

Medicaid/CHIP and Medicare Rules: What's New and Relevant for HIV Stakeholders?

Rita Vandivort-Warren and Kerri Cornejo
August 25, 2016

*U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration
Office of Planning, Analysis, and Evaluation*

Disclosures

The presenters have no financial interest to disclose.

This continuing education activity is managed and accredited by Professional Education Services Group in cooperation with HSRA and LRG. PESG, HSRA, LRG and all accrediting organization do not support or endorse any product or service mentioned in this activity.

PESG, HRSA, and LRG staff has no financial interest to disclose.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Identify the new managed care policies that apply to Medicaid and CHIP and updated quality reporting requirements under Medicare
2. Recognize how these changes will affect the HIV community
3. Apply recommendations for action to ensure that the design and implementation of federal and state policies support access to high-quality care and treatment for people living with HIV

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

<http://ryanwhite.cds.pesgce.com>

What's New in 2016?

Background on Three Major
Medicaid and Medicare Rules

Changes to Medicaid Rules

- Medicaid and CHIP Managed Care Final Rule
 - Updates managed care regulations to Medicaid and Child Health Insurance Program (CHIP) for the first time since 2002
 - Reflects that Medicaid Managed care programs began with incorporating generally healthy children and mothers, but states are now increasingly including children and adults with disabilities
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
 - Prohibits certain discriminatory practices that limit insurance coverage for behavioral health treatment and services
 - Final rule issued on March 29, 2016 applying MHPAEA to Medicaid and the Children's Health Insurance Program (CHIP)

Changes to Medicare under MACRA

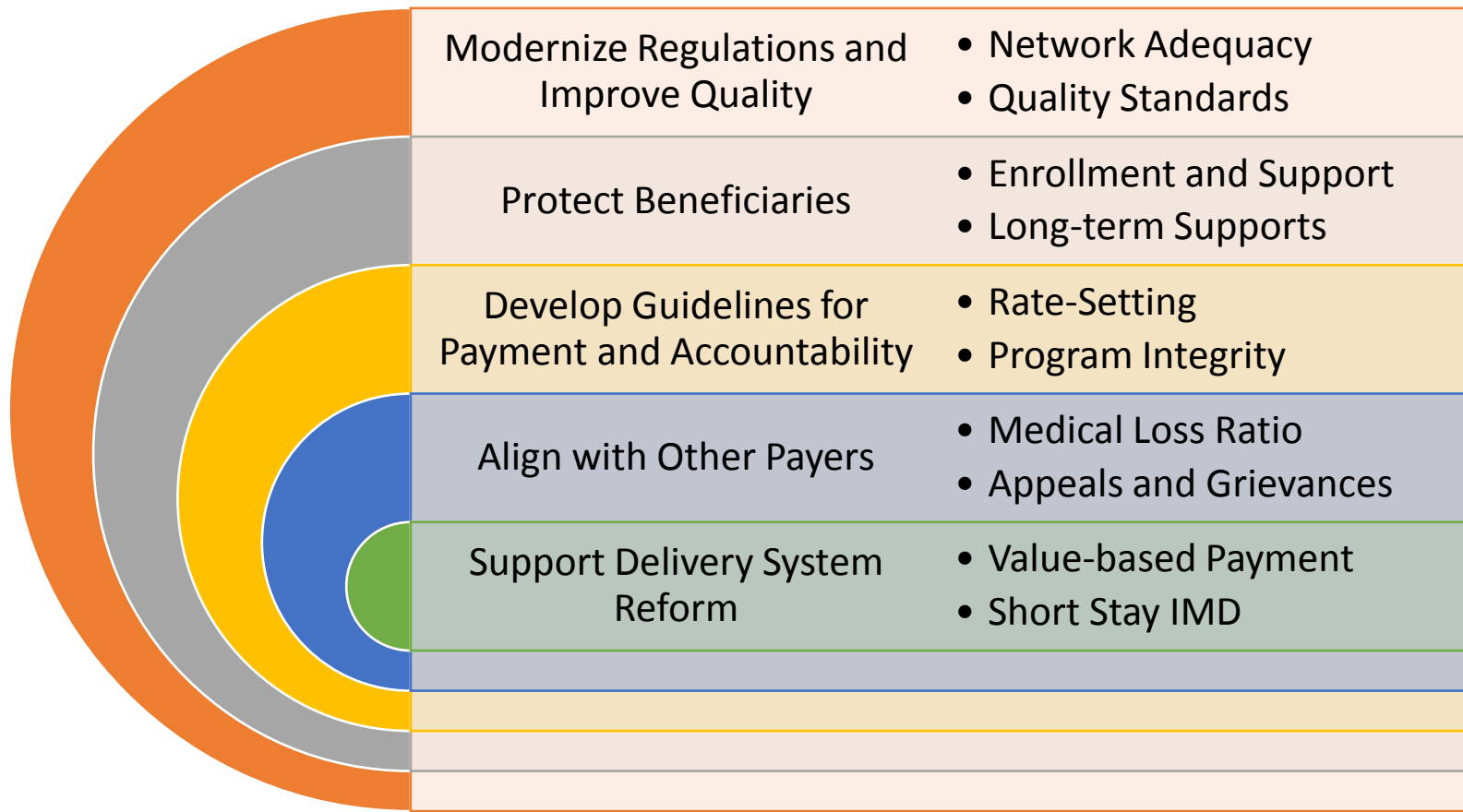
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) signed into law on April 16, 2015
- Repealed the Medicare sustainable growth rate (SGR) formula (Title I)
 - Provides predictable Medicare payment schedule for clinicians
 - Moves providers towards value-based payment
- Extends certain Medicare, CHIP, and other HHS health programs (Titles II and III)

