

# CMS's 2018 Proposed Medicaid Managed Care Rule: A Summary of Major Provisions

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## Executive Summary

Managed care is the predominant Medicaid delivery system in most states, with over two-thirds of beneficiaries enrolled in comprehensive risk-based managed care organizations as of July 2016, and millions of others covered by limited-benefit risk-based plans or primary care case management programs. On November 14, 2018, the Centers for Medicare and Medicaid Services (CMS) proposed revisions to the Medicaid managed care regulations with public comments due by January 14, 2019. CMS previously finalized a major revision to these regulations in 2016. The November 2018 proposed rule is not a wholesale revision of the 2016 final rule but proposes changes in the following key areas:

**Network adequacy.** The proposed rule would remove the requirement that states use time and distance standards to ensure provider network adequacy and instead let states choose any quantitative standard.

**Beneficiary protections.** The proposed rule would relax requirements for accessibility of written materials for people with disabilities and those with limited English proficiency; modify some provider directory requirements; and change the timeframe within which plans must tell enrollees that a provider is leaving the network. It also would let states shorten the timeframe for enrollees to request a state fair hearing and eliminate the requirement to submit a written appeal after an oral appeal.

**Quality oversight.** The proposed rule would revise the requirement that a state's alternative managed care quality rating system (QRS) yield information substantially comparable to the CMS-developed QRS; clarify that health plan encounter data must include allowed and paid amounts; broaden the definition of disability when addressing health disparities under states' managed care quality strategies; and require states to annually post online which health plans are exempt from external quality review.

**Rates and payment.** The proposed rule would allow states to set capitation rate cell ranges instead of a single rate per cell. It also would expressly prohibit states from varying capitation rates based on the amount of federal financial participation for covered populations or any other way that increases federal costs and from retroactively adding or modifying risk-sharing mechanisms after the start of a rating period. The proposed rule would recognize two minimum fee schedules for directed payment arrangements from health plans to providers; allow states to direct the amount or frequency of plan expenditures; codify sub-regulatory guidance for multi-year approvals of value-based purchasing models; and allow states to make new supplemental provider pass-through payments for a time-limited period when transitioning populations or services from fee-for-service to managed care.

**Table 1: Key Provisions in CMS's November 2018 Medicaid Managed Care Rule**

Topic	2016 Final Rule	2018 Proposed Rule
Network adequacy	Requires states to develop and enforce enrollee travel time and distance standards.	Would allow states to choose any quantitative standard.
Beneficiary information	<p>Requires taglines in large print and locally prevalent non-English languages on all written materials.</p> <p>Requires paper plan directories to be updated monthly.</p> <p>Establishes timeframe for plans to notify enrollees when provider leaves network.</p>	<p>Would require taglines only on written materials determined critical to obtaining services.</p> <p>Would require paper directories to be updated quarterly unless mobile-enabled electronic version is available.</p> <p>Modifies timeframe within which plans must notify enrollees when provider leaves network.</p>
Appeals	<p>Requires states to provide enrollees with 120 days to request a state fair hearing after the health plan appeal notice of resolution.</p> <p>Requires enrollees to submit a written signed appeal after an oral appeal submitted.</p>	<p>Would allow states to provide enrollees with 90 to 120 days to request a state fair hearing after the health plan appeal notice of resolution.</p> <p>Would eliminate requirement for written signed appeal after oral appeal submitted.</p>
Quality rating system	Allows states to adopt an alternative quality rating system (QRS) that yields information substantially comparable to the CMS-developed QRS.	Would require a state alternative QRS to yield information substantially comparable to the CMS-developed QRS only to the extent feasible.
Encounter data	Conditions federal matching funds on state reporting of encounter data.	Clarifies that plan submission of encounter data must include allowed and paid amounts.
Quality strategy	Requires state quality strategy to address health disparities for enrollees with disabilities, identified as those who are eligible for Medicaid based on a disability.	Would require state quality strategy to address health disparities for enrollees with disabilities, using a broader definition of disability.
External quality review	Requires states to have an external quality review (EQR) for health plans.	Would require states to annually post online which health plans are exempt from EQR.
Capitation rate development	Requires states to set a single rate per cell.	<p>Would allow states to set a rate range per cell.</p> <p>Would expressly prohibit states from varying rates based on the amount of federal financial participation for a covered population or another way that increases federal costs.</p> <p>Would clarify that states can adjust certified rates within a rating period by +/-1.5% without submitting a revised certification to CMS.</p> <p>Would prohibit states from retroactively adding or modifying risk-sharing mechanisms after the start of the rating period.</p>
Payment	<p>Allows states to adopt minimum or maximum fee schedules for plan payments to providers.</p> <p>Prohibits states from directing the amount or frequency of plan expenditures.</p> <p>Phases out pass-throughs of state supplemental provider payments in capitation rates.</p>	<p>Would recognize 2 minimum fee schedules for states' directed payment arrangements from health plans to providers.</p> <p>Would allow states to direct the amount or frequency of plan expenditures.</p> <p>Would codify guidance on multi-year approvals of value-based purchasing models.</p> <p>Would allow new pass-throughs of supplemental provider payments during a time-limited period when states are transitioning populations or services from fee-for-service to managed care.</p>

