Wisconsin Department of Health Services

Medicaid Managed Care Rules—Key Provisions Impacting Family Care*
(42 C.F.R. Part 438)

1. **Provider Network Adequacy Standards, § 438.68—Implementation 1/1/19**
   - Annually assess and certify the adequacy of each Managed Care Organization's (MCO) provider network or when there's a substantial change in program design (additional services, new service areas, etc.).
   - Develop time and distance standards for primary and specialty care, behavioral health (mental health and substance use disorder), obstetrics and gynecology, pediatric dental, hospital, and pharmacy providers where covered under the plan.
   - Develop network adequacy standards for long-term care services.
     - Time and distance standards for services where enrollee travels to provider.
     - Network adequacy standards for providers who travel to enrollees.
   - State can have exception process for a provider type in limited supply; must monitor member access and publish finding in an annual program report.
   - Publish standards on state's website.
   - Annually, plans must submit evidence of compliance to the state, which must ensure compliance to Centers for Medicare and Medicaid Services (CMS).
   - External Quality Review Organization (EQRO) will assess plan compliance (effective one year after CMS publishes protocol).

2. **Screen and Enroll All Providers Not Enrolled in State Fee-For-Service (FFS) Medicaid Program, § 438.602(b-d)—Implementation 1/1/19**
   - State must screen and enroll all MCO providers not otherwise enrolled in FFS Medicaid. Preamble and CMS discussion indicate the state is permitted to delegate this to MCOs or another third party, but remains responsible for the results.
   - This includes: verifying licenses, revalidations at least every five years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by MCOs and their subcontractors.
   - MCOs may execute provider agreements effective for up to 120 days pending the outcome of the state screening and enrollment process. If notified by the state that a provider cannot be enrolled, or there is no determination within 120 days, the provider agreement must be terminated and affected members notified.
   - Applies to self-directed supports (SDS) providers.

3. **Capitation Payments for Individuals in an Institution for Mental Disease (IMD), § 438.6(e)—MAY implement 7/5/16**
   - States may make capitation payments to MCOs for enrollees, aged 21-64, who are inpatients in an IMD for 15 days or fewer in a calendar month for mental illness or substance use disorder. Enrollee must have days of service in the month when not in the IMD. The 15 days does not need to be consecutive.
   - Coverage of IMD by MCO must meet requirements for in lieu of services, § 438.3(e)(2).
   - Facility must be inpatient hospital providing psychiatric or substance abuse services or a sub-acute facility providing crisis residential services.
   - Such IMD services may be included in future rates, but for that purpose must be priced at the comparable covered service, inpatient psychiatric care in a general hospital.
   - Stay must be voluntary per in lieu of requirements.

4. **In Lieu of Services, § 438.3(e)(2)(i)-(iv)—Implementation 7/5/16**
   - Must be medically appropriate and cost-effective substitute for the covered state plan service.
   - Member cannot be required to use the in lieu of service.

- In lieu of services must be identified in the Department of Health Services (DHS-MCO) contract and offered at the discretion of the MCO.
- Utilization and cost of in lieu of services are taken into account in developing capitation rates, unless a statute or regulation explicitly requires otherwise.

5. **Enrollment Standards, § 438.54—Implementation 1/1/18**
   Develop informational notices explaining implications of not making an active choice. Notices must comply with § 438.10.

6. **Beneficiary Support System, § 438.71—Implementation 1/1/19**
   Prohibition on beneficiary support system providing representation to beneficiaries at state fair hearings might preclude representation by benefit specialists, which they now provide.

7. **Continuation of Benefits During MCO Appeal and State Fair Hearing, §§ 438.210 and 438.420—Implementation 1/1/18**
   - Where the member requests a continuation of benefits, MCO must continue coverage during an appeal or fair hearing even if the previously authorized time period or service limit for the benefit has been met.
   - State must ensure recoupment practices from beneficiaries are consistent across both FFS and managed care delivery systems within the state.