Changes to Medicaid Regulations

Medicaid and CHIP Managed
Care and the MHPAEA Final
Rules

Medicaid and CHIP Managed Care Final Rule

Five Major Principals in Updating Medicaid/CHIP Managed Care Rule



Modernizing Regulatory Requirements

- Adds that states must develop and make public the time and distance standards for network adequacy
 - Must allow out of network if no in-network providers available
 - Must allow out of network for emergencies & family planning
 - Gives states flexibility to differ standards by geography
 - MCO must certify network adequacy at least annually

Modernizing Regulatory Requirements and Improving the Quality of Care

- Additional standards for enrollees in Managed Long-Term Services and Supports (MLTSS)
 - Network adequacy considers travel time of providers to enrollees
 - Network adequacy must also consider language and disability
 - States can consider pediatric MLTSS if adult MLTSS inadequate
 - Stakeholders must be engaged in ongoing monitoring of MLTSS
- Adds new elements to quality rating systems related to health disparities and MLTSS

Outlining Requirements for Beneficiary Protections

- State and plan website must have specific managed care plan information, such as up to date provider list and formulary specifics or like fail first or tiering
 - Provider descriptions must include cultural, linguistic, and accessibility capabilities
 - Must state if accepting Medicaid patients
 - Must provide this plan information free in paper form if requested

Outlining Requirements for Beneficiary Protections

- Includes broad provision which prohibits discrimination against patients AND providers
 - Race and color
 - National origin
 - Sex
 - Sexual orientation and gender identity (for patients only)
 - Disability
 - Age (for providers only)
 - High cost populations or high cost services (for providers only)

Outlining Requirements for Beneficiary Protections

- Requires new enrollees to be provided health risk assessment within 90 days
- Provides protections for Managed Long Term care Services and Supports (MLTSS)
- Requires transition plans developed when changing plans or providers
- Requires plans to provide oral translation services and documents in “prevalent” languages

Developing Guidelines for Payment and Accountability

- Requires greater transparency in the rate setting process
- Provides protections against fraud and abuse by network providers through risk-based screening and enrollment
 - Network providers will be screened, enrolled & revalidated by the state like FFS
 - Managed care providers need not also be provider in FFS

