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Proposed Rule on Medicaid Managed Care: A Summary of Major Provisions

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Executive Summary

On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rulemaking (NPRM) to modernize federal Medicaid managed care regulations. Since the rules were last updated, in 2002, states have significantly expanded their managed care programs to include beneficiaries with more complex needs; larger geographic areas; additional services; and millions of adults newly eligible for Medicaid under the Affordable Care Act. Today, over half of all Medicaid beneficiaries are enrolled in comprehensive risk-based health plans and many also receive some services, such as behavioral health care, through limited-benefit risk-based plans. In addition, millions of beneficiaries are enrolled in managed fee-for-service arrangements.

CMS has articulated several principles and goals that underlie the NPRM. In particular, the proposed rule aims to: strengthen beneficiary protections; better align Medicaid managed care rules with standards for other coverage programs; increase fiscal integrity in rate-setting; address delivery and payment system reform in the context of managed care; improve the quality of care across Medicaid delivery systems; increase health plan and state accountability; and strengthen state and federal oversight of Medicaid managed care programs.

This issue brief summarizes major provisions of the NPRM. In it, we review proposed changes in the following key areas, among others:

- Beneficiary support and information;
- Enrollment and disenrollment;
- Provider network adequacy and access to care;
- Managed long-term services and supports;
- Appeals;
- Capitation rate-setting;
- Quality of care;
- State monitoring; and
- Program integrity

The proposed rule will affect a variety of stakeholders, including states, health plans, providers, and beneficiaries. The public comment period closes on July 27, 2015, and the provisions of the final rule may be revised in light of stakeholder input.

Introduction

On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rulemaking (NPRM) to modernize federal Medicaid managed care regulations.¹ The Medicaid managed care regulations were last updated in 2002. Since then, the role of managed care in Medicaid has grown significantly in both size and scope. States have come to rely increasingly on managed care programs, expanding them to include beneficiaries with more complex needs; larger geographic areas; additional services, especially behavioral health care and long-term services and supports (LTSS); and, in states that have adopted the Affordable Care Act's (ACA) Medicaid expansion, millions of newly eligible adults. Today, over half of all Medicaid beneficiaries are enrolled in comprehensive capitated managed care organizations (MCO), the dominant form of managed care in Medicaid, and millions of beneficiaries also receive at least some Medicaid services, such as behavioral health or dental care, through capitated limited-benefit plans, known in Medicaid terminology as prepaid inpatient health plans (PIHP) and prepaid ambulatory health plans (PAHP). Millions of beneficiaries are also enrolled in primary care case management (PCCM) programs, which range from basic managed fee-for-service (FFS) arrangements to more enhanced systems that perform some of the same administrative and other functions as MCOs.

In the NPRM preamble, CMS identified a number of principles and goals that guided its development of the new rule. In particular, the proposed changes are designed to: address important service delivery and payment reforms as they relate to Medicaid managed care; strengthen beneficiary protections; better align Medicaid managed care rules with standards for Medicare Advantage (MA) plans and qualified health plans (QHP) offered through the new ACA Marketplaces to ease beneficiary transitions between coverage programs and simplify state and health plan administration; measure and improve the quality of care in managed care and across Medicaid delivery systems; increase transparency and accountability at the health plan level and the state level; and strengthen state and federal oversight of Medicaid managed care programs.

This issue brief summarizes major provisions of the NPRM that would change the current regulatory framework for Medicaid managed care programs. It is neither an exhaustive review of the proposed changes, nor an assessment of policies outlined in the rule. Rather, it is designed to serve as an informational guide to key proposed new federal expectations and requirements of states and managed care arrangements, and federal oversight interests moving forward. The 60-day period for public comment on the NPRM, which will help shape CMS' development of a final rule, closes July 27, 2015. Major provisions of the proposed rule are discussed below.

