CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

Overview of the Final Rule

Center for Medicaid and CHIP Services

Background

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Today, the predominant form of service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children's Health Insurance Program Reauthorization Act of 2009 adopted key Medicaid managed care provisions for CHIP
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs

Goals of the Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

Key Dates

- Publication of Final Rule
  - On display at the **Federal Register** on April 25th
  - Published in the **Federal Register** May 6th (81 FR 27498)
- Dates of Importance
  - Effective Date is July 5th
  - Provisions with implementation date as of July 5th
  - Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017
  - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
  - Applicability dates/Relevance of some 2002 provisions

Resources

- Medicaid.gov – Landing and Managed Care Pages
  - Final Rule
  - 8 fact sheets and implementation timeframe table
  - CMS Administrator's "Medicaid Moving Forward" blog
- ManagedCareRule@cms.hhs.gov

Goal: Delivery System Reform (DSR)

To further support state and federal delivery system reforms, the final rule:

- Provides flexibility for states to have value-based purchasing models, delivery system reform initiatives, or provider reimbursement requirements in the managed care contract
- Strengthens existing quality improvement approaches with respect to managed care plans

<u>Examples</u>

- Capitation Payments for Enrollees with a Short-Term Stay in an Institution for Mental Disease
- Value-Based Purchasing

DSR: Institution for Mental Disease

- Permits state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-64, that has a short term stay in an Institution of Mental Disease (IMD)
  - Short term stay: no more than 15 days within the month
  - Establishes rate setting requirements for utilization and price of covered services rendered in alternative setting of the IMD
- "In lieu of services" (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings
  - Establishes contractual requirements for ILOS
  - Establishes rate setting requirements for ILOS

These provisions apply as of the effective date of the final rule

DSR: Approaches to Payment

- Clarifies state payment-related tools for managed care plan performance
  - Establishes requirements for withhold arrangements
  - Retains requirements for incentive arrangements
- Acknowledges that states may require managed care plans to engage in value-based purchasing initiatives
- Permits states to set min/max network provider reimbursement levels for network providers that provide a particular service
- Transition period for pass-through payments to hospitals, physicians and nursing facilities

These provisions apply to rating periods for contracts starting on or after July 1, 2017

Goal: Modernization and Improving Quality of Care

Recognizes advancements in State and managed care plan practices and federal oversight interests

Examples

- Network Adequacy
- Information Standards
- Quality of Care

Modernization: Network Adequacy

- States will develop and implement time and distance standards for:
  - primary care – adult and pediatric;
  - specialty care – adult and pediatric;
  - behavioral health (mental health and substance use disorder) – adult and pediatric ;
  - OB/GYN; hospital; pharmacy; and
  - pediatric dental
- States will develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- Managed care plans will certify the adequacy of the networks at least annually

Modernization: Network Adequacy

- States will be permitted to have an exceptions process for a provider type and, if granted, will need to monitor access on an ongoing basis and include findings in the annual program report
- States will publish network adequacy standards on the State's website
- Upon request, the standards must be made available in alternative formats or through auxiliary aids for enrollees with disabilities (such as American Sign Language or TTY/TDY)

Provisions apply to any rating period for contracts starting on or after July 1, 2018

Modernization: Information Requirements

- States will operate a website that provides specific managed care information (or links) including each managed care plan's handbook, provider directory, and formulary
  - The State's website may link to the information on the managed care plan's website
- States will develop definitions for key terms and model handbook and notice templates for use by managed care plans
- Subject to certain parameters, States and managed care plans may provide required information electronically if the information is available in paper form upon request and free of charge

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at 438.10 from 2002 rule are applicable

Modernization: Information Requirements (cont.)

- Enrollee materials will include taglines in each prevalent non-English language explaining the availability of written materials in those languages and interpreter assistance, if requested, and at no cost to the enrollee
- Managed care plans will post provider directories online
  - Updating schedule: paper – monthly; electronic - 30 calendar days after managed care plan receives updated provider information
- Managed care plans will post drug formularies online and make available in paper form upon request

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at 438.10 from 2002 rule are applicable

Improving Quality: Quality Rating System

- States must implement a quality rating system (QRS) for Medicaid and CHIP managed care plans and to report plan performance for MCOs, PIHPs, and PAHPs
- CMS expects to implement the QRS over 5 years including:
  - A public engagement process to develop a proposed QRS framework and methodology using summary indicators adopted by the Marketplace QRS
  - Publication of the proposed QRS in the *Federal Register* with comment period, followed by notice of the final Medicaid and CHIP QRS
- States will have flexibility to adopt alternative QRS, with CMS approval