Aligning with Other Payers and Supporting Delivery System Reform

- Plans must report the minimum medical loss ratio (MLR)
 - IF states set a MLR, it must be at least 85%
- Aligns CHIP with Medicaid in most requirements, including:
 - Enrollment and disenrollment
 - Network adequacy
 - MLR
 - Information requirements
 - Quality measures
 - Grievance system and EQR

Aligning with Other Payers and Supporting Delivery System Reform

- Plans must not use a step therapy in family planning services and supplies (in preamble)
- Definitions and timeframes on grievances and appeals align with Medicare Advantage & private market
 - Plan must continue denied service when appealed until determination
 - MCO only allowed one, time-limited appeal before appeal decided under State Fair Hearing processes

Aligning with Other Payers and Supporting Delivery System Reform

- Requires managed care plans to develop a plan to exclude outpatient prescription utilization when provided thru 340B discounts
- Encourages the use of “telemedicine, e-visits...other evolving technology solutions”
- Provides incentives for states to support value-based purchasing under managed care contracting
- Permits capitation payments for enrollees with a short-term stay (no more than 15 days) in an Institution for Mental Disease (IMD)
- Provides more accountability for “in lieu of services” and gradual elimination of pass through payments

Medicaid and CHIP MHPAEA Final Rule

Important Dates for the Federal Parity Law

October 2008

- MHPAEA becomes law

February
2010

- Interim Final Rule and accompanying guidance on the MHPAEA (effective July 2010)

November
2013

- Final MHPAEA Regulations for large group employer plans

March 2016

- Medicaid MHPAEA Final Rule
- Presidential Task Force on Mental Health & Substance



How ACA Super-Charged the 2008 Mental Health Parity and Addictions Equity Act

IF large employer group covers MH/SUD, then compared to medical/surgical coverage, the MH/SUD benefits cannot be:

- more limited (# days, visits)
- greater cost sharing (deductible/co-pays)
- stricter management (prior auth, fail first, etc)

2008 Mental Health Parity & Addictions Equity Act



2010 Affordable Care Act



More Access & Better Care

Essential Health Benefits for MH/SUD at parity in Marketplace or Medicaid Exp

Medicaid MHPAEA Final Rule



- Rule require all categories of MH/SUD benefits meeting MHPAEA for enrollees with any services through MCO
- Prohibits different processes in determining access standards to MH/SUD providers than to med/surgical providers
- Effectively prohibits “fail first” drug policies
- Requires CHIP and Alternative Benefit Plans to continue meeting MHPAEA for MH/SUD benefits
- Requires state to assure compliance with parity analysis; may delegate to managed care