8. **Continued Services to Beneficiaries, and Coordination and Continuity of Care, § 438.62—Implementation 1/1/19**
   - State must have a transition of care policy for individuals moving from FFS to the MCO, or from one MCO to another MCO when an enrollee would experience serious detriment to the enrollee's health or put him/her at risk of hospitalization or institutionalization. The transition policy must include:
     - Permitting the enrollee to receive the services they are currently receiving from his or her current provider for a specified period of time.
     - Referring the enrollee to an appropriate participating provider.
     - Assuring that the state or MCO comply with requests for historical utilization data.
     - Assuring that the enrollee's new provider can obtain appropriate medical records.
   - The transition policy should be included in the state's comprehensive quality strategy and MCO contract, and included in information provided to potential enrollees.

9. **Assurances of Adequate Capacity and Services, § 438.207—Implementation 1/1/19**
   - MCO must submit documentation to the state that its provider network is sufficient in number, mix, and geographic distribution to meet the needs of enrollees when (1) the MCO enters into a contract with the state, and (2) anytime there is a significant change in the MCO's operations that would affect adequate capacity and services (current requirement). Must be done annually and when there is "a significant change in the composition of its provider network."
   - State must certify to CMS that the MCO meets the state's standards for access to services (current practice), and include with its certification documentation of the analysis supporting the certification (new).

10. **Quality Rating System (QRS), Performance Improvement Projects (PIPs), and External Quality Review (EQR), §§ 438.334, 438.364, 438.370, 438.66, 438.68—Implementation Dates Below**
    - State must either adopt a CMS-developed Medicaid managed care quality rating system or develop their own comparable one, which must be approved by CMS. Implementation: three years after final notice published in federal register. Final notice expected in 2018, with implementation expected in 2021.
    - The CMS Medicaid QRS will use the same or similar indicators to those used for the Marketplace QRS, with some flexibility to choose measures in light of the different populations served. CMS will issue the QRS through a final notice in the federal register, probably in 2018, with implementation required three years later (see above).

- State must collect data from each plan and calculate ratings for each plan. Implementation: three years after final notice published in federal register. Final notice expected in 2018, with implementation expected in 2021.
- Expands areas that the state monitors from three to 13: administration and management; appeals and grievances; claims management; enrollee materials and customer services; finance, including medical loss ratio; IT systems, including encounter reporting; marketing; medical management, including utilization and care management; program integrity; provider network management; availability and accessibility of services; quality improvement; and areas related to long-term services and supports (LTSS) not otherwise covered. Implementation 1/1/18
- Areas in which performance is to be improved with data collected in monitoring are: enrollment and disenrollment, grievances and appeals, EQRO findings, enrollee satisfaction surveys, performance on quality measures, medical management, quality improvement plans, financial and encounter data, medical loss reporting, customer service performance, and other areas for which LTSS data is collected. Implementation 1/1/18
- Changes to EQR include:
  - Adds the evaluation of network adequacy. Implementation no later than one year from issuance of associated EQR protocol
  - Clarifies that the EQRO must produce the technical report and that states cannot substantively alter the report. Implementation 1/1/19
  - The report must be completed by April 30 of each year and be published on the state's website. Implementation 1/1/19
  - Changes the match rate for EQR activities to 50% for all entities other than MCOs (it appears to mean that EQR activities for Family Care MCOs, which are technically Pre-Paid Inpatient Health Plans (PIHPs), would not be eligible for 75% match as they are currently). Implementation immediate

11. Contract Requirements Involving Indians, Indian Health Care Providers (IHCP), Indian Managed Care Entities (IMCE), § 438.14—Implementation 1/1/18

- Permit Indian members to receive covered services from out-of-network IHCPS.
- Permit an out-of-network IHCP to refer an Indian member to a network provider.
- Require an MCO to pay an IHCP enrolled in Medicaid as a Federally Qualified Health Center (FQHC), but not a network provider, at the rate it would pay an FQHC network provider, including any supplemental payment from the state to make up the difference between the MCO and FFS payment rates.
- Require an IHCP not enrolled in Medicaid as a FQHC, whether or not a network provider, to be paid for covered services at the rate the Indian Health Service would pay, or absent that, at the Medicaid FFS rate. The state shall make up the shortfall, if any, between the amount the MCO pays and the required rate.

