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To: **ANCOR Membership**
From: **Katherine Berland, Esq., Director of Public Policy**
Date: **July 27, 2016**
Re: **Department of Health and Human Services Final Rule RIN 0938-AS25; Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability [Medicaid Managed Care Rule]**

INTRODUCTION

On May 6, the Centers for Medicare & Medicaid Services (CMS) finalized a rule that impacts managed care under the Medicaid and Children's Health Insurance Program (CHIP).[1] The purpose of the rule is to align the rules governing these programs with other health insurance coverage programs, modernize how states purchase managed care for beneficiaries, and strengthen the consumer experience and key consumer protections.[2]

In the preamble to the rule, CMS notes that prior to the early 1990s, most Medicaid beneficiaries received coverage through fee-for-service arrangements. However, over time, states are increasingly turning to managed care in an effort to create efficiency, streamline services, and realize cost savings. All states use some form of managed care in their public health systems, with many expanding the use of managed care to more beneficiaries and/or additional populations.

Given the increasingly widespread use of managed care for Medicaid services, CMS determined that the managed care regulations, which were last updated in 2002, were due for an update to reflect changes in the health care delivery landscape over the past decade.

As will be discussed in more depth later in this analysis, there are multiple provisions in the rule which will go into effect at various times between the rule's publication date and July 1, 2019.

This document is intended to provide a high-level summary of the new managed care final rule. The content is drawn from the final rule's preamble as well as various fact sheets published on the CMS Medicaid Managed Care website. It should not be construed or relied upon as legal advice on any specific facts or circumstances.

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[1] 81 Fed. Reg. 27498 (May 6, 2016), *available at* https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

[2] *See* CMS' Medicaid and CHIP Managed Care Final Rule website at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-final-rule.html (visited July 13, 2016)

KEY TAKEAWAYS

The Medicaid Managed Care final rule seeks to align Medicaid managed care and CHIP managed care provisions with those found in Medicare Advantage and private insurance plans. In doing so, the rule requires states to establish certain quality and network adequacy measures to ensure system access and protection of beneficiaries. It also seeks to create efficiency in a managed care framework and allows the use of financial incentives to meet outcomes.

The rule seeks to increase fiscal transparency and integrity in the managed care rate setting process, by setting standards for provider screening and enrollment, establishing a medical loss ratio, and adding requirements related to encounter data submissions.

While the final rule is generally viewed favorably by stakeholders in the disability community, some advocates were disappointed that it did not include stronger stakeholder engagement provisions.

SUMMARY OF KEY PROVISIONS

The final rule is comprehensive and covers Medicaid and CHIP services that may or may not include services of particular relevance to people with intellectual and developmental disabilities (IDD). This document will move through the major provisions of the rule, noting any that are significant for people with IDD.

Improved Alignment with Medicare Advantage and Private Coverage Plans

Medical Loss Ratio:

A medical loss ratio (MLR) is the percent of premium an insurer spends on claims and expenses, as opposed to administrative costs, profits, or other expenditures not directly related to the provision of services. CMS noted that Medicaid and CHIP are currently the only health benefit coverage programs in which a MLR standard does not apply to managed care plans. Though some states have already adopted an MLR standard, the rule requires that Medicaid and CHIP plans calculate and report an MLR. The standards for calculating the MLR are consistent with the standards applied are consistent with the standards applied by Medicare Advantage plans and the private market, with some variation as necessary to account for unique characteristics in Medicaid and CHIP. Capitation rates must be developed such that managed care plans can reasonably be expected to achieve at least an 85% MLR.

Appeals:

The final rule aligns definitions and timeframes for the resolution of appeals, streamlines levels of internal appeals, and requires that enrollees utilize the managed care plan's internal process before proceeding to a fair hearing by the state. These aspects of the final rule align with those already in place for Medicare Advantage and the private market.

Consumer Information:

The rule aligns the scope of enrollee information and dissemination practices with the Medicare Advantage program and the private market. States may use a range of

communication methods (*e.g.* mail, email, website posting) while maintaining the ability of consumers to obtain these materials in paper form at no cost upon request. Managed care plans are required to include provider directories and drug formularies on their websites.