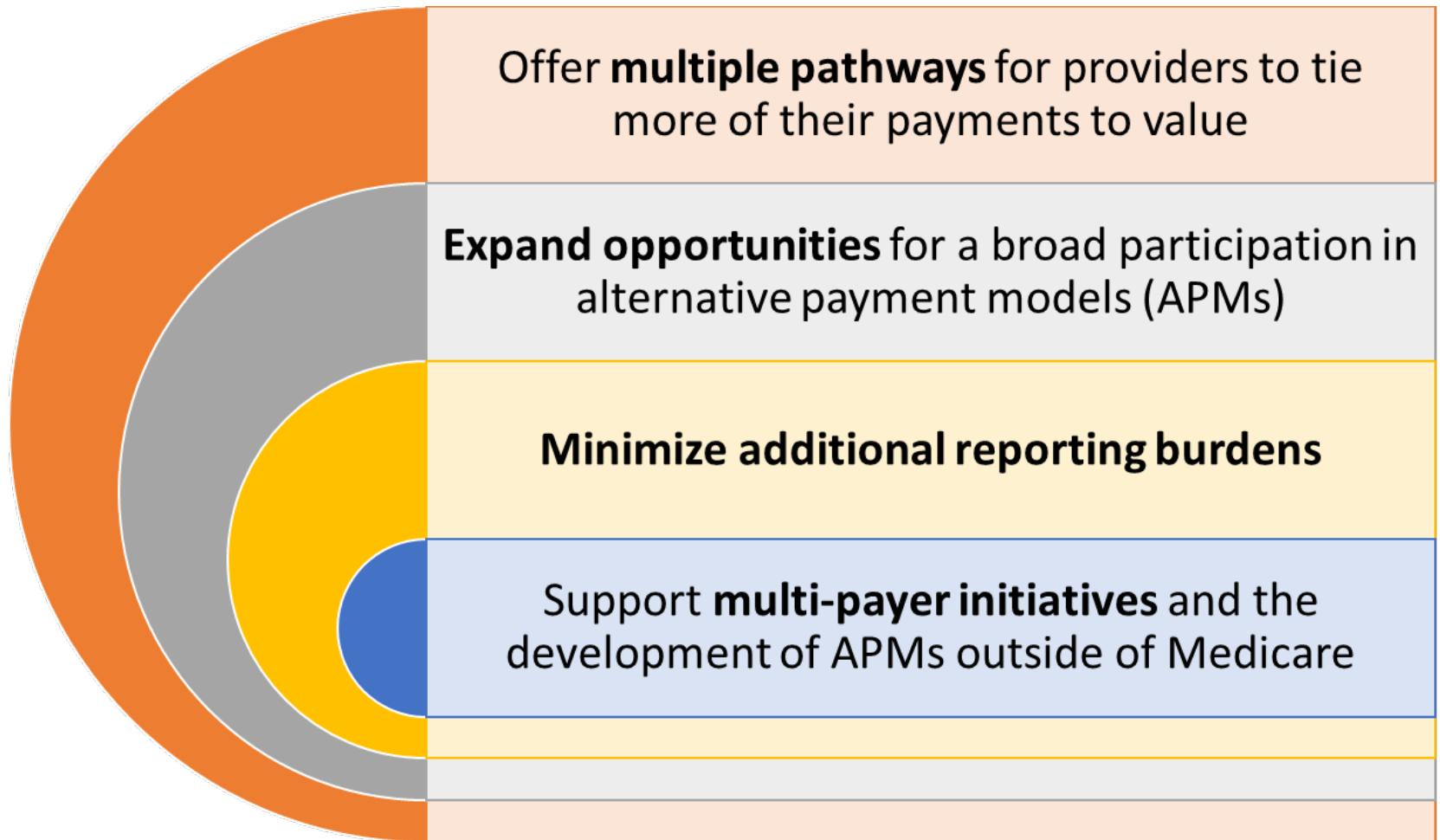
Changes to Medicare Regulations



Quality Payment Program
Proposed Rule

Quality Payment Program Proposed Rule

MACRA Implementation Goals



Quality Payment Program Basics

- Proposed rule put on display in the Federal Register on April 27, 2016
- Final rule expected by November 2016
- Streamlines multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- Provides incentive payments for participation in Advanced Alternative Payment Models (APMs)

The Merit-based
Incentive
Payment System
(MIPS)

or

Advanced
Alternative
Payment Models
(APMs)

Merit-based Incentive Payment System (MIPS)

- MIPS is a new program for clinician payment under Medicare
 - Streamlines 3 currently independent programs to work as one and to ease clinician burden
 - Adds a fourth component to promote ongoing improvement and innovation to clinical activities



Who Will Participate in MIPS?

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2



Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who Will NOT Participate in MIPS?