States must implement a QRS no later than 3 years from the date of a final notice published in the Federal Register

Improving Quality: Quality of Care

- Extends managed care quality strategy, QAPI, and external quality review (EQR) to PAHPs and to PCCM entities whose contracts include financial incentives
  - *Applies 60 days after publication; see QS, QAPI and EQR applicability below*
- Adds two new elements to states' managed care quality strategies related to health disparities and long term services and supports; adds Tribal consultation to public input process
  - *Applies July 1, 2018*
- Adds new mandatory EQR activity to validate network adequacy
  - *Applies no later than one year from the issuance of the EQR protocol*
- Improves transparency of quality information
  - *Applies no later than the rating period for contracts starting July 1, 2017 for QAPI and posting of accreditation status; applies July 1, 2018 for QS and EQR*

Goal: Strengthen Beneficiary Experience

Strengthens the beneficiary experience of care and key beneficiary protections

Examples

- Enrollment Process
- Beneficiary Support System, Including Choice Counseling
- Managed Long-Term Services and Supports (MLTSS)
- Provisions for Indians, Indian Providers, and Indian Managed Care Entities

Beneficiary Experience: Enrollment and Supports

Enrollment

- States retain flexibility to design their enrollment processes to best meet population needs and programmatic goals
- States will be required to provide notices to explain implications of enrollees' choices as well as all disenrollment opportunities
- Improved information content and distribution methods
  - *Applies to rating periods for contracts starting on or after July 1, 2017*

Supports

- Establishment of a beneficiary support system - An independent system to provide choice counseling and assist enrollees post-enrollment
  - *Applies to rating periods for contracts starting on or after July 1, 2018*

Beneficiary Experience: Managed Long Term Services & Supports

Rule implements elements of CMS' May 2013 MLTSS guidance, such as:

- Requires States to establish and maintain a structure for stakeholder engagement in planning and oversight of MLTSS programs
- Requires that enrollees with LTSS needs are involved in person-centered treatment and service planning
- Creates for cause disenrollment reason to another plan if institutional, employment, or residential provider leaves enrollee's plan
- Ensures there is more accurate and timely data gathering and sharing among managed care plans and providers
  - *Above apply to any rating period for contracts starting on or after July 1, 2017*
- Requires transition plans when a beneficiary moves from FFS to managed care or into a new managed care plan
  - *Applies to any rating period for contracts starting on or after July 1, 2018*

Beneficiary Experience: Indians, IHCPs, and IMCEs

The final rule implements provisions in section 5006(d) of the American Reinvestment and Recovery Act (ARRA) of 2009 (section 1932(h) of the Social Security Act):

- Defines Indian, Indian Health Care Provider (IHCP), Indian Managed Care Entity (IMCE) consistent with statutory and existing regulatory definitions
- Permits Indian enrollees to choose an IHCP that participates in the managed care plan's network as their primary care provider
- Permits Indian enrollees to obtain services from out-of network IHCPs

Beneficiary Experience: Indians, IHCPs, and IMCEs

- Specifies that managed care plans must demonstrate that there are sufficient IHCPs participating in the network. If there are few or no IHCPs in the State:
  - Indian enrollees will be permitted to access out-of-State IHCP, or
  - A State may treat this as good cause reason for the Indian enrollee to disenroll from the managed care plan
- Sets forth payment standards for IHCPs that may or may not be part of the network.
  - States must provide a supplemental payment to meet the applicable rate under the State plan
- Added requirement that managed care plans must permit out-of-network IHCPs to refer Indians to network specialists.

These provisions apply to any rating period for contracts starting on or after July 1, 2017

Beneficiary Experience: Indians, IHCPs, and IMCEs

CMS expects to issue sub-regulatory guidance on:

- Mandatory enrollment of Indians under section 1932(a), 1915(b), and 1115(a) authorities through the tribal consultation process

- I/T/U Managed Care Contract Addendum

Goal: Payment and Accountability Improvements

The final rule retains state flexibility to meet state goals and reflect local market characteristics while:

- Ensuring rigor and transparency in the rate setting process
- Clarifying and enhancing state and managed care plan expectations for program integrity

- Examples
  - Better defining Actuarial Soundness
  - Transparency in the Rate Setting Process and Approval
  - Encounter Data
  - Program Integrity