12. Marketing, § 438.104—Implementation 7/5/16

- Expands prohibited "cold-call" methods of advertising to include email and texting.
- MCO contract must contain specific language to clearly define the state's intent that the contract is specific to the Medicaid plan being offered by the entity.

13. Appeals and Grievances, §§438.400, 438.402, 438,404, 438.406, 438.408, 438.410, 438.414, 438.416 and 438.424—Implementation 1/1/18

- Replaces "action" with more broadly defined "adverse benefit determination," which means that MCOs will need to provide notices for more situations.
- Specifies language that must be included in adverse benefit determination notices.
- MCOs can have only one level of appeal for enrollees.
- Enrollees must start with, and exhaust, the MCO appeals process before they can request a fair hearing.
- If an MCO fails to produce a decision on the member's appeal within the required timeframe, the MCO's appeal process is deemed to have been exhausted and the member can proceed to fair hearing.

- The state can offer an optional external medical review, which is not a formal level of appeal, and can be accessed at the option of the enrollee.
- Sets timeframe for enrollees to file an appeal at 60 days. (Wisconsin's is 45 days.)
- Permits the enrollee to view the case file "sufficiently in advance" of the appeal resolution timeline as opposed to current requirement of "before and during" the appeals process.
- Increases the amount of time an enrollee has to request a fair hearing from 45 days to 120 days.
- Enrollees would be entitled to request a grievance if they do not agree with an MCO extending the timeframe to make a decision on a grievance or appeal.
- Sets minimum standards for the types of information that must be collected: reason for the appeal or grievance, date received, date of each review or review meeting if applicable, resolution at each level, date of resolution, and name of enrollee. State must review the information and update and revise its comprehensive quality strategy.
- Reversed appeal resolutions have to be effectuated by MCO within 72 hours of receiving notice of the adverse benefit determination being overturned.
- Requires several additional (not listed above) technical contract language changes for processes, notices, etc.

14. Readiness Reviews, § 438.66(d)—Implementation 1/1/18

- State must conduct readiness review prior to start of new program, MCO, or populations.
  - Must be started at least three months prior to implementation.
  - Results must be submitted to CMS in written form prior to any CMS contract approval.
  - Must include both a review of documents and an onsite review, including interviews with staff who manage key operational areas. Onsite reviews are optional when new populations are added. They are required when the state is implementing a new program or when the MCO has not previously contracted with the state.
  - Review must address four broad areas: operations and administration, service delivery, financial management, and systems management.
- Readiness reviews are optional when new benefits or service areas are added.

15. Submission of Annual Program Assessment Report to CMS, § 438.66(e)—Implementation TBD (no later than rating period after CMS issues guidance)

- State must submit to CMS an annual report assessing the performance of each managed care program within 180 days of the end of the program year. The report must cover eight areas for each MCO: beneficiary support system; financial performance; encounter reporting; enrollment and service area expansion; modifications to covered benefits; grievances, appeals and state fair hearings; availability and accessibility of services and network adequacy standards, performance on quality measures; and results of any sanctions, corrective action plans, and informal interventions with the plan. Additionally, it must cover "any other factors" in the delivery of LTSS.
- Reports must be provided to required stakeholder consultation group and be posted on the state's website.

16. State Monitoring Standards, § 438.66 (a)-(c)—Implementation 1/1/18

- Expanded the areas that must be monitored from three to 13 and requiring the use of data collected in monitoring to be used in improving MCO performance in at least 12 specified areas.
- Areas that must be monitored are: administration and management; appeals and grievances (for both enrollees and providers, and satisfaction surveys from both); claims management; enrollee materials and customer services (including beneficiary support system); finance including medical loss ratio; IT systems, including encounter reporting; marketing; medical management, including utilization and care management; program integrity; provider network management (including provider directory standards); availability and accessibility of services (including network adequacy); quality improvement; and areas related to LTSS not otherwise covered.