Wider application of Medicaid managed care rules

Extension to additional Medicaid managed care entities. The NPRM would apply many new and existing Medicaid managed care standards to PAHPs as well as PIHPs and MCOs. It would also apply certain of these standards to newly defined "PCCM entities," which, as distinct from individual FFS providers of basic PCCM services, provide a more robust set of administrative functions similar to a managed care plan, such as intensive case management, provider contracting or oversight, enrollee outreach and education, and/or performance measurement and quality improvement. Under the proposed rule, states would have to obtain CMS approval of all contracts with PCCM entities, monitor and evaluate their networks and performance, and include them in their quality strategies.

Extension to CHIP managed care plans. The proposed rule would incorporate and extend to CHIP benefits delivered through managed care many of the definitions, standards, and requirements that apply to Medicaid managed care. Medicaid managed care provisions in the following areas, among others, would carry over to CHIP: access to care and network adequacy; enrollee information requirements; enrollment and disenrollment; continuity of care; marketing activities; quality measurement and improvement; external quality review; and grievances and appeals. The minimum 85% MLR standard, discussed later, would also apply to CHIP managed care plans. The proposed rule also includes some CHIP-specific provisions, such as a requirement for state submission of CHIP MCO, PIHP, and PAHP contracts, including final contract rates, in accordance with standards specified by the HHS Secretary.

Beneficiary support and information

Beneficiary support system. The proposed rule would require states to establish a beneficiary support system to provide services to both potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity and current enrollees who are changing plans. The system would be required to provide assistance by phone, internet, and in person. The beneficiary support system would offer: 1) personalized choice counseling to assist beneficiaries with evaluating their health plan options and facilitate enrollment; 2) training for health plans and network providers on community-based resources and supports that can be linked with covered benefits; 3) assistance to beneficiaries in understanding managed care; and 4) assistance for enrollees who use or wish to use long-term service and supports (LTSS). The beneficiary support system also would provide outreach. Entities providing choice counseling would be subject to existing HHS independence and conflict of interest requirements. To the extent that states already provide the required resources and functions, they could draw upon and expand them to meet the requirements of the beneficiary support system.

With respect to enrollees who use or wish to use LTSS, the beneficiary support system must provide: an access point for complaints and concerns about health plan enrollment, access to services, and related matters; education on enrollees' grievance and appeal rights, the state fair hearing process, and beneficiary rights and responsibilities; assistance, upon request, in navigating the plan's grievance and appeal process and in appealing adverse benefit determinations made by a health plan to a state fair hearing; and review and oversight of LTSS program data to guide the state Medicaid agency in identifying and resolving systemic issues. Assistance with navigating the appeals process would not include representation of beneficiaries in appeals.

Standards for beneficiary information. Current regulations pertaining to the information that must be made available to beneficiaries would be replaced with a more structured and coherent set of standards that would apply to states and all managed care plans, including MCOs, PIHPs, PAHPs, PCCM entities, and, to a limited extent, PCCM arrangements. Particularly in light of the expansion of managed care to people with disabilities and complex needs, and recognizing the linguistic and cultural diversity of Medicaid beneficiaries, these more robust standards are designed to improve the content and format of information available to help beneficiaries understand how managed care works and the implications of participating in managed care, and evaluate and compare their managed care options. Current requirements that beneficiary information be easily understood and readily accessible would be strengthened in numerous ways, as follows:

- **Information for potential enrollees.** States would be required to provide specified information to potential enrollees, in either paper or electronic format, to help them understand the Medicaid managed care program and their options. The required information would include beneficiary disenrollment rights; basic information about managed care; populations excluded from enrollment; and each plan's service area, covered benefits, provider directory, cost-sharing requirements, network adequacy standards, responsibilities for care coordination, and, to the extent available, quality and performance indicators, including enrollee satisfaction.
- **Information for current enrollees.** Existing federal requirements regarding state and plan information for Medicaid beneficiaries already enrolled in managed care plans would continue to apply. In addition, plans would be required, within a reasonable time after an enrollee receives an enrollment notice from the state, to provide each enrollee with an enrollee handbook that compiles specified information already required under various provisions of existing regulations. Plans would also be required to provide enrollees with a provider directory and drug formulary information, as described further in the following section. States would be required to ensure, through their contracts, that all managed care plans provide all required information to enrollees. Each plan would also be required to have a mechanism to help enrollees and potential enrollees understand the plan's requirements and benefits.
- **Standardization of information.** To improve the consistency and usefulness of beneficiary information, states would be required to develop definitions of key managed care terms and model handbooks and member notices that all managed care plans would be required to use.
- **Accessibility of information.** States and plans would be required to make written beneficiary materials, including, at a minimum, provider directories, network adequacy standards, member handbooks, appeal and grievance notices and other notices critical to obtaining services, available in locally prevalent non-English languages and in alternative formats. In addition, plans would be required to provide interpretation services, as well as auxiliary aids and services for enrollees and potential enrollees with disabilities, upon request and free of charge, and to notify enrollees and potential enrollees about how to access these services. Taglines in large print and in locally prevalent non-English languages would be required on all written materials to explain the availability of interpretation and translation services and provide the toll-free choice counseling number. In addition, disability is added to the list of prohibited bases of discrimination by managed care plans.
- **Availability of electronic information.** States would be required to operate a Medicaid managed care website that, directly or by linking to individual plan websites, provides enrollee handbooks, provider directories, and network adequacy standards for each managed care plan. The NPRM specifies that required enrollee information may be provided electronically by the state or plans as long as it is compliant with all language, format, and disability accessibility standards, can be printed, and is available in paper form without charge upon request. These proposed new standards are similar to those applicable to the MA program and the commercial insurance market.

Provider directories and drug formulary information. In addition to currently required provider information, plans' provider directories would be required to include four new elements for each provider: 1) its group practice/site affiliation; 2) its website URL; 3) its cultural and linguistic capabilities, including languages spoken by the provider or by a skilled medical interpreter at the provider's office; and 4) whether the provider's offices, exam rooms, and equipment are accessible for individuals with disabilities. Provider directories would be required to include information on pharmacies, behavioral health care providers, and LTSS providers furnishing services under the contract, as well as primary care physicians, specialists, and hospitals as required under current rules. Paper provider directories would have to be updated at least monthly and electronic directories no later than three business days after the managed care plan receives updated provider information. In addition, each plan would be required to post its directory on its website in a machine readable file and format as specified by the HHS Secretary.

Managed care plans would also be required to make information on their drug formularies available electronically or in paper form, including which medications are covered (both generic and name brand) and which tier each medication is on. They would also be required to make their formulary drug lists available on their websites in a machine readable file and format as specified by the HHS Secretary.

Marketing. The proposed rule would revise, and extend to PCCM entities, current marketing restrictions on MCOs, PIHP, PAHPs, and PCCMs, by amending the definition of "marketing" to exclude communications from a Marketplace QHP to Medicaid beneficiaries, even if the QHP issuer is also the entity providing Medicaid managed care services. This change is intended to improve coordination of coverage and care for individuals who may experience periodic transitions between Medicaid and QHP eligibility due to fluctuations in income, and families whose members are divided between Medicaid and QHP coverage. The NPRM also includes minimum marketing standards that state contracts with plans would be required to include.

Enrollment and disenrollment

The proposed rule adds a new section requiring that states have an enrollment system for both voluntary and mandatory Medicaid managed care programs. The enrollment system must meet a number of requirements, as follows:

Enrollment

- **Choice period.** States would be required to provide a minimum 14-calendar-day "choice period" during which beneficiaries can obtain services on a FFS basis while they evaluate their plan options and make a choice. (CMS specifically seeks comment on the length of the choice period.) States would be required to send beneficiaries informational notices about the choice period at least three days before it begins. Enrollment in a plan would be effective at the end of the choice period or when the enrollee notifies the state of his or her choice, whichever comes first.
- **Voluntary managed care programs.** In voluntary managed care programs in which the state uses passive enrollment (i.e., selects a plan for each potential enrollee), the enrollment notice must explain the implications of not making an active choice between managed care and FFS and declining enrollment in the plan selected by the state. In voluntary programs with passive enrollment, beneficiaries would be able, during the choice period, to accept the plan selected for them, decline it and select a different plan, or decide to remain in FFS. States would be required to send individuals who are

passively enrolled confirmation of their enrollment into a plan within five calendar days of processing the enrollment, and that notice must clearly explain the enrollee's right to disenroll within 90 days from the effective date of his or her enrollment.