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare Part B participation



Below low patient volume threshold

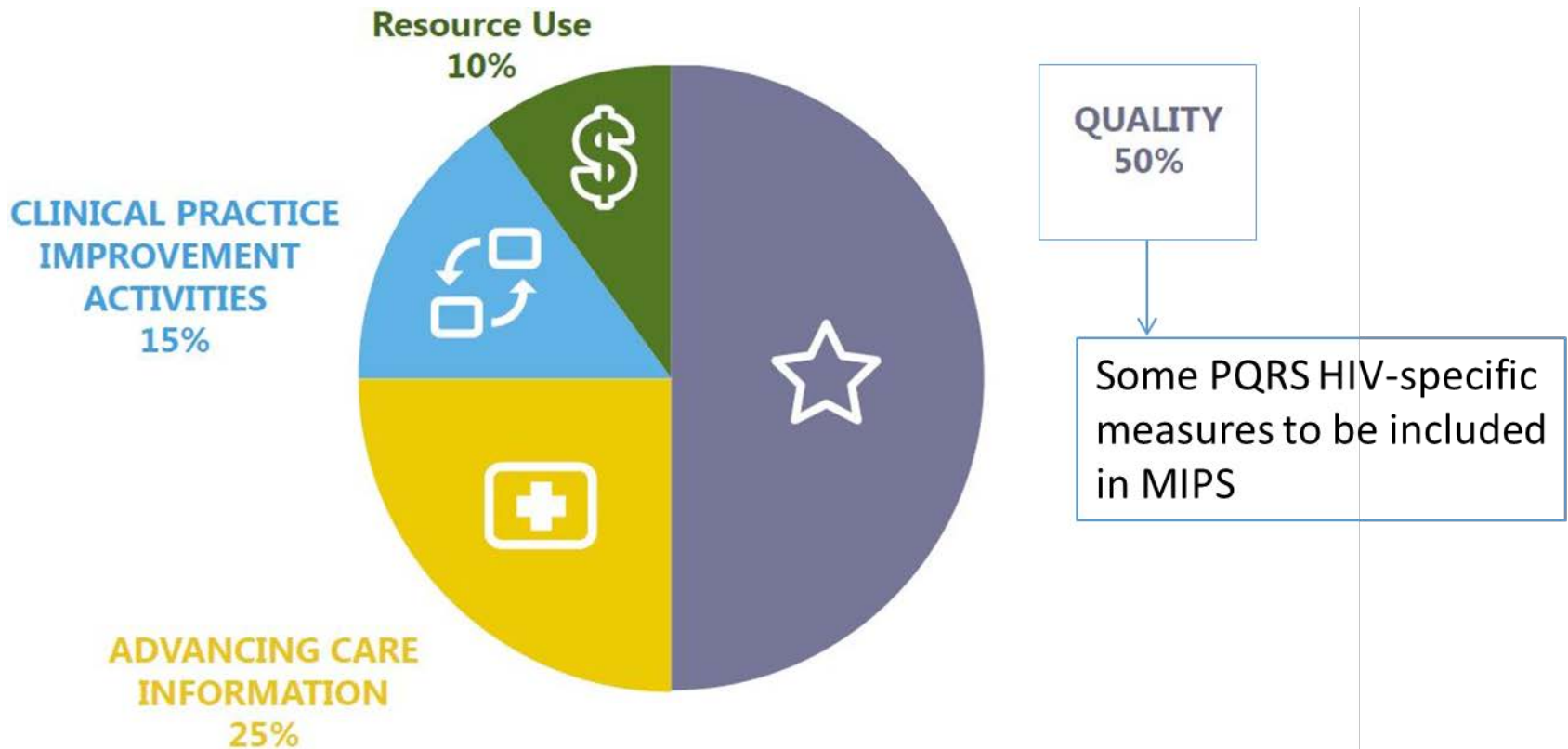


Certain participants in ADVANCED Alternative Payment Models

↓
Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

MIPS Performance Categories



Measuring Quality under the QPP

- Quality Measure Development Plan
 - CMS strategic framework for future quality measure development
- Core Quality Measures Collaborative has provided core-measures in seven sets:
 1. Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care
 2. Cardiology
 3. Gastroenterology
 4. [HIV and Hepatitis C](#)
 5. Medical Oncology
 6. Obstetrics and Gynecology
 7. Orthopedics

