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CMS Proposes Major Update to Medicaid Managed Care Regulations

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The ***Centers for Medicare and Medicaid Services*** ("CMS") released, on May 26, 2015, the a far-ranging proposal for revising the ***Medicaid*** managed care regulations ("Proposed Rule"). The number of individuals enrolled in Medicaid managed care plans has increased to over 40 million. Federal Medicaid managed care regulations have not been substantially revised since they were issued in 2002. The Proposed Rule represents CMS' focused effort to modernize and update those regulations.

CMS describes its proposals as responsive to changes that have occurred in the managed care marketplace, as well as to statutory changes made by the Affordable Care Act and other laws. CMS intends for the Proposed Rule to increase the uniformity of requirements applicable to Medicaid managed care plans and to other federally regulated managed care plans, including Medicare Advantage plans and plans offered on the health insurance marketplaces. The Proposed Rule also incorporates or responds to recommendations made in recent reports from the Office of the Inspector General of the Department of Health and Human Services (the "OIG", reporting on access issues, provider credentialing, and fraud and abuse concerns) and the Government Accountability Office ("GAO," reporting on oversight of managed care payments, and rate setting).

Medical Loss Ratio

The Proposed Rule would impose a medical loss ratio ("MLR") requirement on Medicaid managed care plans of at least 85 percent, similar to the requirements applicable to commercial plans in the health insurance marketplaces (exchanges). The MLR would limit the ability of plans to retain Medicaid premiums or expend them for use on administrative functions. Under the Proposed Rule, the MLR would be calculated as the ratio of the amount the plan incurred for claims and for activities that improve health care quality to the plan's adjusted premium revenue.

The Proposed Rule grants discretion to the state to determine whether a remittance is required if the MLR is not met. Regardless of whether a remittance is required, states and actuaries are required to consider a plan's past MLR when developing future rates. The Proposed Rule also would direct states to scrutinize whether a plan's MLR is too low, which could suggest inadequate

reimbursement. Plans would be required to submit audited financial reports annually for use in future rate setting. If finalized as proposed, the MLR provisions would apply to rate years that begin on or after January 1, 2017.

Actuarial Soundness

The Proposed Rule would include greater specificity in the requirements applicable to Medicaid managed care rate setting, including amendments to the requirement that rates be “actuarially sound” to incorporate standards previously included in non-binding guidance issued by the American Academy of Actuaries. The proposed definition of “actuarially sound” would require rates paid to Medicaid managed care plans to “provide for all reasonable, appropriate, and attainable costs” required under the terms of the managed care contract. In addition, CMS would review rates to determine whether they are appropriate for the populations to be covered and the services to be furnished, whether they are adequate to allow the plan to meet the network adequacy and access standards, and whether the plan will reasonably be able to meet the MLR. The Proposed Rule would specifically prohibit states from justifying differences among proposed capitation rates according to whether the population is eligible for the enhanced federal matching rate made available by the Affordable Care Act.

Ability to Direct Plan Payments to Particular Providers

The Proposed Rule would codify a current CMS policy that prohibits state Medicaid agencies from directing expenditures made by Medicaid managed care plans. The Proposed Rule would carve out a limited exception to this prohibition, and would allow states to require Medicaid managed care plans to implement value-based purchasing models (including pay-for-performance arrangements, bundled payments, or other value- or outcome-based models), to require plans to participate in multi-payer delivery-system reform or performance-improvement initiatives, or to require the plans to adopt minimum fee schedules or uniform increases across all providers. Any such arrangements would require prior federal approval. States would continue to be prohibited from making payments to providers for services covered under a Medicaid managed care contract.

IMD/Alternate Settings

Since its inception, Medicaid has prohibited the payment of federal financial participation (“FFP”) for services to adults who are patients in an institution for mental disease (“IMD”). The Proposed Rule would add new authority allowing Medicaid managed care plans to receive capitation payments from a state for adult enrollees who spend a portion of the month that is less than 15 days in an IMD. This limited exception to the long-standing IMD exclusion is explained by CMS as reasonable in light of the “flexibility that managed care plans have historically had to furnish care in alternate settings that meet an enrollees needs,” and to respond to access issues for short-term inpatient psychiatric and substance-use-disorder treatment.