- **Mandatory managed care programs.** In mandatory programs with passive enrollment, the enrollment notice must explain the process for choosing and enrolling in a plan and enrollees' right to disenroll from their assigned plan and select an alternative plan within 90 days from the effective date of their enrollment.
- **Auto-assignment.** Passive enrollment processes in voluntary systems, and default enrollment processes that operate in mandatory systems when potential enrollees do not select a plan, would be required to preserve existing provider-beneficiary relationships with providers that have traditionally served Medicaid beneficiaries, or, if that is not possible, equitably distribute individuals among participating plans. States would be also be permitted to consider additional criteria, including the enrollment preferences of family members, previous plan assignment, accessibility of provider offices for people with disabilities, and other reasonable criteria in automatically assigning enrollees to plans.

Disenrollment

- Under the NPRM, enrollees would have good cause to disenroll from their managed care plan if their residential, institutional, or employment supports LTSS provider leaves the managed care plan's network.
- The proposed rule would clarify that states have the flexibility to accept beneficiaries' disenrollment requests orally and/or in writing. It would also clarify that disenrollment requests that are denied by a plan must be referred to the state for review. The proposed rule also provides that an enrollee may disenroll from a health plan without cause only once within 90 days following the date of the beneficiary's initial enrollment; the enrollee would not receive additional opportunities to change plans within the 90-day disenrollment period.

Network adequacy and access to care

Time and distance standards. The proposed rule would require states that contract with MCOs, PIHPs, or PAHPs to establish and enforce network adequacy standards that, at a minimum, include time and distance standards, to be specified by each state, for certain types of providers: primary care (separate adult and pediatric), OB/GYN, behavioral health, specialists (separate adult and pediatric), hospitals, pharmacies, and pediatric dental, as well as additional provider types when it promotes the objectives of the Medicaid program. In addition, states that contract with plans that cover LTSS would be required to develop time and distance standards for LTSS providers when the enrollee must travel to the provider and network adequacy standards other than time and distance standards for LTSS providers that travel to the enrollee to deliver services. States would be permitted to vary their time and distance standards by geographic area. States would have authority to grant exceptions to the provider-specific network standards under limited circumstances. In such cases, states would be required to monitor enrollee access to the relevant provider type and include their findings in their annual program report to CMS, discussed later in this brief.

In setting network adequacy standards, states would be required to consider anticipated Medicaid enrollment and utilization, the characteristics and health needs of different populations, the supply of providers and their Medicaid participation status, providers' ability to communicate with limited-English-proficient enrollees in their native language, and providers' ability to ensure physical access and accessible equipment for people with physical or mental disabilities, reasonable accommodations, and culturally competent communication. In setting network adequacy standards for LTSS providers, states would also be required to consider elements that would support an enrollee's choice of provider, strategies that would support enrollees' community integration, and other factors that promote the interests of enrollees who need LTSS.

Plan and state assurances of plan capacity and access. Plans would be required to submit annual documentation to the state that they have the capacity to serve the expected enrollee population (in addition to providing this documentation at the time they enter into a state contract or when there is a change in their operations that would affect the adequacy of their capacity, as required now). A change in a plan's services, geographic service area, or the composition of or payments to its network would also trigger this documentation requirement. The rule would add a requirement that, after states review the documentation provided by plans, they submit an assurance to CMS that the plans meet the state's requirements for availability of services, including documentation of an analysis that supports the state's certification of the adequacy of each contracted plan's provider network. States must also ensure that each plan contract requires the plan to meet state standards for timely access to care, participate in the state's efforts to promote linguistically and culturally competent care, and provide physical access, accommodations, and accessible equipment for enrollees with disabilities.

Criteria for "medical necessity" definitions. Under the proposed rule, state contracts with MCOs, PIHPs, and PAHPs must use criteria for defining "medical necessity" that comply with federal EPSDT law. The EPSDT medical necessity standard requires the provision of all services for beneficiaries up to age 21 necessary to identify physical and mental health problems, and treatment to correct or ameliorate those conditions, regardless of whether those services are covered under the state Medicaid plan benefit package for adults. The medical necessity definition specified in state contracts with plans would also be required to address the extent to which the plan is responsible for covering services that address the opportunity for enrollees receiving LTSS to have access to the benefits of community living.

