Medicaid and CHIP Managed Care Notice of Final Rulemaking (CMS-2390-F)

Overview of CHIP Provisions

Centers for Medicaid & 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 ofservice 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 (CHIPRA) 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
- Dates of Importance
  - Effective date was 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
  - Link to the Final Rule
  - 8 fact sheets and implementation timeframe table
  - Link to the CMS Administrator's "Medicaid Moving Forward" blog
- ManagedCareRule@cms.hhs.gov

Principles for Change

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

<u>Key Final Rule Principles</u>

- Alignment with Other Insurers
- Delivery System Reform
- Payment and Accountability Improvements
- Beneficiary Protections
- Strengthen Beneficiary Experience of Care
- Modernizing Regulatory Requirements and Improving the Quality of Care

Topics for Today's Presentation

- Background on CHIP managed care
- Alignment with Medicaid
- CHIP-specific provisions
- Provisions CHIP is not adopting
- Compliance dates

Background on CHIP Managed Care

- CHIPRA applied several Medicaid managed care provisions to CHIP
- Guidance was provided in two 2009 SHO letters (#09-008 & #09-013)
- This final rule supersedes and clarifies the guidance provided in the SHO letters and institutes additional changes to support principles of alignment and modernization

Background on CHIP Managed Care

- Scope of CHIP regulations is narrower than Medicaid, but aligns where appropriate
- Medicaid revised existing requirements that are new in some cases for CHIP

Aligning with Medicaid

CHIP adopts the following Medicaid managed care provisions, as revised in the final rule:

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

Aligning with Medicaid: Medical Loss Ratio

- Medical Loss Ratio (MLR) is a tool used to assess the appropriateness of capitation rates
  - Sets target for the proportion of premium revenues spent on care and quality improvement
- New rules require MLR calculation and reporting:
  - Rates developed based on actuarially sound principles must be set to achieve a target MLR of at least 85%
  - State flexibility to set a standard higher than 85% and/or impose a remittance requirement

§457.1203, cross referencing to §438.8 and §438.74

Aligning with Medicaid: Information Requirements

- Standards for communication with beneficiaries:
  - Electronic communication
  - Language access
  - Handbooks and provider directories
- Final rule aligns Medicaid and CHIP with commercial market

§457.1207, cross referencing to §438.10

Aligning with Medicaid: Disenrollment

- Disenrollment standards ensure beneficiaries' rights are maintained and administrative and medical inefficiencies are reduced
- CHIP standards in the final rule:
  - include PCCM entities
  - clarify the start of beneficiary 90 day without cause disenrollment
  - express state option to accept oral or written disenrollment
  - specify additional cause for disenrollment
- Managed care contracts must specify reasons for and methods by which the plan can request that an individual disenroll
- Beneficiary can disenroll within 90 days of enrollment or anytime with cause
- Note: existing CHIP provisions require states to have an alternative plan or FFS delivery system for disenrolled beneficiaries

§457.1212, cross referencing to §438.56

Aligning with Medicaid: Conflict of Interest

- Provides against conflicts of interest for employees or agents of the state

- Medicaid requirements not revised in final rule

§457.1214, cross-referencing to §438.58

Aligning with Medicaid: Continued Services to Enrollees

- States must develop Transition of Care Policy
- Ensure continuity of services for enrollees moving between plans or delivery systems
- Beneficiaries must have access to existing providers for a limited time

§457.1216, cross referencing to §438.62

Aligning with Medicaid: Network Adequacy

- Network adequacy standards ensure beneficiaries can access covered services
- Final rule aligns and CHIP standards with Marketplace
- States must develop and use time and distance standards for:
    - primary care (including pediatric);
    - specialty care (including pediatric);
    - OB/GYN;
    - behavioral health;
    - hospital;
    - pharmacy; and
    - pediatric dental
- Standards may vary based on geographic area served by plans

§457.1218, cross referencing §438.68

Aligning with Medicaid: Enrollee Rights and Protections

- Establishes requirements for plans to provide enrollees with treatment options and opportunity to participate in decision-making regarding their care
- Standards address:
  - Enrollee rights
  - Provider-enrollee communications
  - Marketing
  - Liability for payment
  - Emergency and post-stabilization services

§457.1220, 457.1222, 457.1226 cross referencing §§438.100, 438.102, 438.104 (except for 438.104(c)), 438.106, 438. 114.