## Introduction

On November 14, 2018, the Centers for Medicare and Medicaid Services (CMS) published proposed revisions to the Medicaid managed care regulations.<sup>1</sup> CMS last revised these regulations in 2016 (“the 2016 final rule”) under the Obama Administration.<sup>2</sup> The 2016 final rule represented a major revision and modernization of federal regulations in this area, which had not been updated since 2002.<sup>3</sup> CMS’s major goals in issuing the 2016 final rule were to align Medicaid managed care requirements with other major health coverage programs where appropriate; enhance the beneficiary experience of care and strengthen beneficiary protections; strengthen actuarial soundness payment provisions and program integrity; and promote quality of care.<sup>4</sup>

In March 2017, the HHS Secretary and CMS Administrator under the Trump Administration released a [letter to state governors](#) noting the new Administration’s plan to conduct a “full review of [Medicaid] managed care regulations to prioritize beneficiary outcomes and state priorities.”<sup>5</sup> CMS then released an [Informational Bulletin](#) in June 2017, indicating it would use “enforcement discretion” to work with states on achieving compliance with the 2016 final rule, except for specific areas that “have significant federal fiscal implications.”<sup>6</sup> CMS’s stated goals in releasing the November 2018 Notice of Proposed Rulemaking (NPRM) to revise the 2016 final rule are to streamline the managed care regulatory framework; reduce state and federal administrative burden; support state flexibility; and promote transparency, flexibility, and innovation in care delivery. The NPRM is not a wholesale revision of the 2016 final rule but proposes changes in the following key areas, which are summarized in this issue brief and Table 1: network adequacy, beneficiary protections, quality oversight, and rate setting and payment.<sup>7</sup> The 60-day period for public comment on the proposed rule closes on January 14, 2019.

## Background

According to the most current national data, as of July 1, 2016, 54.6 million Medicaid beneficiaries, or just over 68%, were enrolled in comprehensive risk-based managed care organizations (MCOs).<sup>8</sup> Currently, 38 states and DC contract with MCOs; in many of these states, at least 75% of all beneficiaries are enrolled in these health plans.<sup>9</sup> While MCOs are the predominant form of Medicaid managed care, millions of other beneficiaries receive at least some Medicaid services, such as behavioral health or dental care, through limited-benefit risk-based plans, known as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). Several million beneficiaries are also enrolled in primary care case management (PCCM) programs that range from basic managed fee-for-service (FFS) models to more enhanced models.<sup>10</sup>

## Key Changes in the Proposed Rule

### Network adequacy

**The proposed rule would remove the requirement that states use time and distance standards to ensure health plans’ provider network adequacy and instead allow states to choose another**