The preamble to the Proposed Rule includes further discussion of the concept of Medicaid managed care flexibility to provide “in lieu of services” that are alternatives to the services covered under the Medicaid state plan. Medicaid managed care plans may not require the use of such alternative services (including IMD services), but the preamble broadly affirms the ability of Medicaid plans to offer alternative services that are not covered by the state.

Long-Term Services and Supports

The Proposed Rule would integrate long-term services and supports ("LTSS") into the Medicaid managed care regulations. The rule proposes to define LTSS, and sets forth conditions that must be met for a state to claim FFP for LTSS-specific beneficiary support system activities. In the preamble, CMS references ten key principles released in earlier guidance, and states that the Proposed Rule would require Medicaid managed LTSS programs to comply with these principles. States and plans would be required to meet the following with regard to managed LTSS programs:

- Ensure that the views of beneficiaries, providers, and stakeholders are solicited and addressed with regard to design, implementation, and oversight;
- Establish specific time and distance standards to ensure network adequacy in managed LTSS programs, and require that plans must ensure that LTSS network providers have the capability to ensure physical access, accommodations, and accessible equipment for enrollees with physical and mental disabilities;
- Implement mechanisms to identify persons who need LTSS (as states currently do for "persons with special health care needs"), and comprehensively assess such individuals and produce a treatment plan with the enrollee's provider and other health care professionals, and update such plans at least every 12 months or when the enrollee's circumstances or needs change significantly.
- Ensure that medical-management and service-authorization standards do not disadvantage those individuals who have ongoing chronic conditions or need long term services and supports.
- Changes to the standards for providing "medically necessary services" would ensure that enrollees have the opportunity to access the benefits of community living.
- CMS would also remove authority for Medicaid managed care plans to discontinue coverage of services pending appeal when authorizations for those services have expired.

Network Adequacy

The Proposed Rule would require states to develop network adequacy standards in their contracts with Medicaid managed care plans that satisfy minimum parameters and apply to contracts for medical services, behavioral health services, and LTSS. States would be required to establish and publish on their website time and distance standards that are specific to classes of network providers, including pediatric providers. States would be required to certify the network adequacy of Medicaid managed care plans at least annually, and would be required to submit documentation to CMS when there is a significant change in the composition of a provider network.

Program Integrity

CMS also proposes a more comprehensive system for monitoring and reporting program integrity issues related to Medicaid managed care plans. Under the Proposed Rule, states would be required to:

- Screen and enroll, and periodically re-evaluate all plan network providers;

- Review ownership and control disclosures submitted by plans and subcontractors;
- Conduct routine checks of Federal databases to confirm the identify and the exclusion status of plans, plan subcontractors, persons with an ownership interest or who is an agent or managing employee of a plan;
- Conduct or contract for periodic independent audits (no less than once per every three years) of encounter and financial data submitted by plans;
- Receive and investigate information from whistleblowers relating to integrity issues of plans, subcontractors, or network providers;
- Make available (such as through its website, or upon request) plan contracts, the results of state independent audits, and certain data reports required from plans, including encounter data, data used to establish capitation rates and medical loss ratios, data related to assuring against the risk of insolvency, documentation of the availability and accessibility of services, information on ownership and control, and annual reports of overpayment recoveries.

In addition, plans would be required to maintain a written compliance program meeting federal standards, and to have a method to verify (such as through sampling) whether services represented to have been delivered by network providers were received by enrollees. Plans would be required to promptly notify the state of improper payments identified or recovered, changes of an enrollee's circumstances (including changes in income or residence), and changes in a provider's circumstances that affects its eligibility to participate in the managed care program. In addition, plans would be required to promptly refer potential fraud, waste, or abuse identified by the plan to the state Medicaid program integrity unit or the state Medicaid Fraud Control Unit.

CMS Disallowance Authority

The Proposed Rule would clarify that CMS could disallow or defer the availability of FFP for all, or for a portion of, payment amounts associated with specific services under an MCO contract. CMS uses the example in the preamble of disallowing the portion of a capitation rate associated with inpatient hospital costs if only that portion of the rate is determined not to be actuarially sound. This authority would allow CMS greater flexibility to disallow or defer sanctions to specific components of rates, without holding up payment for the full capitation rates.