Authorization of services and utilization management. States would be required to ensure, through their contracts with MCOs, PIHPs, and PAHPs, that each plan's utilization management strategies are applied so that services are authorized in a manner that is appropriate for and does not disadvantage individuals who have ongoing or chronic conditions or ongoing needs for LTSS. In addition, utilization controls must not interfere with enrollees' freedom to choose their method of family planning. The proposed rule would also add a contract standard to require that plans authorize LTSS based on the enrollee's current needs assessment and, in the case of states that require health plans to establish a person-centered service plan for each enrollee, consistent with his or her person-centered service plan. It would also include a corresponding requirement that decisions to deny authorization for a service or authorize a scope of services less than requested be made by health care professionals who have appropriate expertise in addressing the enrollee's medical, behavioral health, or LTSS needs. The rule would also change the required timeframe in which plans must make expedited

authorization decisions from three working days, as current regulations provide, to 72 hours after receipt of the request for the service; this change would align the Medicaid standard with MA and commercial standards.

Care coordination. The proposed rule would, effectively, broaden current care coordination requirements to ensure that MCO, PIHP, and PAHP enrollees have access to ongoing sources of all care appropriate to their needs, including not only primary care but also behavioral health services and LTSS. Federal standards for care coordination would also be expanded to encompass coordination between settings and with services provided outside the plan by a different plan or through FFS. MCOs, PIHPs, and PAHPs would be required to make their best effort to conduct a health risk assessment within 90 days of enrollment for all new enrollees.

Continued services during transitions. States would be required to have a continuity of care policy to ensure continued access to services during beneficiary transitions from FFS to a managed care plan (including PCCM and PCCM entities) or from one plan to another when, absent continued services, an enrollee would suffer serious health consequences or a risk of hospitalization or institutionalization. The continuity of care policy must, among other requirements, ensure access to services consistent with the access that enrollees previously had and permit enrollees to retain their current provider for a period of time (to be specified by the state) if that provider is not in the managed care plan's network. State contracts would have to require that MCOs, PIHPs, and PAHPs implement continuity of care policies that meet these standards. States would also be required to make their continuity of care policy publicly available and instruct enrollees and potential enrollees about how to access continued services during a transition.

Prescription drug coverage. The proposed rule would clarify that MCOs, PIHPs, and PAHPs whose contracts include covered outpatient prescription drugs are required to meet federal Medicaid FFS standards regarding the availability and prior authorization of these drugs as if these standards applied directly to the health plans.

Capitation payments for enrollees with short stays in IMDs. The proposed rule would permit states to make a monthly capitation payment (and receive federal matching funds) to an MCO or PIHP for an enrollee age 21-64 who is a patient in an institution for mental disease (IMD), if the facility is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or sub-acute facility providing psychiatric or SUD crisis residential services, and the stay in the IMD is for no more than 15 days in that month. This proposed policy departs from current rules, which prohibit capitation payments on behalf of adult Medicaid enrollees who are patients in an IMD. CMS' stated purpose in proposing this change is to improve access to short-term inpatient psychiatric and SUD treatment for Medicaid managed care enrollees when cost-effective and medically appropriate, and to improve the coordination and management of psychiatric and SUD treatment for managed care enrollees who need such care.

Managed long-term services and supports (MLTSS)

For the first time, CMS proposes standards specific to the provision of MLTSS, acknowledging the significant expansion of this delivery system model since the Medicaid managed care regulations were last revised. CMS proposes a definition of LTSS and throughout the NPRM, includes references to LTSS in existing regulations that currently apply to the provision of medical services by health plans, discussed in the other sections of this brief. In addition, CMS also proposes some new requirements particular to MLTSS, detailed below. Many of

the provisions in the NPRM seek to codify the best practices in MLTSS programs identified by CMS in guidance issued in 2013.²

Identification and assessment of enrollees with LTSS needs. States would be required to have mechanisms to identify enrollees with LTSS needs, and MCOs, PIHPs, and PAHPs would be required to implement comprehensive assessments by appropriate health professionals to identify ongoing special conditions of these enrollees that require a course of treatment or regular care monitoring.

Person-centered process. The proposal would require that, when an MCO, PIHP, or PAHP authorizes LTSS for an enrollee, it take into account the enrollee's current needs assessment and person-centered service plan.

Services to be provided in home and community-based settings. CMS proposes that plan contracts that include MLTSS comply with the recent home and community-based services settings rules.³

Provider credentialing. CMS proposes that the state's provider credentialing process must address behavioral health and LTSS providers.

Stakeholder engagement. New rules would require states to create and maintain a stakeholder group to solicit the opinions of beneficiaries, providers, and other stakeholders in the design, implementation, and oversight of a state's MLTSS program, consistent with CMS' 2013 guidance. In addition, plans providing MLTSS would be required to have a member advisory committee, which must include at least a reasonably representative sample of the populations receiving LTSS covered by the plan.

Appeals

The proposed rule includes provisions intended to better align the Medicaid managed care appeals process with the processes required for Marketplace and MA plans.

Timeframes for requesting and resolving appeals. The NPRM would change the timeframes for several components of the appeals process, as summarized below in Table 1.

Internal plan appeal process and access to state fair hearing. The NPRM would allow plans to offer only one level of internal plan appeals for enrollees. Once an enrollee exhausts this single level of internal appeal, the enrollee would be able to request a state fair hearing. CMS also proposes to remove the existing regulation that allows states to determine whether enrollees can bypass the internal plan appeal process and instead proceed directly to a state fair hearing; under the proposed rule, all enrollees would have to exhaust the internal plan appeal process.

Table 1: Proposed Changes to Timeframes for Service Authorization and Appeals Processes

Process	Current Rule	Proposed Rule
Beneficiary request for an internal plan appeal	State selects a period between 20 and 90 days from notice of adverse benefit determination	60 calendar days from receipt of the notice of adverse benefit determination
Standard timeframe for decision on an internal plan appeal	45 days from receipt of appeal	30 calendar days from receipt of appeal
Notice of expedited resolution of an appeal by health plan	3 working days from plan receipt of appeal	72 hours from plan receipt of appeal
Beneficiary request for a state fair hearing	State selects a period between 20 and 90 days from notice of adverse benefit determination; state option about whether beneficiaries can bypass internal plan appeal and go directly to fair hearing	120 calendar days from the date of the notice of internal plan appeal resolution; beneficiaries must exhaust internal plan appeal before accessing fair hearing
Implementation of state fair hearing decision by health plan when an adverse benefit determination is overturned on appeal	3 working days from receipt of notice of state fair hearing decision	72 hours from receipt of notice of state fair hearing decision

Continuation of benefits during appeals. In the preamble to the NPRM, CMS indicates that it seeks to modify existing regulations to enable beneficiaries to continue to receive services while an appeal of a plan’s decision to terminate existing services is pending, regardless of whether the original service authorization period has expired. However, the language in the proposed regulation does not exactly track CMS’ stated intention in the preamble and may not extend to all circumstances in which beneficiaries seek continued services while appeals are pending if an authorized period for the services at issue has expired.

If an enrollee loses an appeal and had received continued services during the appeal, the plan can recoup the cost of the continued services, but the proposed rule specifies that a plan can do so only to the extent that the state does so in FFS.

Beneficiary access to documents and records. The proposed rule clarifies that beneficiaries must have timely access, free of charge, to documents, records, and other information relevant to their claims for benefits, including medical necessity criteria and any processes, strategies, or evidentiary standards used by the plan in setting coverage limits.

Information considered during appeals. The proposed rule clarifies that plans must consider all information submitted by beneficiaries in appeals, regardless of whether the information was considered in the plan’s initial decision.

Recordkeeping. The proposed rule sets minimum standards for the types of information that states, through their contracts, must require plans to include in their appeals records. The rule also clarifies that states must review these records as part of their ongoing monitoring and oversight procedures.

Capitation rate–setting

The proposed rule seeks to strengthen federal requirements pertaining to the development of capitation rates for MCOs, PIHPs, and PAHPs to better assure fiscal integrity, increase transparency in the rate-setting process, ensure beneficiary access to care, increase state accountability, and support federal oversight.

Actuarial soundness standards. The proposed rule establishes new standards for the development of actuarially sound capitation rates, which states must meet and CMS would apply in its review and approval of rates. Capitation payment amounts must be adequate to enable plans to efficiently deliver covered services to enrollees in a manner that complies with all contractual requirements (e.g., requirements to assure availability of and timely access to services, adequate networks, and coordination and continuity of care).

Minimum medical loss ratio (MLR). A MLR is the ratio of a health plan’s incurred claims and expenditures for health care quality improvement activities to the plan’s adjusted premium revenue. Under the proposed rule, states would be required to use the MLRs of their contracted MCOs, PIHPs, and PAHPs in the development of actuarially sound capitation rates and would be required to set capitation rates such that the health plans can reasonably achieve a minimum MLR of at least 85% in the rate year. The MLR provisions would apply to states for contracts starting on or after January 1, 2017. The minimum MLR of 85% is consistent with the standard that applies in the MA and private health insurance markets under the ACA. However, while MA and Marketplace plans that do not meet the minimum MLR must remit payments to CMS and make rebates to consumers, respectively, the proposed rule does not require Medicaid managed care plans whose actual experience does not meet the MLR standard to remit payment to the state. If a state does elect to mandate a minimum MLR (i.e., require remittances) for its Medicaid managed care plans, the minimum must be at least 85%.

Consistent with the proposed requirement for states to consider MLRs in the rate-setting process, the proposed rule would require contracted MCOs, PIHPs, and PAHPs to calculate and report their MLR to the state annually. The proposed rule sets forth standards regarding how the MLR for Medicaid managed care plans must be calculated, and it specifies the information that health plans must include in the required MLR report that they must submit to the state. Health plans would be required to attest to the accuracy of the calculation of their MLR in accordance with the federal specifications.

Specificity of capitation rates. The rule would require that capitation rates be specific to each rate cell under the contract (i.e., the payment rate under one rate cell must not subsidize the payment rate under any other). Also, states would have to certify a specific rate, rather than a rate range, for each rate cell.

Certification and documentation requirements. States would have to certify each individual rate paid under each contract as actuarially sound and document in their rate certification submissions to CMS the data, assumptions, and methodologies underlying the rates in sufficient detail to permit CMS to understand and assess them. The NPRM specifically defines the documentation that states would be required to include in the

rate certifications they submit for CMS review and approval concurrent with their submission of contracts for CMS review and approval.

Delivery system and provider payment incentives. The proposed rule would codify longstanding CMS policy on the (limited) extent to which states may direct health plan spending under a risk contract. At the same time, it would explicitly establish that states may require plans to implement value-based purchasing models for provider payment, participate in multi-payer delivery system reform or quality improvement initiatives, adopt a minimum fee schedule for providers, or raise provider payment rates.

The proposed rule would also modify and build on current rules and standards regarding special contract provisions related to payment to MCOs, PIHPs, and PAHPs, specifically, risk-sharing mechanisms, incentive arrangements, and withhold arrangements. Under the proposed standards, incentive arrangements would have to be necessary to support initiatives tied to performance and quality improvement. Contracts that provide for withhold arrangements would be required to ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound.

Quality of care

CMS proposes a number of changes in and additions to existing requirements to strengthen quality measurement and improvement efforts in Medicaid managed care. The proposed rule articulates three principles that underlie these changes: increased transparency of plan quality to Medicaid beneficiaries; alignment of quality standards for Medicaid managed care with MA and Marketplace standards where appropriate, to create a more integrated approach across programs and states; and consumer and stakeholder engagement in developing state strategies for measuring and improving quality in Medicaid managed care programs, including those delivering LTSS (discussed above).