**quantitative standard.** Health plan efforts to recruit and maintain their provider networks can play a crucial role in determining enrollees' ability to access covered services. The 2016 final rule required states to develop and enforce enrollee travel time and distance standards for certain specified provider types as well as additional providers to be determined by CMS, for health plan contracts beginning on or after July 2018. The proposed rule would instead allow states to use an alternative standard such as minimum provider-to-enrollee ratios, maximum travel time or distance to providers, minimum percentage of contracting providers accepting new patients, maximum wait times for an appointment, or hours of operation requirements. The proposed rule also would allow states to use any quantitative network adequacy standard for long-term services and supports providers to whom enrollees must travel to receive services, eliminating the requirement in the 2016 final rule for states to develop time and distance standards for these providers. Additionally, the proposed rule would allow states to define the specialists to which network adequacy standards apply. Finally, the proposed rule would eliminate the "other provider type" language, curtailing CMS's ability to add to the list of providers subject to network adequacy standards without further rule-making.

## Beneficiary protections

### BENEFICIARY INFORMATION

**The proposed rule would relax the requirements for accessibility of written materials for people with disabilities and those with limited English proficiency.** The 2016 final rule requires taglines in large print and in locally prevalent non-English languages on all written materials (e.g., enrollee handbooks, provider directories, enrollee notices) to explain the availability of interpretation and translation services and to provide the toll-free choice counseling number and the plan's toll-free customer service number, for plan contracts beginning on or after July 2017. The proposed rule would only require taglines on written materials for potential enrollees that "are critical to obtaining services." The proposed rule would also change the definition of "large print" from at least 18-point font to font that is "conspicuously visible."

**The proposed rule would eliminate the requirement to identify in health plan provider directories whether a provider has completed cultural competence training and would decrease the frequency of updating paper provider directories.** The 2016 final rule requires plan directories to indicate whether a provider has completed cultural competence training and specifies that paper directories must be updated at least monthly, for plan contracts beginning on or after July 2017. The proposed rule would only require monthly updates to paper directories if a mobile-enabled, electronic directory is not available; otherwise, updates would be required quarterly.

**The proposed rule would change the timeframe within which plans must tell enrollees that their provider is leaving the plan network.** The 2016 final rule requires plans to make a good faith effort to give written notice of termination of a contracted provider to enrollees within 15 calendar days after receipt or issuance of the termination notice, for plan contracts beginning on or after July 2017. The proposed rule would change this requirement to the later of 30 calendar days prior to the *effective termination date*, or 15 calendar days after receipt or issuance of the termination notice.

## APPEALS

**The proposed rule would allow states to shorten the timeframe within which an enrollee can request a state fair hearing to appeal a health plan decision to deny or terminate covered services.**

The 2016 final rule provides enrollees with 120 days from the plan's notice of resolution of the internal plan appeal to request a state fair hearing, for contracts beginning on or after July 2017. The proposed rule would let states set the timeframe for enrollees to request a fair hearing between 90 to 120 days, to allow states to align this period with the timeframe for enrollees to appeal decisions covered under Medicaid fee-for-service.

**The proposed rule would also eliminate the requirement for beneficiaries to submit a written, signed appeal after an oral appeal is submitted.** The 2016 final rule requires enrollees to submit a written, signed appeal following an oral appeal, for contracts beginning on or after July 2017.

## Quality oversight

### QUALITY RATING SYSTEM

**The proposed rule would revise the requirement that states' alternative managed care quality rating systems (QRS) yield information substantially comparable to the CMS-developed QRS, instead requiring this only "to the extent feasible."** Under the 2016 final rule, CMS was to develop performance measures and a methodology for a managed care QRS framework to rate health plans and enable comparisons across states.<sup>11</sup> States could also implement an alternative QRS with CMS approval. Under the proposed rule, a state's alternative QRS would have to include the mandatory performance measures established by CMS, although the alternative QRS would have to yield information substantially comparable to the CMS-developed QRS only to the extent feasible. The proposed rule also would eliminate the requirement that states obtain prior approval from CMS before implementing an alternative QRS. CMS may request states to submit their alternative QRS for review. The proposed rule would allow states to complete the public stakeholder process for an alternative QRS before implementation instead of before submission to CMS.