State Monitoring Standards

The Proposed Rule would require states to have a monitoring system that addresses specific aspects of the managed care program. Under the rule, states would use data collected from the monitoring program to improve performance. The Proposed Rule would also require states to conduct readiness reviews of Medicaid managed care plans prior to effective start dates, and to submit the results of such review to CMS before a contract can be approved. States would also be required to provide an annual program assessment report to CMS within 150 days of the end of a managed care plan's period of performance.

Quality of Care

The Proposed Rule would strengthen quality measurement and improvement efforts in managed care by focusing on transparency, alignment with other systems, and consumer and stakeholder engagement. For instance, it would give CMS the authority to specify standardized performance measures and topics for performance-improvement projects for inclusion alongside state-specific measures in state contracts with Medicaid managed care entities. Medicaid managed care plans would also be required to undergo a performance review that is at least as stringent as reviews by private accreditation entities recognized by CMS prior to entering a contractual relationship with a state. In addition, CMS proposes that states would be required to develop and implement a Medicaid managed care quality rating system based on three summary indicators: clinical quality management; member experience; and plan efficiency, affordability, and management.

In addition to addressing quality efforts specific to managed care, the Proposed Rule would also amend Medicaid provisions requiring a state comprehensive quality strategy, applicable to all state Medicaid programs, including fee-for-service Medicaid programs. States would be required to update their state comprehensive quality strategy at least every 3 years and to post their quality strategy on the state's Medicaid website.

Enrollment Process

CMS proposes a new regulation governing enrollment into voluntary and mandatory Medicaid managed care plans. States would be required to provide potential enrollees with at least 14 days of fee-for-service coverage during which they can make an active enrollment choice, and states would be required to develop and provide informational materials to enrollees in advance of the 14-day period. For mandatory managed care programs, individuals failing to select a Medicaid plan during this enrollment period could be default enrolled into a qualified plan, based on a methodology that seeks to maintain existing provider-beneficiary relationships. For voluntary managed care programs, states would be able to use a passive enrollment process for individuals who do not select a plan during the enrollment period if the implications of not making an active choice are clearly explained. The Proposed Rule would also revise existing rules related to plan disenrollment to clarify that states may limit an individual's ability to disenroll from a plan without cause to the first 90 days after the individual's initial enrollment in a plan, even if the enrollee subsequently changes plans, and every 12 months thereafter.

Enrollee Education, Counseling, and Marketing

The Proposed Rule would require states to develop and implement a beneficiary support system that provides personal counseling and education about Medicaid managed care plans and primary care providers to enrollees. Under the Proposed Rule, choice counselors would be considered enrollment brokers and be required to meet independence and conflict-of-interest standards. In addition, the Proposed Rule would revise the Medicaid managed care marketing regulations to allow marketing communications from qualified health plans ("QHPs") to Medicaid beneficiaries, even if the QHP is also a Medicaid managed care entity, and to include in the definition of marketing the use of social media and forms of electronic communication.

Appeals and Grievances

The Proposed Rule would modify the regulations governing plan appeals and grievance procedures to increase uniformity with the procedures that apply to Medicare Advantage and to private insurance.

Coordination and Continuity of Care

The Proposed Rule would require that states have a transition-of-care policy for all Medicaid beneficiaries transitioning from one delivery system to another within Medicaid. The transition policy would be required to meet minimum standards, such as permitting enrollees to continue to receive services from current providers for a limited period of time and referring enrollees to appropriate providers. In addition, Medicaid managed care plans would be required to complete an initial health risk assessment within 90 days of enrollment, and to maintain and share an enrollee health record. This requirement is based on requirements for Medicare beneficiaries.

340B/Covered Outpatient Drugs

The Proposed Rule would require Medicaid managed care entities that offer outpatient drug coverage to collect information necessary to allow the state to obtain rebates from drug manufacturers pursuant to the Medicaid Drug Rebate Program ("MDRP"). The MDRP was expanded by the Affordable Care Act to apply to prescriptions for Medicaid managed care enrollees.

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