Aligning with Medicaid: Access Standards

- Access standards ensure access to timely, adequate and coordinated care
  - Availability of services
  - Assurances of adequate capacity and services
  - Coordination and continuity of care
  - Coverage and authorization of services

§457.1230 cross referencing to §§438.206, 438.207, 438.208, 438.210 (except 438.210(a)(5) and 438.210(b)(2)(iii))

Aligning with Medicaid: Structure and Operations Standards

- Structure and operations standards for MCOs, PIHPs, and PAHPS
  - Provider selection
  - Subcontractual relationships and delegation
  - Practice guidelines
  - Health Information Systems
  - Privacy protections

§457.1233 cross referencing to §§438.214, 438.230, 438.236, 438.242 and 457.1110

Aligning with Medicaid: Quality Measurement & Improvement

- Standards are important for ensuring enrollees receive quality care through collecting, reporting and using data
- Regulations require:
  - Quality strategy
  - Quality assessment and performance improvement program
  - Posting plans' accreditation status
  - Managed care quality rating system

§457.1240, cross-referencing to §§438.330 (except 438.330(d)(4)), 438.332, 438.334, and 438.340

Aligning with Medicaid: External Quality Review

- CMS develops protocols
- Performed annually by qualified External Quality Review Organization (EQRO)
- 4 Mandatory EQR activities
  - Validations of performance improvement projects, performance measures, and network adequacy
  - Compliance review of managed care plans
- 6 Optional EQR activities
- CHIP does not adopt §438.362 or §438.360 for Medicare review

§457.1250 cross-references to §§438.350, 438.352, 438.356, 438.358, 438.360 (in part), and 438.364

FFP for CHIP External Quality Review

- Enhanced Title XXI FMAP applies to all CHIP administrative expenses
- Ten percent limit on total CHIP administrative expenses

Aligning with Medicaid: Grievances

- Regulations provide for streamlining the appeals and grievances process
- Final rule further aligns Medicaid and CHIP with Marketplace and Medicare Advantage, where appropriate, including:
  - Common definitions
  - Appeal timeframes
  - Processes for appeals and grievances

§457.1260, cross-referencing to §§438.400 – 438.424, except for §438.420

Aligning with Medicaid: Sanctions

- Sets forth state enforcement responsibilities when violations found
- State flexibility:
  - Defining the types of sanctions that may be imposed
  - Option to also extend sanctions to PCCMs and PCCM entities (not PIHPs or PAHPs)

§457.1270, cross-referencing to §§438.700 – 438.730

Aligning with Medicaid: Program Integrity

- Defines key state responsibilities for ensuring program integrity
- Specific areas addressed:
  - Fraud committed by managed care plans
  - Fraud committed by providers

§457.955, redesignated at §457.1280
§457.1285, cross-referencing to §§438.600 – 438.610, except for §438.604(a)(2)

CHIP-Specific Provisions

- CHIP-specific standards:
  - Contracting
  - Enrollment
- Maintain principle of alignment where appropriate.

CHIP-Specific Provisions: Contracting

- States required to submit CHIP contracts to CMS for review
- Prior approval not required
- Maintains some standards from existing CHIP regulations:
  - e.g., plan attestations regarding claims and payment data
- Adopts many Medicaid requirements
  - Prohibition on enrollment discrimination
  - Parity in mental health and substance use disorder benefits

§457.1201, including many provisions in §438.3

CHIP-Specific Provisions: Enrollment

- Sets standards for states that opt to have default enrollment process
- Default enrollment process not required
- Priority for existing enrollees at renewal
- Informational notices required for potential enrollees

§457.1210

Medicaid Provisions CHIP is Not Adopting

CHIP does not adopt Medicaid provisions related to:

- Rate development
  - States must develop payment rates consistent with actuarially sound principles, however specific Medicaid rate development standards do not apply
- Plan choice at enrollment
- Provisions related to dual beneficiaries or LTSS
- Prior approval of plan contracts

CHIP Compliance Dates

States must comply with existing regulations until new provisions are implemented

Description	Compliance Date
Withholding of FFP for failure to comply with federal requirements (§457.204)	**July 5, 2016**
All changes to part 457, including new subpart L, except as otherwise noted: §§457.10, 457.902, 457.940, 457.950, 457.955	**No later than state fiscal year beginning on or after July 1, 2018**
Mandatory EQR activity of validation of network adequacy), as applied to CHIP (§438.358(b)(1)(iv), as applied to CHIP per §457.1250)	**No later than one year from the issuance of the associated EQR protocol (or July 1, 2018, if later)**
Managed care quality rating system (§457.1240(d))	**No later than 3 years from the date of a final notice of Medicaid/CHIP QRS framework published in the Federal Register**

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