### ENCOUNTER DATA

**The proposed rule clarifies that health plan submission of encounter data must include allowed and paid amounts.** CMS underscores the importance of these data for monitoring and administration of the Medicaid program. The 2016 final rule conditions federal matching funds for Medicaid managed care payments to states on state reporting of validated, complete, and timely enrollee encounter data, for contracts beginning on or after July 2018.

### QUALITY STRATEGY

**The proposed rule would broaden the definition of disability when addressing health disparities in the state's managed care quality strategy.** Under the 2016 final rule, states must have a written quality strategy for assessing and improving the quality of care and services furnished by health plans and PCCM entities, for health plan contracts effective on or after July 2018. Among other elements, state

quality strategies must describe their plans to reduce health disparities based on certain demographic factors including disability. Current regulations identify enrollees with a disability based on whether they qualify for Medicaid in a disability-related eligibility pathway. Under the proposed regulations, “disability” would not be limited to those who qualify for Medicaid based on a disability, recognizing that enrollees with disabilities may qualify for Medicaid on another basis (such as low income) and that there are other definitions of and sources to determine disability, such as the Americans with Disabilities Act and other federal and state laws. CMS proposes this change to avoid an “unintentionally narrow” definition of disability for purposes of identifying enrollees with disabilities for whom health disparities should be assessed under the state’s managed care quality strategy.<sup>12</sup>

## EXTERNAL QUALITY REVIEW

**The proposed rule would require that states annually post online which health plans are exempt from external quality review (EQR) and specify when the exemption began.** Under the 2016 final rule, states must ensure that a qualified organization performs an annual EQR for each health plan or PCCM entity to assess quality, timeliness, and access to health care services, for contracts beginning on or after July 2018. In the NPRM, CMS notes that it instead might allow states to identify exempted plans in their annual EQR technical report instead of online.

## Rate setting and payment

### CAPITATION RATE DEVELOPMENT

**The proposed rule would allow states to set capitation rate cell ranges<sup>13</sup> instead of a single rate per cell.** The 2016 final rule required a single rate per cell for contracts beginning on or after July 2016. In support of the proposed change, CMS notes that the single rate requirement could diminish a state’s ability to obtain the best rates. The proposed rule also notes that states would not be able to change capitation rates within the range during the rating year, unless they meet specified criteria.

**The proposed rule would expressly prohibit states from varying capitation rates based on the amount of federal financial participation for a covered population or in any other way that increases federal costs.** CMS also proposes clearly listing certain rate development practices that increase federal costs and therefore are prohibited.<sup>14</sup> The proposed rule would clarify that rate development standards must be based on actual cost differences in providing covered services to covered populations and that during rate review, CMS may require states to provide written documentation and justification that any differences in the assumptions, methodologies, and factors used to develop capitation rates represent actual cost differences based on the characteristics or mix of covered services or populations.

**The proposed rule would clarify that states may adjust certified capitation rates within a rating period by +/-1.5%, without submitting a revised rate certification or justification to CMS.** Under the proposed rule, CMS could specifically request documentation from states. In addition, CMS proposes to

issue guidance at least annually that describes the federal standards for capitation rate development and related documentation requirements.

**The proposed rule would prohibit states from retroactively adding or modifying risk-sharing mechanisms after the start of the rating period.** CMS also proposes requiring states to document risk-sharing mechanisms in health plan contracts and rate certification documents prior to the start of the rating period.

## **PAYMENT**

**The proposed rule would recognize two distinct minimum fee schedules for states' directed payment arrangements from health plans to providers.** The 2016 final rule allows states to adopt a minimum or maximum fee schedule for health plan payments to network providers that provide a particular service, for contracts beginning on or after July 2017. The first proposed minimum fee schedule would apply to directed payment arrangements that use state plan approved rates. These rates would be defined as those that are specified under the approved state plan methodology to ensure adequate provider access but excluding supplemental payments. The other proposed minimum fee schedule would apply to directed payment arrangements that use rates other than state plan approved rates for network providers that provide a particular service. CMS also proposes allowing states to direct plans to adopt a cost-based rate, a Medicare equivalent rate, a commercial rate, or another market-based rate. The proposed rule would eliminate the requirement for CMS prior approval of states' directed payment arrangements based on state plan approved rates, as CMS believes this is duplicative of the state plan amendment process.