Provider Screening and Enrollment:

All providers participating in managed care networks must be screened and enrolled by the state Medicaid program. This standard is in line with Medicare and Medicaid fee-for-service programs. Providers that participate in a Medicaid managed care plan are not required by the final rule to also provide services under a fee-for-service program.

Strengthening Managed Care in CHIP

Improving Access:

The final rule sets forth requirements for states when setting and monitoring network adequacy standards in both Medicaid and CHIP managed care programs. States have flexibility in setting the actual standards. States must assess and certify the adequacy of a managed care plan's provider network at least annually or whenever there is a substantial change to the program design.

Enhancing Quality:

The final rule establishes a framework for states to ensure that CHIP beneficiaries receive high quality care. The framework is largely adopted from the one established for Medicaid managed care, and focuses on promoting transparency, supporting states in contracting with health plans that offer higher-value care, and improving consumer and stakeholder engagement. The final rule establishes authority to develop and implement a quality rating system (QSR) similar to that that exists for the Marketplace established by the Affordable Care Act (ACA). While several components of the QRS will be established by CMS, states may request approval for an alternative rating system.

Improving Care Coordination and Management:

The final rule creates standards for care coordination, assessments, and treatment plans for CHIP managed care. Plans will be required to coordinate and facilitate transition of services between settings of care, make every effort to complete an initial health risk assessment within 90 days of enrollment for new beneficiaries, and ensure that enrollees with special health care needs receive an assessment and treatment plan that is regularly updated.

Strengthening Program Integrity:

The final rule applies most of the Medicaid managed care program integrity provisions to CHIP managed care, including provider screening and enrollment provisions. Plans will also be required to adopt administrative and managerial procedures to prevent, monitor, identify, and report potential fraud, waste or abuse, report potential changes in an enrollee's circumstances that may impact eligibility as well as changes in circumstances that may impact

that provider's participation in the plan's network, and suspend payments to a network provider when the state determines a credible allegation of fraud exists.

Modernizing Communications:

The final rule gives states and CHIP managed care plans various options to communicate with beneficiaries. Specifically, the final rule:

- Advances plans' abilities to communicate with beneficiaries by permitting states and managed care plans to use a range of electronic communication methods, including email, texts, and website posting for the dissemination of required information, while ensuring that beneficiaries are able to obtain paper materials upon request and at no cost;
- Ensures that information is accessible to individuals with limited English proficiency by providing that enrollee materials (such as provider directories, member handbooks, appeal and grievance notices, and other informational notices) include taglines in each state's prevalent languages explaining the availability of oral interpretation services or written translation if requested; and
- Makes information about providers and prescription drugs more available and accessible to all consumers by requiring that additional information be included in the provider directory (such as provider's group/site affiliation, website URL and physical accessibility for enrollees with physical disabilities) as well as certain information about the managed care plan's drug formulary.

Requiring Calculation and Reporting of Medical Loss Ratio (MLR)

The final rule requires that CHIP managed care plans calculate an MLR according to standards that are similar to Medicare Advantage and the private markets in order to meet a target MLR of 85%. (See "Medical Loss Ratio" section under "Improved Alignment with Medicare Advantage and Private Coverage Plans" for more information.)

Strengthening the Consumer Experience

Strengthening Communications

The final rule updates the options available to states and Medicaid and CHIP managed care plans to communicate with beneficiaries. The final rule allows states to use a range of communication methods to disseminate required information, including emails, texts, and website postings, while requiring that paper materials are available at no cost upon request. It further requires that enrollee materials be available in the state's prevalent languages and provide information on the availability of oral interpretation services or written translations. A large print tag line is required for the visually impaired. The rule requires that managed care plans maintain updated provider directories on their websites. Finally, the rule requires that the provider directories include information such as provider's group/site affiliation, website URL and physical accessibility for enrollees with physical disabilities, as well as certain information about the managed care plan's drug formulary.

