Medicaid Statewide Managed Care System Rule Revision

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Objectives

- General Approach to Rule
- Accountable Care Collaborative (ACC) Phase II
  - ➢ Overview
  - ➢ Key Concepts
- Medicaid Statewide Managed Care Rule
  - ➢ Overview of Primary Changes
  - ➢ Outline of Rule
  - ➢ Section 8.205.10 Utilization Management

General Approach to Rule

Rule Webpage

- To view the rule and to provide public comment you may visit page:
  - hcpf.colorado.gov/public-comment-medicaid-statewide-managed
- Comments can be submitted through an electronic form
  - https://forms.gle/uTBzE2i9w1UUQFKz5

General Approach

- Primarily technical in nature
- Ensure rule reflects federally authorized policies and procedures
- Align with existing authorities for managed care
  - 42 CFR Part 438
  - ACC 1915(b) waiver
  - SUD Continuum 1115(a) Waiver
  - C.R.S. 25.5 Article 5 Part 4
  - ACC Contracts

General Approach

- All ACC policies have been vetted through public comment
  - ➢ACC Phase II Design Activities (2014-2018)
    - 2014 Request for Information
    - 2015 Concept Paper
    - 2016 Draft RFP
    - 2017 Waiver
  - ➢Inpatient and residential SUD (2018-2021)
- Managed care subject to CMS approval

ACC Phase II Overview and Key Concepts

Accountable Care Collaborative

Improve Health and Reduce Costs

Medical Home

Ensure Medicaid members have a focal point of care.

Behavioral Health

Comprehensive community-based system of mental health and substance use disorder services.

Regional Coordination

Medicaid members have complex needs and are served by multiple systems. Regional umbrella organizations help to coordinate across systems.

Data

Members, providers and the system receive the data needed to make real-time decisions that improve care, increase coordination of services and improve overall efficiencies.

Goals

- To improve member health & reduce costs

Objectives

1. Join physical and behavioral health under one accountable entity
2. Strengthen coordination of services by advancing team-based care and health neighborhoods
3. Promote member choice and engagement
4. Pay providers for the increased value they deliver
5. Ensure greater accountability and transparency

Join Physical & Behavioral Health

Regional Accountable Entity

Physical health care	Behavioral health care
Per member/ per month	Behavioral health capitation

Limited Managed Care Capitation Initiatives

Region 1 and 5 only

- Rocky Mountain Health Plans
- Denver Health Medicaid Choice

These initiatives are part of the ACC program

- Increase value-based arrangements in contracts

Medicaid Statewide Managed Care Rule

Language changes

- Aligned language and terminology with C.R.S. 25.5-5 Part 4 on the Statewide Managed Care System
  - "Medicaid Managed Care Program" now "Medicaid Statewide Managed Care System"
  - "Community Behavioral Health Services" now "Statewide System of Community Behavioral Health Care"

Language changes

- New federal designation of Primary Care Case Management Entity (PCCM Entity)
- Defined and created consistency between use of “client” and “member”
- Modified language to include gender neutral terms
- Clarified Medical Loss Ratio requirements

New Content

- Definitions Section
- Covered Services for the inpatient and residential substance use disorder benefit
- Utilization Management Section

ACC Phase II Policy Alignment

- Mandatory enrollment into statewide managed care system (ACC)
  - ➢Members cannot opt out of the statewide managed care system
- Client eligibility criteria

Content Rearrangement

- Section 8.212 Community Behavioral Health Services incorporated into Section 8.205 Statewide Managed Care System

Outline of Rule

- 8.205.1 Definitions
- 8.205.2 Client Eligibility
- 8.205.3 Member Responsibilities
- 8.205.4 Member Rights and Protections
- 8.205.5 Client Enrollment and Disenrollment
- 8.205.6 Essential Community Providers
- 8.205.7 Qualified Pharmacy Providers
- 8.205.8 Persons with Special Health Care Needs
- 8.205.9 Statewide System of Community Behavioral Health Care
- 8.205.10 Utilization Management
- 8.205.11 Emergency Services
- 8.209 Medicaid Managed Care Grievance and Appeal Processes
- 8.215 Medicaid Statewide System of Community Behavioral Health Care Capitation Rate Setting

Utilization Management Specifics

Rule Citation	Primary Source
A. Medical Necessity	42 CFR § 438.210(a)(5)
B1. Establish and update policies and procedures	42 CFR § 438.210(b)
B2. Compliance with 42 CFR 438	42 CFR § 438
B3. Parity compliance	42 CFR § 438 subpart K
B4. Inpatient and residential SUD authorization	1115 SUD Waiver

Utilization Management Specifics

Rule Citation	Primary Source
B5. Public availability of criteria	42 CFR § 438.404(b)(2)
B6. Licensed medical professional oversight	42 CFR § 438.210(b)(3)
B7. Standards for provider consults	42 CFR § 438.210(b)(2)(ii)
B8. Protect timely access	42 CFR § 438.206(a)
C. Sufficiency of Services	42 CFR § 438.210(a)(3)(i)

Utilization Management Specifics

Rule Citation	Primary Source
D & E. Co-occurring Disorder protections	CRS 25.5-5-402(3)(a)
F. Medication Assisted Treatment	CRS 25.5-5-422(2)(a)
G. SUD prescriptions	CRS 25.5-5-422(2)(b)
H. Coordinate non-covered FFS benefits	42 C.F.R. § 438.208
I. Grievances and appeals	42 CFR § 438 subpart F

Comments or Questions?

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Contact Info

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Thank you!

APPENDIX

8.205.10 A. Medical Necessity

The MCOs and PIHPs must ensure Covered Services delivered to Members are Medically Necessary as defined in Section 8.076.1.8 as well as Section 8.280 for Members under 21 years of age, delivered in the least restrictive setting, and most likely to address the Member's health care needs by employing utilization management best practices.

1. If it is determined that the Member does not meet criteria of Medical Necessity or the Member has a diagnosis not covered by the capitated payment arrangement, MCOs and PIHPs must inform the Member about how other appropriate Medicaid State Plan services may be obtained and coordinate referrals to appropriate providers within the region.

8.205.10 B. UM Guidelines

Utilization management practices shall align with the following guidelines:

1. Establish and regularly update utilization management policies and procedures for evaluating the clinical appropriateness, efficacy, or efficiency of Covered Services, referrals, procedures or settings in accordance with the most recent national and industry standards or guidelines and with federal and department rules and regulations.

2. Ensure utilization management policies and procedures are designed in compliance with 42 CFR 438. Part 2.

8.205.10 B. UM Guidelines

3. Design and implement utilization management policies and procedures in compliance with the federal Mental Health Parity and Addiction Equity Act requirements defined in 42 CFR 438 Subpart K, including the application of financial requirements, treatment limitations, and non-quantitative treatment limitations, as well as the process for determining access to out-of-network providers.

8.205.10 B. UM Guidelines

4 Incorporate use of prior authorization and continued stay reviews for residential and inpatient behavioral health services that are not for treatment of an Emergency Medical Condition to ensure that the services requested or furnished are medically necessary and sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

a. Utilize the American Society of Addiction Medicine criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.

b. Engage in care coordination and discharge planning to appropriately transition members across the continuum of care.

8.205.10 B. UM Guidelines

5. Make utilization management decision-making criteria available to members and providers upon request.

6. Designate a licensed medical professional to provide oversight and evaluation of the utilization management policies and activities.

7. Establish standards for utilization management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.

8. Ensure utilization management processes do not impede timely access to services.

8.205.10 C,D,E

C. The MCOs and PIHPs must ensure that the services requested or furnished are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

D. The PIHPs must cover all medically necessary Covered Services for covered behavioral health diagnoses under the Capitated Behavioral Health Benefit, regardless of any co-occurring conditions.

E. The MCOs and PIHPs must not deny a Covered Service based solely on the Member having a diagnosis of a co-occurring intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury.

8.205.10 F,G,H,I

F. The MCOs and PIHPs must not require prior authorization for the non-pharmaceutical components of medication-assisted treatment.

G. The MCOs must not impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the Food and Drug Administration for the treatment of substance use disorders.

H. The MCOs and PIHPs must coordinate State Plan covered services that are paid fee-for-service.

I. The MCOs and PIHPs must have a grievances and appeals process as specified in Section 8.209.