**The proposed rule would allow states to direct the amount or frequency of plan expenditures, which is prohibited under current regulations.** The 2016 rule specified that plans could not direct the amount or frequency of plan expenditures made to providers as part of delivery system or payment initiatives. CMS believes that this may have created unintended barriers to the implementation of innovative payment modes, like global payment initiatives.

**The proposed rule would codify sub-regulatory policy guidance governing multi-year approvals of value-based purchasing models or those tied to larger delivery system reform efforts.** Specifically, the proposed regulation would adopt the criteria in the November 2017 [CMCS Informational Bulletin](#). The 2016 final rule describes states' authority to require managed care plans to implement value-based purchasing models for provider payment (such as pay-for-performance arrangements, bundled payments, or other models intended to reward value over volume) or participate in multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives.

**The proposed rule would allow states to make new supplemental provider pass-through payments during a time-limited period when states are transitioning populations or services from fee-for-service to managed care.** The 2016 final rule phases out pass-throughs of state supplemental provider payments in the capitation rates paid to managed care plans because these payments are not tied to the

provision of services covered under plan contracts and therefore conflict with the actuarial soundness requirement.<sup>15</sup> Specifically, the 2016 rule phases out pass-through payments to hospitals from 2017-2027, and to physicians and nursing facilities from 2017-2022.

**The proposed rule would allow states to specify how health plans covering enrollees dually eligible for Medicare and Medicaid would receive crossover claims, instead of requiring plans to have a coordination of benefits agreement and participate in the automated Medicare process.**

Crossover claims arise for dual eligible beneficiaries because Medicaid may cover the portion of the service charge that is not covered by Medicare. The 2016 final rule required health plans that cover dually eligible enrollees to participate in the Medicare automated crossover claim process in an effort to simplify billing for providers.

**The proposed rule would not change the “institution for mental disease” (IMD) “in lieu of” authority codified in the 2016 final rule.**<sup>16</sup> Under the 2016 final rule, states can receive federal

matching funds for capitation payments made to health plans on behalf of enrollees ages 21-64 who receive psychiatric or substance use disorder (SUD) inpatient or crisis residential services in an IMD for up to 15 days in a month, as services covered “in lieu of” those under the Medicaid state plan benefit package.<sup>17</sup> This is an exception to the general federal prohibition against Medicaid payments for services for non-elderly adults in IMDs. Instead of proposing a regulatory change, CMS in the November 2018 NPRM notes that states may continue to apply for [Section 1115 demonstration waivers](#) to receive federal Medicaid matching funds for longer IMD SUD stays.<sup>18</sup> Additionally, the recently enacted federal [Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities \(SUPPORT\) Act](#) creates a new option from October 2019 through September 2023, for states to receive federal Medicaid payments for non-elderly adults with SUD in an IMD up to 30 days per year. In November 2018, CMS also issued [new guidance](#) inviting states to apply for Section 1115 waivers of the federal IMD payment exclusion for services for individuals with serious mental health conditions.<sup>19</sup>

## Looking Ahead

CMS’s November 2018 proposed changes to the Medicaid managed care regulations are subject to revision based on public comments, which are due by January 14, 2019. While the proposed rule is not a wholesale revision of the comprehensive 2016 final rule, it does propose changes in key areas, including network adequacy standards, beneficiary information and appeals, quality oversight, and capitation rate development and provider payment. Federal rules governing Medicaid managed care are important as managed care remains the predominant care delivery system in most states. States, health plans, providers, beneficiaries, and other stakeholders will be interested in following CMS’s proposed regulatory changes in this area as the proposed rule is finalized.

