HLB
Hooper, Lundy & Bookman, PC
HEALTH CARE LAWYERS & ADVISORS

HEALTH LAW PERSPECTIVES

Newsletter | Volume 18 | No. 4

April 2016

At a Glance: What Providers Need to Know About the Medicaid Managed Care Final Rule

On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued its final rule on managed care in the Medicaid program (the Final Rule), which will be published in the Federal Register on May 6, 2016. This is the first major update to the federal Medicaid managed care program requirements in 42 C.F.R. Part 438 in over a decade. As nearly two-thirds of Medicaid enrollees are enrolled in some form of managed Medicaid, this Final Rule will impact every health care provider that treats Medicaid patients both financially and operationally.

Through this Final Rule, CMS seeks to align Medicaid managed care with Medicare Advantage and private market policies, bolster state delivery reforms, strengthen consumer protections, impose new quality ratings and program integrity requirements, and set up best practices. The proposed rule directly impacts states, Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Managers (PCCMs) and will have downstream impacts on healthcare providers.

Key components of the rule include:

- **Continued Authorization of "Pass-Through" Payments for a Limited Time:** The Final Rule restricts the authority of states to direct how Medicaid managed care plans pay providers, except to implement value-based purchasing models, to support delivery system reform or performance improvement initiatives, or to adopt a minimum fee schedule, a uniform dollar or percentage increase or maximum fee schedule for network providers. Importantly, CMS will permit states to make pass-through payments, such as the "Upper Payment Limit" payments under various state Medicaid programs, for a limited period of time to hospitals, physicians and nursing facilities. Pass-through payments to hospitals must be phased out on a 10-year schedule, starting on or after July 1, 2017, and must decrease by 10 percentage points each successive year. Pass-through payments to physicians or nursing facilities must be phased out for contracts beginning on or after July 1, 2022.

- **Medical Loss Ratio:** CMS adopted its proposal to require Medicaid managed care plans to calculate and report a medical loss ratio (MLR). The Final Rule finalizes the authorization to states to

In This Issue

establish a minimum MLR of at least 85 percent. Despite comments from many stakeholders requesting that the MLR become a mandatory requirement, the Final Rule grants states the discretion as to whether to require Medicaid managed care plans to provide a remittance if the plan does not meet the MLR.

- **Actuarial Soundness:** The Final Rule requires that capitation rates for Medicaid managed care plans be actuarially sound and establishes a set process to be used by states in setting capitation rates. This process must consider, among other things, the plan's past and projected MLR. In addition, the Final Rule provides for CMS review and approval of rates for actuarial soundness.

- **Benefit Flexibility:** CMS finalized its proposal to permit MCOs and PIHPs to receive a capitation payment from the state for an enrollee aged 21 to 64 that spends a portion of the month for which the capitation is made as a patient in an institution for mental disease (IMD). In a departure from the proposed rule, the Final Rule grants increased flexibility for Medicaid managed care plans to cover services or settings in lieu of services or settings covered under fee-for-service Medicaid upon certain conditions, including approval by the State.

- **Network Adequacy/Accessibility:** The Final Rule requires states to develop network adequacy requirements that apply to contracts covering medical services, behavioral health services and Long Term Supports and Services (LTSS). States will be required to establish time and distance standards for certain network provider types, including: primary care (adult/pediatric); OB/GYN; behavioral health (mental health and substance use disorder, adult and pediatric); specialist (adult/pediatric); hospital, pharmacy; and pediatric dental. In addition, in acknowledging the special situation of LTSS where the provider site is the enrollee's residence, states with managed Medicaid contracts covering LTSS will be required to develop: (1) time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services and (2) network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. The Medicaid managed care entity will be required to ensure that network providers meet the state standards for timely access and offer hours of operation that are no less than the hours of operation offered to commercial enrollees or fee-for-service beneficiaries.