- Areas in which performance is to be improved with data collected in monitoring are enrollment and disenrollment, member and provider grievances and appeals, EQRO findings, member satisfaction surveys, performance on quality measures, medical management, quality improvement plans, financial and encounter data, medical loss reporting, customer service performance, and other areas for which LTSS data is collected.

17. **Stakeholder Engagement in LTSS, §§ 438.70, 438.110—Implementation 1/1/18**
    - State must have a stakeholder advisory group (must include family members or other individuals that represent enrollees) for managed LTSS programs.
    - MCO must have an enrollee advisory committee reasonably representative of the populations served (must include family members or other individuals that represent enrollees).

18. **Information Requirements—Readily Accessible (electronic), § 438.10—Implementation 1/1/18**
    - Permit states and MCOs to make enrollee and potential enrollee information available in electronic form. Electronic information must be easily understood and readily accessible. "Readily Accessible" means compliance with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and World Wide Web Consortium's (W3C's) Content Accessibility Guidelines.
    - Added definition of limited English proficient to the final rule.

19. **Enrollee Information—Standards for Language and Format, § 438.10(c) and (d)—Implementation 1/1/18**
    - MCOs must inform enrollees that all information provided electronically is available in paper form upon request, at no cost, and be provided within five business days.
    - State and MCO must include taglines on enrollee materials in each prevalent non-English language, as well as large print (18 point), explaining the availability of written materials in those languages, as well as oral interpretation to aid in understanding the materials. Oral interpretation applies to all languages, written interpretation is available in prevalent languages; and includes auxiliary aids and services that must be made available at no cost (including, but not limited to, use in TTY and American Sign Language (ASL) interpreters).
    - Lists written materials that are "critical to obtaining services" and must be made available in prevalent languages in service area.
    - Written materials must be in 12-point font.

20. **Information Requirements for Potential Enrollees, § 438.10(e)—Implementation 1/1/18**
    State must provide all potential enrollees (in paper or electronic format) when first eligible, and within a timeframe that enables them to use the information: rights and process to disenroll and alternative options; features of managed care; explanation of enrollment and enrollment periods; service area for each MCO; covered benefits (explaining those provided by MCO versus the state); provider directory and formulary; cost-sharing; requirements of MCO to provide access to services, including network adequacy standards; MCO responsibility for coordination of care; and quality and performance indicators for each MCO, including consumer satisfaction.

21. **Disenrollment—Annual Notification, § 438.10(f)—Implementation 1/1/18**
    State must notify all enrollees of their right to disenroll at least annually. Notification must clearly explain the process for exercising their rights, as well as the alternatives available.

22. **Provider Directory, §§ 438.10(h)(1), 438.10(h)(3), 438.10(h)(4) and (i)(3)—Implementation 1/1/18**
    Paper directories only need to be provided upon request.

MCOs must:

- Include the provider's group or site affiliation, network provider's website address (URL), and indicate whether the provider will accept new enrollees. The provider directory must include whether provider's office or facility has accommodations for people with disabilities, including offices, exam rooms, and equipment.
- Update paper provider directory monthly, and electronic provider directories no later than 30 calendar days after the MCO receives updated provider information.
- Post provider directories and formularies in a machine-readable format specified by CMS.
- Include in the provider directory American Sign Language (ASL) as part of linguistic capabilities (not just non-English languages spoken) by the provider or medical interpreter at provider's office, and whether the provider has completed cultural competency training.

23. Provider Directory Machine Readable Format, § 438.10—Implementation pending CMS guidance—Implementation 1/1/18 (CMS intends to issue clarifying guidance)

Provider directories and formularies on MCO website must be in a machine-readable format.