Strengthening Access to Care

The final rule requires states to establish network adequacy standards in Medicaid and CHIP managed care for key types of providers, while leaving states the flexibility to set the actual standards to better reflect local market and geographic conditions. The final rule provides that states will develop and implement time and distance standards for primary and specialty care (adult and pediatric), behavioral health (adult and pediatric), OB/GYN, pediatric dental, hospital, and pharmacy providers if these providers services are covered under the managed care contract. States will also develop and implement network adequacy standards for Medicaid managed long term services and supports programs that include criteria for providers who travel to the enrollee to provide services and assess and certify the adequacy of a managed care plan's provider network at least annually and when there is a substantial change to the program design (such as adding a new population, benefits, or service area).

Improving Care Coordination and Management

The final rule sets standards for care coordination, assessments, and treatment plans. CMS requires that Medicaid and CHIP managed care plans coordinate and ensure that individuals are able to make smooth transitions between settings of care to enhance access to services, and complete an initial health risk assessment within 90 days of enrollment for all new beneficiaries. Additionally, managed care plans must assess enrollees with special health care needs and/or using long term services and supports and develop a treatment plan based on the assessment and ensure that it is regularly updated.

Enhancing Enrollment and Disenrollment Processes

The final rule establishes standards for voluntary and mandatory managed care enrollment processes and informational notices to beneficiaries to ensure consistency among states. The final rule also clarifies additional criteria a state could use in its default enrollment process to facilitate plan assignments that best meet enrollees' needs and better support program objectives. The final rule adds a new rationale for for-cause disenrollment for enrollees in managed long term services and support (MLTSS) programs. Specifically, MLTSS enrollees will be permitted to disenroll from their current managed care plan if the enrollee experiences a disruption in their employment or residence due to a change in the network status of their current provider of employment, residential, or institutional supports. For CHIP, the final rule sets standards for states that assign a child to a managed care plan when the family does not pick one.

Requiring Choice Counseling

The final rule requires states to provide choice counseling services for any new enrollee or for enrollees when they have the opportunity to change enrollment. Choice counseling is the provision of unbiased information on managed care plan or provider options and answers to related questions for Medicaid beneficiaries. Access to personalized assistance—whether by phone or in person—to help beneficiaries understand the materials provided by managed care plans or the state, to answer questions about each of the options available, and to facilitate

enrollment with a particular managed care plan or provider is an essential enrollment tool and can help enrollees select the managed care plan that best meets their needs. This is particularly true for enrollees in need of or utilizing long term services and supports, given their complex health care needs and use of ongoing critical support services.

Strengthening States' Delivery System Reform Efforts

The final rule clarifies that states may encourage managed care plans to develop and participate in broad-ranging delivery system reform of performance improvement initiatives. Some examples given by CMS of initiatives include patient-centered medical homes, efforts to reduce the number of low birth weight babies, broad-based provider health information exchange initiatives, and initiatives to improve access to providers.

The rule allows states to structure reimbursements and fees in a way to support timely access to care, adopt value-based purchasing approaches that linked to performance on quality measures, and use incentive or withhold arrangements to support targeted outcomes.

The rule notably permits states to make a capitation payment for enrollees with a short-term stay (15 days or less) in an institution for Mental Disease. This is a departure from a prior prohibition on using Medicaid funds for this type of service.

The rule sets parameters for the first Medicaid and CHIP quality rating system (QRS), modeled on the existing QRS for the Marketplace. Additionally, the rule requires states to post information on managed care plan accreditation status and annual external quality reviews on their websites.

Strengthening Program and Fiscal Integrity and Accountability

Promoting Transparency in Rate Setting

Medicaid managed care capitation rates are required to be actuarially sound. In addition to already-existing requirements that capitation rates be developed in accordance with generally accepted actuarial principles (GAAP) and certified by a qualified actuary, the final rule sets forth the types of data to be used for rate setting purposes and the level of documentation and detail that must be included. This is similar in concept to the CMS Access final rule, which sets forth various factors that states must consider and report on to CMS to demonstrate the adequacy of rates to support the cost of services. (Note that the Access final rule did not include Medicaid managed care or HCBS waiver services in its scope. ANCOR prepared a separate analysis of that rule's provisions, which is available to members upon request.) States do not need to get new approvals for increases or decreases in the capitation rate of less than one and a half percent.