- **Integration of Long Term Supports and Services:** The Final Rule addresses the rapid expansion of Medicaid managed care in the delivery of LTSS by, among other things, requiring Medicaid managed care plans to address the unique needs and vulnerabilities of this population in all aspects of their operations. In order to effectuate this integration of LTSS into the more established Medicaid benefits implemented by these plans, CMS is requiring a heightened level of stakeholder engagement, including the development of beneficiary support systems and "choice" counseling specifically tailored for LTSS recipients and those who represent them. CMS is likewise requiring the implementation of comprehensive assessments of individuals requiring LTSS as well as the production of treatment/service plans for these individuals that are developed by experts in LTSS service coordination and "person-centered" care. These required processes are designed to ensure that LTSS recipients are able to understand the benefits available to them through Medicaid managed care plans and how to access necessary services. This includes the significant requirement that Medicaid managed care plans allow enrollees to disenroll if they would have to change their LTSS provider based on the provider's change of status from an in-network to an out-of-network provider. The overarching goal in the Final Rule as to LTSS is to ensure that these individuals' transitions through different care settings (particularly between home, nursing facility and/or hospital) are handled in a manner that best addresses their medical and non-medical needs and maximizes their quality of life and independence.

- **Provider Screening and Enrollment:** Prior to the Final Rule, states varied as to whether they require that network providers with MCOs, PIHPs, PAHPs and PCCMs be enrolled in the respective state Medicaid program. The Final Rule

requires the screening, enrollment, and revalidation by states of all network providers of MCOs, PIHPs, PAHPs, and PCCMs or PCCM entities, to the extent the primary care case manager is not otherwise enrolled with the state to provide services to Fee-for-Service (FFS) beneficiaries. State enrollment of these providers does not obligate the providers to render services to FFS beneficiaries. Network providers will also be required to be credentialed pursuant to the applicable state's uniform credentialing and recredentialing policy for acute, primary, behavioral, substance use disorders and LTSS providers

- **Other Provider Program Integrity Provisions:** One welcome change in the Final Rule is the distinction between a "network provider" and a "subcontractor," and a clarification of the different obligations of Medicaid managed care entities with respect to each of these categories. The Final Rule clarifies that a network provider is not a subcontractor by virtue of entering into a network provider agreement with a Medicaid managed care plan. A network provider may become a subcontractor if it enters into a contract that relates directly or indirectly to the performance of the entity's obligations under its contract with the State. A network provider would likely be treated as a subcontractor under arrangements where the provider accepts risk for Medicaid managed care beneficiaries or performs administrative functions like utilization management for a Medicaid managed care entity. The Final Rule requires that Medicaid managed care entities impose broader obligations on subcontractors than network providers.

  With respect to network providers, the Final Rule confirms that Medicaid managed care entities will also have to have processes in place for: (1) notifying the State when the entity receives information about a change in a network provider's circumstances that may affect the provider's eligibility to participate in Medicaid managed care; (2) verifying whether services are actually provided by network providers; and (3) suspending payments to a network provider for which the State determines there is a credible allegation of fraud. In addition, CMS finalized its proposal that each MCO, PIHP or PAHP requires and has a mechanism for a network provider to report to the entity when it has received an overpayment, to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify the entity as to the reason for the overpayment.

- **Quality Reforms:** The Final Rule authorizes states to develop and implement a Medicaid quality rating system, and extends requirements for external quality review and a managed care quality strategy to all types of managed care. CMS adopted a policy not previously proposed to require states to include in their quality strategy a plan to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, and mechanisms to identify individuals who need LTSS or who

HLB Briefs

- HLP Attorney John Hellow has joined the National Health Law Program Board of Directors. NHeLP Board Chair Robert N. Weiner welcomed Mr. Hellow to the Board lauding him as a "distinguished attorney who will bring impressive knowledge and leadership abilities to help advance NHeLP's mission to fight for quality health care for our nation's most vulnerable individuals and families."
- HLB is pleased to announce that Robert Roth and Precious Murchison Gittens have been recognized as 2016 Washington, D.C. SuperLawyers.

have special health care needs. The Final Rule will also require states to make their quality strategy reviews available on the internet.

- **Appeals and Grievances:** The Final Rule revises the appeal and grievance requirements on managed Medicaid to align those provisions with Medicare Advantage and private insurers. Importantly for providers, the Final Rule limits a plan's internal appeal processes to a single level and would only permit a state fair hearing until after that internal plan appeal is exhausted. The Final Rule also authorizes states to offer and arrange for external medical review under certain conditions.

