Contract Management
  - Network Policy Development
  - Credentialing, Privileging and Primary Source Verification
Core Managed Care Functions: INFORMATION
SYSTEM MANAGEMENT

Information Systems within the behavioral healthcare system usually fall into two categories:

- **Managed Care Information System Management** functions are those which support all other Managed Care Administrative functions.

- **Practice Management Information System Management** functions which allow providers to deliver clinical services and manage the interests of the provider agency. It is typical for MSHN regional providers to directly operate their own electronic medical record that supports practice management.

Core functions of the (IS) Management include:

- Required reporting
- Information security/privacy
- Data validation
- Data analytics support
- System and infrastructure management & Support
Core Managed Care Functions: FINANCIAL MANAGEMENT

Critical components of financial management include:

- Budgeting, General Accounting (AR, AP, etc.), and Financial Reporting
- Service unit and Client-centered Cost analyses and Rate-setting
- Risk Analysis and Risk Modeling
- Purchasing
- Payroll and employee benefits management
- Supervision of audit and financial consulting relationships
- Claims adjudication and payment
Retained vs. Delegated Functions

- Clearly defined in PIHP / CMHSP contract
- PIHP must retain the right to revoke delegation
- PIHP must monitor compliance with delegated functions
- CMHSP must track and report delegated administrative cost

DISCUSSION & SHARING DELEGATION MODELS
Medicaid and CHIP Managed Care Final Rule
Overview

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) put on display at the Federal Register the Medicaid and CHIP Managed Care Final Rule, which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections.

First update since 2002
Rule advances CMS’s mission to the Triple Aim
Publication of Final Rule:
  Published May 6th
  Effective July 5th
  Implementation dates vary
Medicaid and CHIP Managed Care Final Rule
Resources

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

NEW Managed Care Rules

Current Structure

- Subpart A—General Provisions
- Subpart B—State Responsibilities
- Subpart C—Enrollee Rights and Protections
- Subpart D—Quality Assessment and Performance Improvement
- Subpart F—Grievance System
- Subpart H—Certifications and Program Integrity
- Subpart I—Sanctions
- Subpart J—Conditions for Federal Financial Participation

New Structure

- Subpart A—General Provisions
- Subpart B—State Responsibilities
- Subpart C—Enrollee Rights and Protections
- Subpart D—MCO, PIHP and PAHP Standards
- Subpart E—Quality Assessment and Performance Improvement
- Subpart F—Grievance System
- Subpart H—Certifications and Program Integrity
- Subpart I—Sanctions
- Subpart J—Conditions for Federal Financial Participation
Delivery System Reform

- Provides flexibility for states to support value-based purchasing models, delivery system initiatives and provider reimbursement requirements

- Strengthens existing QI approaches

Examples:

- Capitation payments for enrollees with short-term stay in an institution for Mental Disease
- Value-Based Purchasing

Institution for Mental Disease

- 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
- Applicable as of the effective date of the final rule

Approaches to Payment

- 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
- Applicable to contracts starting on or after July 1, 2017

Payment and Accountability Improvement

- 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

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

- Applicable to contracts starting on or after July 1, 2017

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

Examples

- Medical Loss Ratio (MLR)
  - Managed care plans are required to calculate and report their MLR experience for each contract year (applicable contracts after July 1, 2017)
  - Actuarially sound rates are set to achieve a MLR of at least 85% (applicable contracts after July 1, 2019)
  - States have the flexibility to set a standard higher than 85% and/or impose a remittance requirement
- Appeals and Grievances
Next Steps

- PIHP’s are meeting June 3, to review BBA Managed Care Compliance and develop a statewide implementation and compliance plan

- CMS Future Presentations
  - June 2, Rate Setting, DSR and MLR
QUESTIONS