Payment and Accountability: Actuarially Sound Capitation Rates

- Establishes standards for the documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification
  - *Applies to any rating period for contracts starting on or after July 1, 2017*
- Permits states to increase or decrease the certified capitation rate by 1.5% (overall 3% range) without submission of a new rate certification
  - *Applies to any rating period for contracts starting on or after July 1, 2018*
- Requires that differences among capitation rates for covered populations must be based on valid rate development standards
  - *Applies to any rating period for contracts starting on or after July 1, 2017*
- Permits certain mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval
  - *Applies to any rating period for contracts starting on or after July 1, 2017*

Payment and Accountability: Encounter Data

- The Affordable Care Act and this rule condition payment of FFP on timely, accurate, and complete reporting of encounter data
- For contracts starting on or after July 1, 2017, States must require that managed care plans:
  - Collect and submit encounter data sufficient to identify the provider rendering the service;
  - Submit all encounter data necessary for the State to meet its reporting obligation to CMS; and
  - Submit encounter data in appropriate industry standard formats (i.e., ASC X12N 837, ASC X12N 835, NCPDP)

Payment and Accountability: Program Integrity

- Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse
  - *Applies to rating periods for contracts starting on or after July 1, 2017*
- Network providers will be screened, enrolled and revalidated as done in FFS
  - Network providers are not required to participate in the FFS program.
  - States can require managed care plans or a third party to conduct the screening process
  - *Applies to rating periods for contracts starting on or after July 1, 2018*
- Requires managed care contracts to address treatment of recovered overpayments by managed care plans and to take these amounts into account in the rate setting process
  - *Applies to rating periods for contracts starting on or after July 1, 2017*

Goal: Alignment with Other Insurers

Aligns Medicaid and CHIP managed care requirements with the private market or Medicare Advantage requirements to:

- Smooth beneficiary coverage transitions
- Ease administrative burdens of managed care plans that participate across publicly-funded programs and the commercial market

<u>Examples</u>

- Medical Loss Ratio (MLR)
- Appeals and Grievances

Alignment: Medical Loss Ratio

- Managed care plans are required to calculate and report their MLR experience for each contract year
  - *Applies to rating periods for contracts starting on or after July 1, 2017*
- Actuarially sound rates are set to achieve a MLR of at least 85%
  - *Applies to rating periods for contracts starting on or after July 1, 2019*
- States have the flexibility to set a standard higher than 85% and/or impose a remittance requirement
- Expenditures for program integrity activities in the MLR calculation will align with a future standard adopted in the private market rules

Appeals and Grievances

- Definitions and timeframes for resolution of appeals are consistent with the private market and Medicare Advantage
- Extends managed care appeals and grievance requirements to Pre-paid Ambulatory Health Plans (PAHPs)
- Managed care plans will perform one level of internal appeal for enrollees to use before proceeding to a State Fair Hearing (SFH)
  - The enrollee must exhaust the internal appeal before proceeding to SFH
  - Managed care plans must provide only one level of internal appeal
- Deemed exhaustion of internal appeal if managed care plan does not comply with timing and notice requirements
- States have the option to offer enrollees an external review so long as that process does not extend timeframes for the appeals process

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at subpart F from 2002 rule are applicable

Continuation of Benefits Pending Appeal

- Consistent with the 2002 rule, the enrollee must request continuation of benefits before the expiration of the original authorization
- Benefits must continue for the duration of the appeal or State Fair Hearing rather than the current requirement of continued benefits for the length of the original authorization period
- Because enrollees may be held financially liable for continued services if the final decision is adverse to the enrollee, States must create consistent rules for beneficiary financial liability for services in FFS and managed care

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at subpart F from 2002 rule are applicable

Aligning CHIP with Medicaid

CHIP substantially aligns with Medicaid provisions related to:

- Medical loss ratio
- Information requirements
- Disenrollment
- Conflict of interest
- Continued services to enrollees
- Network adequacy
- Enrollee rights & protections
- Indian Health Care providers and Managed Care entities
- MCO, PIHP, and PAHP standards
- Quality measurement and improvement
- External quality review
- Grievance system
- Program integrity
- Sanctions

Note: CHIP adopts the changes Medicaid finalized in these sections

Non-Aligned CHIP Provisions

Medicaid standards not applied:

- Prior approval of plan contracts
- Enrollment protections related to choice of plans (which is not required in CHIP)
- Rate-setting standards and certification
- Managed long-term services and supports

Questions

Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations