A new ruling on managed care — the first of its kind since 2002 — was issued by the Department of Health and Human Services (HHS) on April 25, 2016. Its intention in just over 1,400 pages? Modernize managed care in Medicaid and the Children’s Health Insurance Program (CHIP).

This rule represents the administration’s goal to deliver better care, smarter spending and healthier people. It supports state delivery system reform efforts by putting more accountability for network adequacy for key types of providers, while giving each state the flexibility to set the actual standards. It also aligns with other health insurance coverage programs.

Accountability and program integrity are also essential aspects of this “Mega-Reg.” Both demand additional transparency from payers on how Medicaid rates are set to help ensure the fiscal integrity of Medicaid managed care programs — including utilization and quality data.

**Here’s how the HHS introduced it:**
The final rule advances delivery system reform, strengthens quality and consumer protections, promotes accountability, and aligns Medicaid managed care rules with other health insurance coverage programs.
The current complex canvas

These are just some of the adherence challenges you face today. And now with Mega-Reg the matrix is even more complex.

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<th>Increase compliance</th>
<th>Grow enrollment</th>
<th>85% MLR</th>
<th>Reduce administration costs</th>
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<td>Accept 100% of encounters</td>
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<td>Align membership into</td>
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<td>appropriate rate cell</td>
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<td>Optimize payment integrity</td>
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Key: Critical, Meaningful, Minimal

Support for the new norm

At Optum®, we believe this is just an indication of rulings to come. Drawing on our Medicaid experience (more than 35 states, federal and municipal agency partnerships nationwide, serving one in four Medicaid enrollees), we can help you navigate the implications of this Mega-Reg and prepare for this evolving environment of modernized manage care.

How well do you understand this ruling and the actions the Centers for Medicare and Medicaid Services (CMS) will take to uphold it? What effect will this have on your operations?
Modernizing Medicaid today and tomorrow: Five implications of the Mega-Reg

Start by asking yourself how well you can address these five key implications

1. **What does this effort to modernize Medicaid mean to your organization in the states you serve?**

For many states — Illinois, for example — Medicaid consumes a significant portion of the budget. As these states move from fee-for-service to managed-care models, they are focused on identifying and eliminating fraud, waste and abuse.

The states are also putting more pressure on health plans that serve their states to do the same. How confident are you about the processes and capabilities you have in place now to support expanded payment integrity efforts moving forward?

2. **What do the network adequacy standards mean to your organization?**

Consider the current canvas of Medicaid in California. This is a state that has gone through tremendous expansion of its Medicaid program — a program that already eclipses other states’ at nearly 13 million members as of August 2015. This accelerated growth significantly strains network adequacy. The state has also put forth legislation that drives more adequacy transparency and validation.

With lower Medicaid reimbursements compelling fewer providers to accept these members, what changes to the contracting vehicle could positively influence your provider network? How can you relieve adequacy pressures by changing how you contract with your networks? What if you could confidently:

- Determine service gaps driving emergency department overuse, such as lack of substance use disorder (SUD) services or respite care
- Define and make investments in services needed to fill specific geographical overuse drivers

3. **How will you address the increased accountability and transparency rules?**

Plans that were already operationally stressed are now under more duress to perform at even higher levels. Validating encounters. Ensuring the reporting is in order. Comprehensive data quality. These have taken on more importance than ever before.

One approach is to consider this question from an actuarial soundness perspective: How can you ensure your members are in the right rate cells so that you get the most appropriate premium payment for each of the groups you serve? How do you know that you’ve identified their rate correctly or that the cost structure you need to provide adequate care is priced effectively?

4. **How are you preparing for the likelihood of having to earn back withheld premiums?**

From a quality standpoint, a new trend is emerging where a state withholds premiums based on quality metrics. For example, in Texas, five percent of what the health plan is owed is held back and has to be earned. What implications does this trend have for your plan’s auto-enrollment algorithm?

5. **Perhaps the most important question: How quickly can you act to manage challenges stemming from the Mega-Reg?**

Plans vary greatly on this. Some will say that, with the right business partner, issues like fraud, waste and abuse initiatives can be implemented in 30 days. Others don’t know how to respond.

Here’s the positive aspect of this challenge: You can influence the priorities and respond with sound solutions to address them. What can you do today to help position your plan to help drive tomorrow’s environment?

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**Key takeaway**

If you keep abreast of the changes and act quickly to be among the first movers, you can engage with your state to help shape what the future looks like.

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The Optum perspective:
Anticipate and act with confidence

Optum offers the consultative insights and proven solutions to help you understand and address all the requirements of the Mega-Reg, driving consistency across your lines of business. We have extensive Medicaid management expertise including long-standing partnerships with most states to identify and overcome geo-specific challenges.

We anticipate even more rulings in the evolution to modernize managed care. Our Medicaid focus aligns with the new ruling and the trajectory of rulings to come.

Optum is helping payers like you prepare for the ongoing evolution of managed care. Working together, we are helping to make the health system work better for everyone.

Optum is helping modernize Medicaid

Empowering consumers
Wellness
Engagement approaches
Health literacy
How to use plan

Advancing care
Community-based care
Specialty care
Vision
Behavioral health
Pharmacy
Network access

Modernizing administration
Fraud, Waste and Abuse
Claims editing
Value-based contracting
Provider directories
Actuarial services

About Optum
Optum is an information and technology-enabled health services business platform serving the broad health marketplace, including care providers, plan sponsors, life sciences companies and consumers.

Learn how Optum can help you address the aspects of modernizing Medicaid today and those to come tomorrow.

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