

Final Rule on Medicaid and CHIP Managed Care

OVERVIEW

On April 25th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP). The final rule aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage plans. The rule also clarifies rate setting methodologies for plans and providers and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. The final rule is the first major update to Medicaid and CHIP managed care regulations in over a decade.

This document summarizes several major provisions of the final rule. The provisions of the final rule will be implemented over the next three years, starting in July 2016. The final rule is available [here](#).

KEY PROVISIONS

Medical Loss Ratio

Currently, Medicaid and CHIP are the only health benefit coverage programs without a federal minimum medical loss ratio (MLR) for managed care plans, though some states have imposed MLRs of their own. CMS finalized its proposal to require all Medicaid and CHIP managed care plans meet a minimum MLR of 85 percent beginning in 2017.

State Delivery System Reform Efforts

The final rule contains provisions to strengthen states' delivery system reform efforts. CMS finalized its policy to permit states to require that managed care plans participate in multi-payer or Medicaid-specific initiatives, such as patient-centered medical homes, health information exchange projects, and delivery reform projects.

The final rule clarifies that states are permitted to partner with managed care plans to adopt value-based purchasing approaches that tie provider reimbursement to performance. Under the final rule, CMS clarifies that states can use incentive and withholding arrangements to encourage managed care plans to meet quality or performance targets.

CMS also clarified that incentive payments for delivery system reform and quality improvement are among the only types of supplemental payments that states will be allowed to direct to providers through managed care contracts. States will no longer be allowed to require managed care plans to pay providers specific amounts based on participation in Intergovernmental Transfers or other metrics unrelated to services delivered or outcomes achieved. States will have up to ten years to phase out supplemental payments to hospitals and up to five years to phase out supplemental payments to other providers.

Rate Development for Managed Care Plans

CMS finalized requirements on how managed care plans must develop actuarially sound rates. The requirement for actuarial soundness of Medicaid managed care rates is longstanding, but has been interpreted broadly. CMS finalized its proposal to no longer allow states to certify broad ranges of rates to be actuarially sound, instead each rate paid to each managed care plan will need to be certified as actuarially sound with enough detail to understand the specific data, assumptions, and methodologies behind the rate. CMS can more adequately review and approve capitation rates with such data.

The final rule provides states with the flexibility to increase or decrease the certified capitation rate by one and a half percent without the need to submit a revised rate certification for review and approval by CMS.

Health Information Exchange Incentives

CMS adopted its policy to allow states to make incentive payments for the use of technology that supports interoperable health information exchange for network providers that were not eligible for Health Exchange Resource incentive payments under the HITECH Act (including long-term/post-acute care, behavioral health, and home and community based providers).

Managed Long-Term Services and Supports (MLTSS)

The final rule revises the Medicaid managed care regulations to ensure that all 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; a comprehensive, integrated service package; qualified providers; participant projections; and quality.

Network Adequacy

CMS finalized its proposal to require states to establish standards of network adequacy for Medicaid managed care plans and MLTSS programs.

Like the Health Insurance Marketplaces and Medicare Advantage, the final rule stipulates that states must establish maximum driving time and driving distance standards for certain categories of providers. Unlike the Marketplaces and Medicare Advantage, CMS declined to set the time and distance standards at the federal level, opting instead for state flexibility. States will set standards for the following types of providers: primary care (adult and pediatric); OB/GYN; behavioral health (adult and pediatric); specialists (adult and pediatric); hospital; pharmacy; and pediatric dental. States have the authority to add additional provider types to their network adequacy standards.

Strengthening Patient Communication

The final rule expands the ways that states and managed care plans may communicate with beneficiaries. CMS finalized its proposal to permit states and managed care plans to use a range of electronic communication methods to communicate with beneficiaries, including emails, texts, and website postings for the dissemination of required information. Beneficiaries must still be able to obtain paper materials upon request at no cost.

The final rule also requires that provider directories include information such as a provider's group and site affiliation, website URL, information on physical accessibility for enrollees with physical disabilities, and information about the managed care plan's drug formulary.

Quality of Care

CMS finalized a quality framework for Medicaid and CHIP managed care plans and a process for adopting core performance metrics and improvement standards. This framework will 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 final rule authorizes CMS to develop a quality rating system to compare Medicaid and CHIP plan performance, similar to the Health Insurance Marketplace quality reporting system. The ratings will be based on a common set of summary indicators, which will align with those used in the Health Insurance Marketplaces. The development of this new quality rating system will include stakeholder engagement and public feedback.

Institutions for Mental Disease

CMS finalized its proposal to allow Medicaid managed care plans to 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). 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 fewer than 15 days.