What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

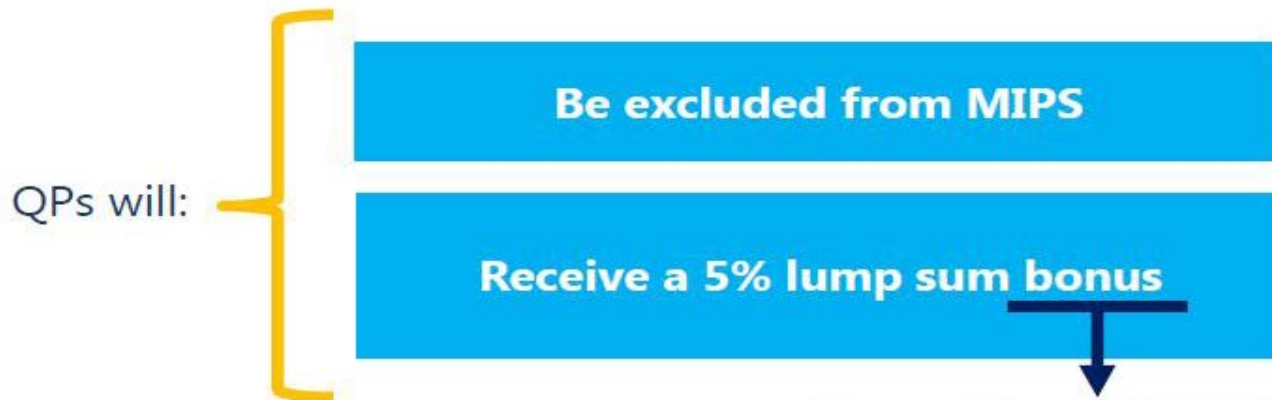
As defined by
MACRA,
APMs
include:

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

Becoming a Qualifying APM Participant (QP)



You must have a **certain %** of your patients or payments through an **Advanced APM**.



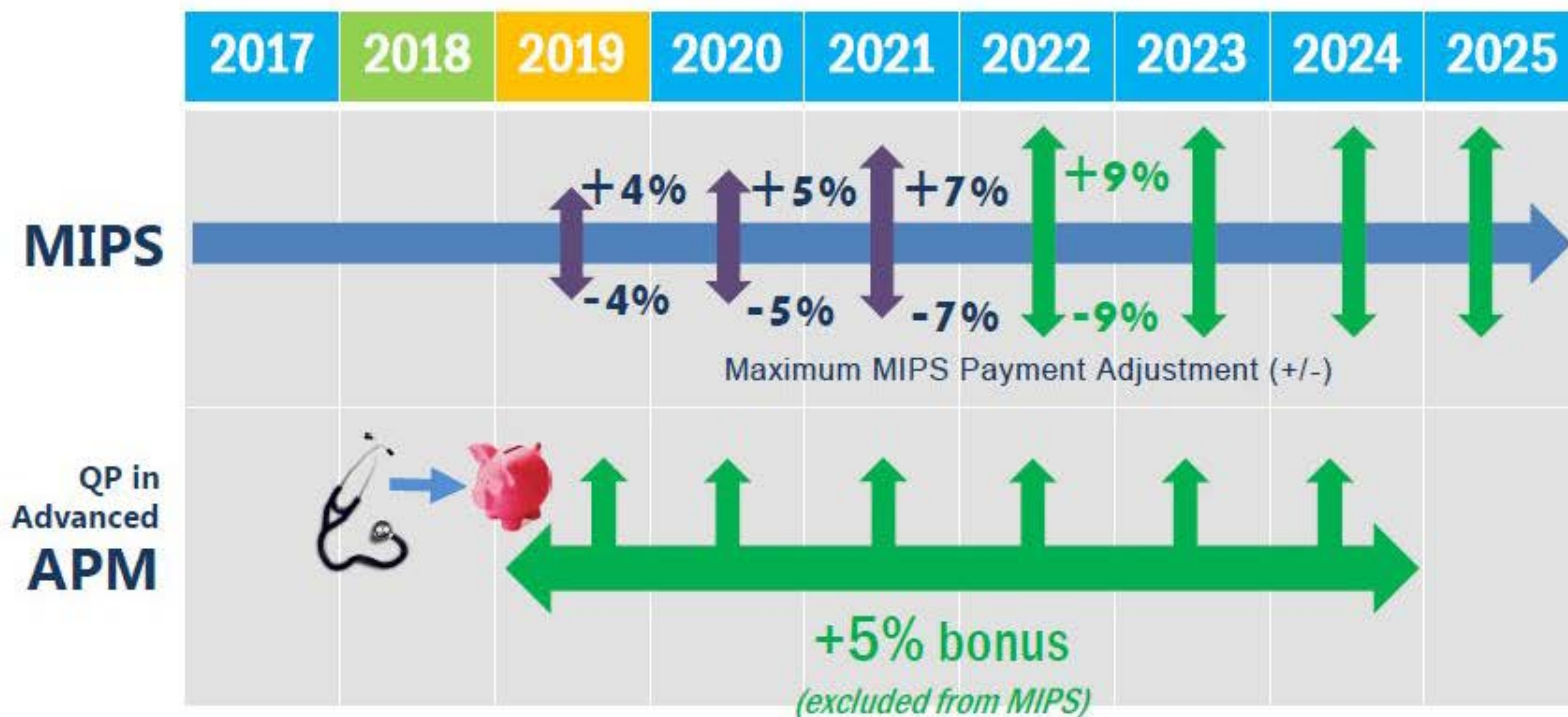
Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