24. Actuarial Soundness Standards, § 438.4—Implementation Dates Below

- If state has minimum provider payment rates, the capitation development must incorporate these minimum rates. Implementation 7/5/16
- Prohibits different capitation rates based on federal financial participation (FFP) for a population. Implementation 7/5/16
- Rates must be sufficient to maintain adequate provider networks, care coordination, and continuity of care. Implementation 1/1/19
- Rates must not cross-subsidize rates for another rate population. Implementation 7/5/16
- Must certify a specific rate for each MCO, not rate range. Ranges can be used to assess appropriateness of rate. Implementation 1/1/19
- All components and adjustments of the rate must be certified by the actuary. Implementation 7/5/16
- MCO reports on medical loss ratio (MLR) added to rate development documentation. Implementation 1/1/18

25. Rate Development Standards, § 438.5—Implementation Dates Below

- Six steps for rate-setting process that CMS will use for evaluating (evaluates each step individually): Implementation 1/1/18
  - Collect or develop appropriate base data from historical experience.
  - Develop and apply appropriate and reasonable trends to project benefit costs in the rating period, including trends in utilization and costs of benefits.
  - Develop appropriate and reasonable projected costs for non-benefit costs in the rating period as part of the capitation rate.
  - Make appropriate and reasonable adjustments to the historical data, projected trends, or other rate components as necessary to establish actuarially sound rates.
  - Consider historical and projected MLR of the MCO.
  - For programs that use a risk adjustment process, select an appropriate risk adjustment methodology, apply it in a budget neutral manner, and calculate adjustments to plan payments as necessary.
- State must provide actuary validated encounter data, FFS data (if applicable), and audited financial reports for three most recent years completed, prior to rating period under development (e.g., 2017 rates are set in 2016, so provide 2013-2015 data). Implementation 1/1/18

26. Special Contract Provisions Related to Payment, § 438.6—Implementation Dates Below

- "Risk corridor" definition revised from state and contractor share in both profits *and* losses outside a predetermined threshold amount to applying to profits *or* losses. Implementation 7/5/16

- Incentive payments: additional standard that incentives tied to meaningful goals and performance measure outcomes. This section applies to state to MCO payments, not MCO to service provider payments. Implementation 7/5/16
- Performance withhold: capitation rate, minus any portion of the withhold that is not reasonably achievable, and the withhold arrangement, should not provide an opportunity for MCOs to receive more than the actuarially certified capitation rate. Implementation 1/1/18
- State may set minimum reimbursement standards or fee schedule for managed care payments to providers, for providers that deliver a particular covered service, or in an effort to enhance the accessibility or quality of covered services. State will need to provide supporting documentation for these arrangements. Implementation 1/1/18
- Pass-through payments are phased out. This phase-out must occur within five years for physicians and nursing facilities. (No pass-through payments after July 1, 2022).
- Allow IMD stays for up to 15 days. Implementation 7/5/16
  - For purposes of rate setting, the state may include IMD services for stays up to 15 days in lieu of comparable state plan services.
  - IMD service costs included in rate development would be limited to the cost of the same services provided through providers included under the state plan, for example inpatient hospital.
  - The Family Care benefit does not currently include the comparable state plan services. Barring a change in the Family Care benefit, IMD services will continue to be excluded from data used to develop capitation rates.

27. Rate Certification Submission, § 438.7—Implementation Dates Below

- Standards for trend, including trend factors for changes in the utilization and price. Implementation 1/1/18
- Material adjustments: methodology, the reasonableness of the adjustment for the population, the cost impacts of each material adjustment, and where in the rate development process the adjustment was applied. Implementation 1/1/18
- Risk-adjustment methodologies: Implementation 1/1/18
  - Prohibit risk adjustment that increases or decreases total payments across all MCOs based on the overall health status or risk of the population.
  - Retrospective adjustments are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection.
- Retroactive adjustments to the rates: submit revised rate certification (and contract amendment) describing specific rationale, data, assumptions, and methodologies of the adjustment in sufficient detail to understand and evaluate the proffered retroactive adjustments to the payment rate. All such adjustments are also subject to federal timely filing standards for federal financial participation. Implementation 1/1/18
- Limitations to need for recertifying rates: reflects the state's ability to modify the certified capitation rate per rate, within a 1.5 percent range without submitting a revised rate certification. Implementation 1/1/19

28. Medical Loss Ratio (MLR) in Capitation Rates, §§ 438.4(b)(8), 438.5(b)(5), 438.8—Implementation 1/1/18

- MCOs must calculate and report MLR for rating period for contracts starting on or after July 1, 2017.
- Permits each state to establish a minimum MLR that may be higher than 85%, although the method of calculating the MLR would still be consistent with CMS standards.
- Rule provides flexibility to include care management as a non-administrative cost.