For additional information, please contact Mark E. Reagan, Felicia Y Sze or Katrina A. Pagonis in San Francisco at (415) 875-8500; Lloyd A. Bookman or Nina Marsden in Los Angeles at (310) 551-8111; or Keith Fontenot in Washington, D.C. at (202) 580-7706.

CMS Announces New Comprehensive Primary Care Plus Model (CPC+)

By Benjamin A. Durie

On April 11th, the Centers for Medicare & Medicaid Services (CMS) announced a major new primary care delivery model for Medicare beneficiaries called Comprehensive Primary Care Plus (CPC+). The program, which will begin in January 2017, will include a hybrid fee-for-service payment with incentives for quality outcomes and a care management fee to support population health infrastructure at the practice level. The new program is intended to further the Department of Health and Human Services goal to have 50 percent of all Medicare fee-for-service payments made via alternative payment models by 2018. CPC+ builds upon the Comprehensive Primary Care Initiative (CPCI) currently operating in Arkansas, Colorado, New Jersey, Oregon, parts of New York, parts of Ohio, parts of Kentucky and parts of Oklahoma. The CPCI originally began in October 2012 and is scheduled to run through December 31, 2016.

1. **Model Overview.**
CMS plans to implement CPC+ in up to 20 geographic areas across the U.S. and will support up to 5,000 individual practices serving up to 25 million Medicare beneficiaries. CMS will select the specific regions for the program based on submissions from third party payors interested in partnering with CMS and individual practices to support the CPC+ program.

   a. Participating Payors.
   CMS anticipates applications from a variety of payers, including, commercial insurers, Medicare Advantage plans, states, Medicaid/CHIP managed care plans, and self-insured businesses or administrators of a self-insured group. Participating payors will enter into MOUs with CMS pursuant to which they will commit to enter into separate contracts with participating CPC+ practices that contain terms that mirror the CPC+ program (quality requirements, performance-based inventive payments, enhanced fee-for-service support). Interested payors can submit applications to CMS until June 1, 2016.

   b. Participating Provider Tracks.
   Once CMS has announced the regions where CPC+ will be implemented, CMS will solicit applications from practices that want to participate. Practices will be able to apply for one of two different tracks – each with different eligibility requirements and payment methodologies. In order to participate in either track, all CPC+ practices must have multi-payer support (meaning private payors have signed MOUs with CMS committing to the program), certified EHR technology, and other infrastructural capabilities. Track 2 will only be available to practices who are able to demonstrate advanced health IT capabilities necessary to support the program's new care delivery requirements. Track 2 practices must enter into MOUs with HIT vendors evidencing that they will be able to provide the required health IT infrastructure. Practices will be able to submit applications to CMS between July 15 and September 1, 2016.

2. **Care Delivery Design and Quality Measures**
Practices participating in the CPC+ model will be required to make changes to the way they deliver care

to Medicare beneficiaries. In addition to fee-for-service evaluation and management visits, CMS will require providers to perform five key "primary care functions" for Medicare beneficiaries: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health. CMS has developed a prescribed framework for each primary care function.

Participating practices will be required to report quality data to CMS throughout the program in order to assess quality performance, track experience and quality of care, identify gaps in care, and focus quality improvement activities. In order to support practices as they transition to the new model, CMS intends to provide what they call a "robust learning system" through both regional and national learning communities.

3. **Hybrid Payment Methodology:**
Practices participating in CPC+ will receive three different categories of payments: (1) a monthly per beneficiary care management fee calculated based on beneficiary risk tiers; (2) annual pre-paid inventive payments subject to repayment based on quality and utilization performance thresholds; and (3) fee-for-service payments. As illustrated in the following table, the payment amounts and specific methodology varies within these three categories depending on whether the practice is participating in Track 1 or Track 2.

For the purpose of calculating the pre-payments, CMS will use a prospective attribution methodology to assign beneficiaries to participating practices based on a plurality of primary care claims over the preceding two years.