What are Advanced APMs?

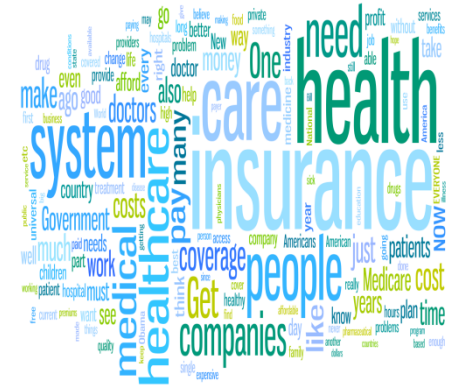
Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

MIPS adjustments and APM Incentive Payment will begin in 2019.



Pulling it All Together



Policy Considerations for
HIV Care and Treatment

Medicaid Rules

- How can we influence state decision to ensure adequate standards and provider access?
- How does Medicaid care coordination under the new regulations interplay with care coordination under RWHAP?
- How can we support outreach and connection to choice counselors and how to use once enrolled?
- Are there ways to coordinate enrollment and disenrollment procedures between Medicaid programs and the RWHAP to support transitions?
- How can we help assure use of appeal rights to further continuity of care and access to medications?
- How can we encourage the adoption of measures relevant to HIV care and treatment?
- How can help monitor the application of parity in Medicaid and the Marketplace?

Quality Payment Program

- What can providers, policymakers, and advocates do to support high-quality, high-value care under Medicare?
- What assistance is available to help providers who want to join APMs?

For More Information...

- **QPP Resources:** [go.cms.gov/QualityPaymentProgram](https://www.cms.gov/QualityPaymentProgram)
- **MACRA Quality Improvement Direct Technical Assistance (MQIDTA):**
https://www.fbo.gov/index?s=opportunity&mode=form&id=7fb6b400ae7d3912a9a935c82b3f0578&tab=core&_cview=1 (Solicitation)
- **Final Quality Measure Development Plan (MDP):**
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>
- **Quality Payment Program Proposed Rule:** <https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf>
- **Medicaid Managed Care Resources:** <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>
- **Medicaid MHPAEA Resources:** <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>

Questions?

- Rita Vandivort-Warren: rvandivort-warren@hrsa.gov
- Kerri Cornejo: kcornejo@hrsa.gov

