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Proposed Rule on Medicaid and CHIP Managed Care

INTRODUCTION

On May 26th, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP). The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans (QHP) and Medicare Advantage plans; clarify rate setting methodologies for plans and providers; and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. This proposed rule is the first major update to Medicaid and CHIP managed care regulations in over a decade.

Key provisions of the proposed rule are summarized below. Comments will be accepted until July 27, 2015. The proposed rule can be found here.

KEY PROVISIONS

Medical Loss Ratio

Currently, Medicaid and CHIP are the only health benefit coverage programs to not utilize a federal minimum medical loss ratio (MLR) for managed care plans, though 27 states have imposed MLRs of their own. The proposed rule would require all Medicaid and CHIP managed care plans to meet a minimum MLR of 85 percent beginning in 2017.

State Delivery System Reform Efforts

In the proposed rule, CMS reiterates that states are allowed to require managed care plan participation in delivery system reform or performance improvement initiatives. This would permit states to specify in contracts with managed care plans that they must participate in multi-payer or Medicaid-specific initiatives, such as patient-centered medical homes, health information exchange projects, and delivery system reform projects. States would be permitted to use managed care plan payments as a tool to incentivize providers to participate in particular initiatives that operate according to state-established and uniform conditions for participation and eligibility for additional payments. The capitation rates to the managed care plans would reflect an amount for incentive payments to providers for meeting performance targets. Managed care plans would retain control over the amount and frequency of payments.

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Rate Development for Managed Care Plans

CMS is proposing further requirements on how managed care plans must develop actuarially sound rates. Under the proposed rule, each individual rate paid to each managed care plan would need to be certified as actuarially sound with enough detail to understand the specific data, assumptions, and methodologies behind that rate, giving CMS more oversight to ensure rates are adequate but not inflated. States may still use rate ranges to gauge an appropriate range of payments on which to base negotiations, but states will have to ultimately provide certification to CMS of a specific rate rather than a rate range.

Whereas CMS has historically given states wide latitude in determining actuarial soundness, the proposed rule outlines a six-step process that states and plans would be required to undertake and document. These include methodologies for collection of historic data, development of trends, risk adjustment, and MLR.

In the process of reviewing and approving capitation rates, CMS also proposes to examine whether the plans' provider payment rates are sufficient to meet their obligations, including network adequacy.

Health Information Exchange Incentives

In the proposed rule, CMS clarifies that states may use their authority to make incentive payments for the use of technology that supports interoperable health information exchange for network providers that were not eligible for EHR incentive payments under the HITECH Act (including long-term/post-acute care, behavioral health, and home and community based providers). CMS is also inviting comments on how it may reinforce standards through rulemaking or guidance that would electronically integrate long-term services and supports.

Managed Long-Term Services and Supports (MLTSS)

The proposed rule would define Long-Term Services and Supports (LTSS) as "services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting."

CMS proposes to revise the Medicaid managed care regulations to ensure that all Managed Long-Term Services and Supports (MLTSS) programs operate in accordance with ten key elements. The ten elements include: adequate planning; stakeholder engagement; enhanced provision of home- and community-based services; alignment of payment structures and goals; support for beneficiaries; person-centered processes; comprehensive, integrated service package; qualified providers; participant projections; and quality.

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Network Adequacy

The proposed rule would set standards for the establishment of network adequacy measures for Medicaid managed care plans and establish criteria for developing network adequacy measures for MLTSS programs.

The proposed rule seeks to align the provider network adequacy standards with the Health Insurance Marketplaces and Medicare Advantage. The proposed rule would stipulate that states must establish time and distance standards for the following types of providers: primary care (adult and pediatric); OB/GYN; behavioral health; specialists (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types.

States would be required to certify provider network adequacy at least annually and when program design is changed. States would also be required to establish a process for external quality review of plan network adequacy.

Quality of Care

CMS proposes a quality framework for Medicaid and CHIP managed care plans and a process for adopting core performance metrics and improvement standards. This framework would be used by states to review and approve plans, and to draft written comprehensive quality strategies to assess and improve the quality of health care and services provided to all Medicaid beneficiaries. The proposed rule would also establish a quality rating system to compare Medicaid and CHIP plan performance, similar to the Medicare Advantage star rating system.

Institutions for Mental Disease

CMS is proposing that Medicaid managed care plans may receive a capitation payment from the state for an enrollee aged 21 to 64 that spends a portion of the month in an institution for mental disease (IMD) in certain cases. The IMD must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services and the stay in the IMD must be less than 15 days.

Marketing

The proposed rule would revise marketing standards applicable to Medicaid managed care programs. The rule would amend the definition of "marketing" to specifically exclude communications from a QHP to Medicaid beneficiaries, even if the issuer of the QHP is also the entity providing Medicaid managed care. Medicaid managed care plans would be allowed to provide information on QHPs to potential enrollees who might enroll in them as an alternative to their Medicaid managed care coverage. This proposal recognizes that "consumers may experience periodic transitions between Medicaid and QHP eligibility … [and that] selecting a carrier that offers both types of products may be the most effective way for some consumers to manage their health care needs." CMS also clarified that Medicaid

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managed care plans still cannot directly or indirectly engage in certain types of cold-call marketing activities, including door-to-door, phone, text, or email methods.