4. **Legal Considerations for Primary Care Practices and Affiliated Hospitals:**
CMS has called the CPC+ the largest ever initiative to "transform and improve how primary care is delivered and paid for in America." The proposed program is just the latest tangible example of how CMS intends to move Medicare reimbursement to alternative payment models. In order to maximize the potential benefits of the CPC+, primary care practices and hospitals working with primary care practices should closely review the program to determine whether to apply prior to the September 1st deadline. Successful applications will require coordination with third party payors and possibly outside HIT vendors, which may require careful advance planning. Because of the proposed partnerships between CMS and both government and non-government payors at the core of the CPC+ model, the program has the potential to have a large impact on the way primary care services are delivered and reimbursed for both commercial patients and Medicare/Medicaid beneficiaries.

	Track 1	Track 2
Monthly Medicare Beneficiary Care Management Fee	Between $6 and $30 a month depending on beneficiary risk tier ($15 per month average)	Between $9 and $33 a month depending on beneficiary risk tier ($28 per month average; $100 per month for complex cases).
Annual Performance-Based Incentive Payment	$2.50 per beneficiary per month.	$4 per beneficiary per month.
Medicare Payment Structure	Regular fee-for-service payments.	A percentage of expected Medicare E&M payment up front the form of Comprehensive Primary Care Payment and a reduced fee-for-service payment for face-to-face E&M claims throughout the year.

Regulatory News from HLB's Government Relations & Public Policy Department
Following are brief, high-level summaries of rules and proposed rules recently released.

MACRA

On April 27, CMS released a proposed rule to implement the two-track Medicare physician reimbursement methodology under Medicare Access and CHIP Reauthorization Act (MACRA). The proposed rule implements these changes through a unified framework called the Quality Payment Program, which includes Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM)

HLB will shortly be releasing an overview of the proposed rule (See our recent report outlining MIPS and APM at http://www.health-law.com/newsroom-advisories-129.html.

Contact: Robert Lundy, Charles Oppenheim, Hope Levy-Biehl, Karl Schmitz in Los Angeles at 310.551.8111; Marty Cory, William Eck, Kelly Carroll or Monica Massaro in Washington, D.C at 202.580.7700; or Ben Durie in San Francisco at 418.875.8502.

Medicaid Managed Care Final Rule

On April 25, CMS released the long-anticipated Medicaid and CHIP Managed Care Final Rule, the first update to the program in over a decade (see article in the current issue of this newsletter). The final rule includes changes to align the program with Medicare Advantage and the private market, network adequacy standards, program integrity, and implantation of an 85 percent medical loss ratio (MLR). CMS will also begin a quality rating system for Medicaid and CHIP plans similar to Medicare Advantage. The effective dates of these provisions have been published on a timeline on the CMS website. Contact Mark Reagan, Felicia Sze or Katrina Pagonis in San Francisco at 415.875.8500; Lloyd Bookman or Nina Marsden in Los Angeles at 310.551.8111; or Keith Fontenot in Washington, D.C. at 202.580.7706.

Post-Acute Care & Hospice Proposed Rules Released

On April 21, the Centers for Medicare and Medicaid Services (CMS) released three proposed payment rules for FY 2017. Many of the proposals are in line with the implementation of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) to streamline quality measurement. The Skilled Nursing Facility (SNF) proposed rule projects an increase aggregate payment to SNFs by 2.1 percent. The proposal also includes new quality measures and new value-based purchasing requirements.

- In the Inpatient Rehabilitation Facility (IRF) proposed rule, CMS proposes to increase payment by 1.6 percent in fiscal 2017. CMS also proposes four claims-based measures for inclusion in the IRF Quality Reporting Program (QRP).
- In the Hospice Proposed Rule, the hospice wage index is updated and CMS projects a payment increase of 2 percent for FY 2017. In addition, the proposal seeks comment on new quality measures, an enhanced data collection instrument, and a plan to publicly display quality data. CMS will accept comments on all three rules through June 20, 2016.

Contact: Mark Reagan or Scott Kiepen in San Francisco at 415.875.8500, Mark Johnson in San Diego at 619.744.7300, or James Segroves in Washington, D.C. at 202.580.7710.