## Endnotes

<sup>1</sup> 83 *Fed. Reg.* 57264-57299 (Nov. 14, 2018), <https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-plan-chip-managed-care>.

<sup>2</sup> 81 *Fed. Reg.* 27498-27901 (May 6, 2016), <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaidand-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

<sup>3</sup> For a summary of the 2016 final rule, see Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), <https://www.kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/>.

<sup>4</sup> Most provisions were effective July 2016, although some provisions became effective later. See *id.*

<sup>5</sup> Letter from HHS Sec'y Thomas E. Price and CMS Administrator Seema Verma to governors (March 14, 2017), <https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html>.

<sup>6</sup> CMCS Informational Bulletin, *Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates* (June 30, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf>.

<sup>7</sup> The November 2018 NPRM also includes some proposals related to CHIP which are outside of the scope of this brief.

<sup>8</sup> [Medicaid Managed Care Enrollment Reports](#), Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2018.

<sup>9</sup> Share of Medicaid Population Covered under Different Delivery Systems, State Health Facts, Kaiser Family Foundation, <http://kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>

<sup>10</sup> This brief generally refers to “health plans.” Provisions in the proposed rule generally apply to MCOs, and some provisions also apply to PIHPs, PAHPs, and PCCM entities.

<sup>11</sup> The 2016 final rule anticipated that CMS would have finalized the QRS by 2018. The proposed rule indicates that CMS has begun the early stages of a stakeholder engagement process and convened a technical expert panel. 83 *Fed. Reg.* 57280 (Nov. 14, 2018).

<sup>12</sup> 83 *Fed. Reg.* 57281-57282.

<sup>13</sup> Rate cell ranges would be allowed provided certain conditions are met. Proposed conditions include: 1) the rate certification identifies and justifies the assumptions, data, and methods specific to the upper and lower bounds of the rate range; 2) both the upper and lower bounds of the rate range are certified as actuarially sound; 3) the upper bound does not exceed the lower bound multiplied by 1.05; 4) the rate certification documents the state’s criteria for paying at different points within the rate range; and 5) the state does not use as criteria for payment the willingness or agreement of plans or their network providers to enter into intergovernmental transfer (IGT) agreements or based on the amount of funding plans or their network providers provide through IGT agreements.

<sup>14</sup> The NPRM proposes that a state may not: 1) use a profit, operating, or risk margin to develop capitation rates that is higher than the margin used to develop capitation rates for the covered population, or contract, with the lowest average rate of FFP; 2) factor into the development of capitation rates the additional cost of contractually required provider fee schedules or minimum levels of provider reimbursement, above the cost of similar provider fee schedules, or minimum levels of provider reimbursement, used to develop capitation rates for the covered population, or contract, with the lowest average rate of FFP; and 3) lower the remittance threshold for a medical loss ratio for any covered population, or contract, below the threshold used for the covered population, or contract, with the lowest average rate of FFP.

<sup>15</sup> On January 17, 2018 CMS posted a final rule clarifying pass-through payment transition periods and maximum allowable pass-through payments. See 82 *Fed. Reg.* 5415-5429 (Jan. 18, 2017), <https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery>.

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<sup>16</sup> For background about the Medicaid IMD payment exclusion, see Kaiser Family Foundation, *Key Questions about Medicaid Payment for Services in “Institutions for Mental Disease”* (June 2018), <https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/>.

<sup>17</sup> To receive federal matching funds for “in lieu of” services, a state must identify the services in the plan’s contract and determine that they are medically appropriate and cost-effective. In lieu of services are offered at plan option, and an enrollee cannot be required to use them. Kaiser Family Foundation, *CMS’s Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), <https://www.kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/>.

<sup>18</sup> In July 2015, the CMS issued a [state Medicaid director letter](#) describing Section 1115 IMD SUD payment waivers. In November 2017, the CMS issued a [state Medicaid director letter](#) revising the 2015 guidance. For current IMD state waiver activity, see Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (Jan. 3, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>.

<sup>19</sup> CMS, SMD #18-011, *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance* (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.