Expanding managed care plans' responsibilities in program integrity efforts

The final rule seeks to strengthen program integrity by adding new components to prevent, monitor, identify, and respond to suspected provider fraud. Several of these components include mandatory reporting of potential suspected instances of fraud or changes

in circumstances that would impact an enrollee's eligibility or a provider's ability to participate. States have flexibility in how to address recovery of misallocated funds, but are required to specify how recovery will be addressed and take this into account in the rate setting process.

Strengthening Encounter Data Submission

The final rule requires that managed care plan contracts require complete, timely, and accurate encounter data submissions to the state in compliance with the level of detail and format required by CMS. The rule clarifies that Medicaid managed care expenditures that do not meet the criteria requirements will be disallowed from receiving a federal match.

Strengthening the Delivery of Managed Long Term Services and Support

The final rule codifies polices that were established in guidance released by CMS in 2013. Because CHIP beneficiaries typically do not receive long-term services and support (LTSS), the final rule does not require CHIP managed care programs to adopt these provisions.

Some of the key provisions relating to LTSS are to create a structure for stakeholder engagement in the ongoing monitoring of MLTSS programs, requiring states to go through a deliberative state planning process, and requiring that MLTSS programs be implemented and operated consistently with federal laws including the Americans with Disabilities Act.

The final rule approaches MLTSS with many of the same values and intent contained in the CMS HCBS rule. Specifically, it requires person-centered processes to ensure that beneficiaries' desires regarding service delivery are taken into account. It also requires the creation of an independent beneficiary support system to serve as a centralized point of contact for choice counseling to help support individuals in navigating the managed care delivery system.

The rule also sets standards to evaluate network adequacy for MLTSS programs, including qualification and credentialing of providers. It requires managed care plans to work with states to prevent, detect, and report critical incidents that adversely impact enrollee health and welfare.

Finally, the rule encourages payment methodologies that reflect the goals of MLTSS programs to improve the health of populations, support beneficiaries' experience of care, support community integration, and control costs.

Modernizing Medicaid and CHIP Managed Care

Modernizing Communications

See the "Strengthening Managed Care in CHIP" section of this document.

Modernizing Information Transparency

The final rule requires that state and managed care plans provide and maintain specific content on a public website accessible to beneficiaries. Annual reports on each managed care plan must include information and assessment on the plan's financial performance, encounter

data reporting, enrollment, benefits covered, grievances and appeals, availability and accessibility of covered services, evaluation of managed care plan performance on quality measures, sanctions or corrective action plans, activities and performance of the beneficiary support system, and factors related to the delivery of LTSS.

Other information that must be included are an enrollee handbook, a provider directory, a list of the plan's formulary drug lists, state-developed network adequacy standards, and program integrity documents and reports that include the managed care plan contract and the results of periodic audits.

Modernizing Appeals

The final rule aligns standards for the Medicaid and CHIP managed care appeals process with those of Medicare Advantage and the private market. Specifically, the rule aligns definitions and timeframes for the resolution of appeals, streamlines levels of internal appeals, and requires that enrollees utilize the managed care plan's internal process before proceeding to a state fair hearing.

Improving the Quality of Care for Medicaid Beneficiaries

The final rule seeks to improve consumer and stakeholder engagement and align quality measurement and improvement in Medicaid and CHIP managed care with other systems. As noted earlier in this document, the rule establishes a quality rating system (QRS) that is similar to the one that exists for the Marketplace. The development of the QRS will be undertaken with what CMS calls a "robust" public engagement process. States are expected to implement the QRS provisions within five years.

Additional quality provisions of the rule include requiring the validation of network adequacy information as part of a state's annual external quality review process and requiring states to make publicly available the results of annual external quality reviews.

CONCLUSION

The new Medicaid and CHIP managed care final rule is comprehensive, technical, and dense. It is also necessary as more states expand services into the managed care sphere. IDD services are among the last to be included in managed care in many states, but given ongoing state budget and federal fiscal challenges, it is not unexpected that IDD services are being provided increasingly within a managed care framework. ANCOR will continue to work with members, CMS, and other stakeholders to fully understand implications of the rule as it is implemented. For questions on this or other federal regulations, contact Katherine Berland, Director of Public Policy, at kberland@ancor.org.