29. Recovery of Overpayments, § 438.608(d)(1), (2), (3)—Implementation 1/1/18

DHS-MCO contract must:

- Address retention policies for the treatment of overpayments, with particular focus on fraud, waste, and abuse.

- Specify process, timeframes, and documentation requirements for plans to report recovery of overpayments.
- Specify process, timeframes, and documentation requirements for plans to pay recoveries to the state if plans are not permitted to retain said recoveries.

30. Program Integrity, §§ 438.600, 438.602, 438.604, 438.606, 438.608 and 438.610—Implementation 1/1/18

- State must:
  - Review ownership and control disclosures from MCOs and any subcontractors.
  - Conduct monthly federal database checks to confirm identity of, and determine exclusion status of, MCO entity, any subcontractor, any person with ownership or controlling interest, or an agent or managing employee.
  - Contract for independent audit of accuracy, truthfulness, and completeness of encounter and financial data every three years.
  - Post on its website, or otherwise make available, data submitted under proposed § 438.604 (includes "encounter data and other data generated by health plan for purposes of rate setting").
- MCO must certify data, information, and documentation.
- Expands MCO staff persons who may certify the data to include individuals reporting directly to MCO chief executive officer (CEO).
- Requires that the person doing the data certification conduct a "reasonably diligent" review of the data to determine accuracy.
- Specifies data MCO must submit to the state. Allows the Secretary of Health and Human Services to specify data not listed.
  - Encounter data
  - Data on the basis of which the state certifies its capitation rates
  - Data on the basis of which the state determines compliance with MLR
  - Data on the basis of which the state determines adequate protections against insolvency
  - Documentation supporting certification decisions regarding adequacy of provider network
  - Information on ownership and control
  - Annual report of overpayment recoveries
- Extends requirements for program integrity and compliance programs, including ownership and disclosure provisions to subcontractors.
- New regulations also include:
  - Compliance officer must report to CEO and the board of directors
  - Regulatory compliance committee must be at the board of directors and senior management level
  - Must have a system of training and education for compliance officer, management and staff that reflects federal and state requirements
  - Must have dedicated staff to monitor compliance, provide prompt response to issues, and ability to investigate
  - Must implement provisions for reporting potential fraud and abuse, and changes in enrollee or provider circumstances to the state
  - Verify that services were provided
  - Develop provisions to suspend payments when there is a credible allegation of fraud

31. Encounter Data and Health Information Systems, §§ 438.2, 438.242 and 438.818—Implementation Dates Below

- Defines enrollee encounter data. Implementation 7/5/16
- Adds requirement that MCO must provide information on claims, and must have claims processing and retrieval systems that comply with the Affordable Care Act. Implementation 1/1/18
- MCOs must ensure that data from providers is accurate and complete and that it is received in standardized format. Implementation 1/1/18

- Encounter data must include data on the rendering provider and be submitted to the state at a frequency and level of detail specified by CMS and in standardized formats. Implementation 1/1/18
- Validated enrollee encounter data must be submitted to CMS as specified, and in the format required under the Medicaid Statistical Information System. Failure to report compliant data could result in loss of FFP. Implementation 1/1/19

32. Choice Counseling, § 438.2—Implementation 7/5/16

States may determine who provides choice counseling.

- If an individual or entity provides choice counseling services, they are considered an enrollment broker. (§ 438.71(c)(2))
- Enrollment broker and those offering choice counseling must be independent and free of conflict of interest. Must meet independence and conflict of interest standards in § 438.810 (cannot have a financial relationship with an MCO, including participating as a contracted provider).
- Add taglines to all printed materials for potential enrollees explaining the availability of translation and interpreter services, as well as the phone number for choice counseling assistance. A potential solution is to modify printed materials for personalization so that Aging and Disability Resource Centers could print local contact info.

* This document does not capture every provision in the rule that may impact Family Care. This is intended to summarize key provisions likely to have greater impact on Family Care.