HRSA Reopens 340B

On April 19, the Health Resources and Services Administration (HRSA) reopened comments on a proposed 340B rule from last June that sets prices and penalties under the drug program. HRSA is specifically requesting comment on its "penny pricing" policy based on the ceiling price for a covered outpatient drug. HRSA will accept public comment on the rule through May 19, 2016. Contact Jordan Keville in Los Angeles at 310.551.8130.

Hospital IPPS and LTCH Proposed Rule Released

On April 18, the CMS released its Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule including policy and rate changes for fiscal year 2017. Overall, CMS estimates the proposal would provide a net increase of .7 percent on average. In addition, CMS proposed that will reverse prior payment cuts related to the two-midnight policy and remove it going forward. The proposal also makes changes to uncompensated care payments, notifications of observation status, the hospital value-based purchasing program and LTCH Prospective Payment System Changes. CMS will accept comments on the proposed rule until June 16, 2016, and will publish the final rule by August 1, 2016. Contact: John Hellow, Hope Levy-Biehl, Tracy Jessner Hale, or Nina Marsden in Los Angeles at 310.551.8111; Robert Roth in Washington, D.C. at 202.580.7701, or Felicia Sze in San Francisco at 415.875.8503.

CALENDAR

April 4

Brookings Institute Health Care Conference
Keith Fontenot co-presented on a panel on *Medicare and Medicaid.*

April 7-9

Care Coordination Institute 2016 Annual Symposium
Keith Fontenot co-presented *CMS Leading the Transformation to Value-Based Health Care.*

April 8-10

2016 CSHA Annual Meeting and Spring Seminar, Monterey
Katrina Pagonis and Felicia Sze presented *From Revolution to Evolution: The Next Chapter of Health Reform;* Steve Phillips (also current CSHA president) co-presented *Issues in Negotiating Health Care Technology Contracts.*

April 15

AHLA Webinar: Hospital-Physician Practice Acquisitions in the Wake of Health Care Reform
Charles Oppenheim and Hope Levy Biehl were co-presenters for this program.

April 19

HCCA 20th Annual Compliance Institute, Las Vegas
Charles Oppenheim co-presented *Kickback and Stark Law Developments.*

April 25

Women in Health Care Southern California Program, Los Angeles
Amanda Hayes-Kibreab participated on the managed care panel: *What's Next for Managed Care?*

April 28-29

Annual Independent Owners & Operators Symposium and Conference, Carlsbad, CA
Mark Reagan presented *Learning to Effectively Manage in a Changing Reimbursement Environment.*

May 19-20

45th CAMSS Annual Education Forum & Anniversary, Anaheim
Harry Shulman and Amy Joseph present *The Privacy of a Medical Staff Member's Health Information When Patient Safety and Quality of Care are an Issue;* Ruby Wood and Ross Campbell present *Two Sides of the Section 1157 Coin: The Necessity of Knowing When Not to Designate Information Confidential.*

May 20

California Orthopedic Association Annual Meeting, Laguna Niguel
Charles Oppenheim presents Understanding & Winning with Bundled Payments.

June 8

AHLA Webinar: Government Relations
Keith Fontenot co-presents.

2016 Edition of CHA Hospital Compliance Manual Includes Final 60-Day Rule and More…

The California Hospital Association (CHA) has released the 2016, 7th Edition of the California Hospital Compliance Manual.

The 2016 edition has been updated to reflect CMS' revised regulations of the 60-day requirement for reporting and returning overpayments, revisions to the federal self-referral (Stark) laws, modifications to CMS's "rare and unusual" exceptions to the "two midnight" rule, and more.

CHA's compliance manual is the only publication written for hospital compliance officers that integrates California with federal laws regarding high-risk compliance areas.

Written by Hooper, Lundy & Bookman, PC, attorneys and CHA, the manual focuses on key components of an effective compliance program. The manual features 700 pages of content including 16 chapters, a model hospital compliance plan, and an index.

To order the new manual or for more information, visit www.calhospital.org/compliance.

HLB
HOOPER, LUNDY & BOOKMAN, PC
HEALTH CARE LAWYERS & ADVISORS
1875 Century Park East, Suite 1600
Los Angeles, California 90067-2799