State comprehensive quality strategy. The NPRM would establish a new requirement that each state draft and implement a written comprehensive quality strategy for assessing and improving the quality of care and services provided to all Medicaid beneficiaries across all delivery systems, including FFS as well as managed care. The comprehensive quality strategy would be required to include the state's goals and objectives for continuous and measurable quality improvements, and the metrics and targets to be used in assessing performance and improvement. It must also identify the measures and outcomes that the state will publish at least annually on its Medicaid website. States would also be required to make their comprehensive quality strategy available on their Medicaid website.

States contracting with MCOs, PIHPs, or PAHPs would be required to incorporate specified managed care elements into their comprehensive quality strategy, including the state's network adequacy and availability of care standards, quality metrics and performance improvement targets, arrangements for annual external reviews of quality and access under each contract, and other elements. The rule would require that states review and update their comprehensive quality strategy at least every three years and publish the results of their reviews on their Medicaid website.

State review and approval of plans. The proposed rule would establish a new requirement that, to enter into a contract with a state, MCOs, PIHPs, and PAHPs must be reviewed and approved by the state on the basis

of performance, using standards at least as stringent as those used by a private accreditation entity recognized by CMS to accredit MA and Marketplace plans. Plans would also have to be reviewed and reapproved at least once every three years. States would have the option to deem compliance of plans with the required standards based on accreditation by a private independent entity.

Quality assessment and performance improvement (QAPI) programs. CMS would expand the scope of the requirements for QAPI programs that currently apply to state contracts with MCOs and PIHPs, and would extend them to apply to PAHPs as well. Through a public notice and comment process, CMS would specify a core set of standardized performance metrics and topics for performance improvement projects to be included along with state-selected standard measures and topics included in state contracts with plans.

In addition, states would need to ensure through contracts that plans have mechanisms to address the quality and appropriateness of care provided to enrollees needing LTSS. These mechanisms would have to address how the needs of these individuals are met when transitioning between care settings and compare the services these individuals receive with those recommended in their treatment plan. Additionally, in their contracts with plans that provide LTSS, states would be required to include performance measures that assess beneficiaries' quality of life and the outcomes of rebalancing and community integration for beneficiaries receiving LTSS.

Medicaid managed care quality rating system. Each state contracting with MCO, PIHP, or PAHPs would be required to establish a quality rating system for such plans. The rating system would address plan quality in three domains: clinical quality management; member experience; and plan efficiency, affordability, and management. States' systems would be required to use the standardized performance measures specified by CMS, as described above, as well as any additional measures specified by the state. Under the rule, CMS would establish a methodology for calculating quality ratings and states would be required to collect performance data from contracted plans to support the rating system; with CMS approval, states could opt to implement an alternative quality rating system that uses different domains or measures or applies a different methodology. States would be permitted to use the MA five-star rating system for plans that serve dually eligible beneficiaries exclusively. States would be required to prominently display each plan's quality rating on its Medicaid managed care website.

External quality review (EQR). The rule would expand the mandatory activities of EQR entities to include validation of MCO, PIHP, and PAHP network adequacy during the previous 12-month period. The rule would preclude an accrediting body from serving as an External Quality Review Organization (EQRO) for a plan that it has accredited within the previous three years, to be consistent with another proposed provision that would allow an EQRO to use the results of an accreditation review to perform the final EQR analysis. It would also require states to submit EQRO contracts to CMS before claiming the 75% federal match for EQR-related activities related to MCOs, and establish that the federal match for such activities related to PIHPs and PAHPs is 50%.

State monitoring standards

State monitoring system. States would be required to have a state monitoring system, including oversight responsibilities, for all its managed care programs. The proposed rule specifies that this monitoring system would have to address the performance of the state's managed care program in virtually every aspect of its

operations and management. The rule would require further that states use data collected from their monitoring activities to improve the performance of their managed care programs, and it specifies minimum requirements regarding the data states must collect.

Readiness reviews. States would be required to conduct readiness reviews of MCOs, PIHPs, PAHPs, and PCCM entities before they implement a managed care program; when a specific plan has not previously contracted with the state; and when any currently contracted plan adds new eligibility groups, benefits, or geographic areas to its scope. Readiness reviews must include both desk reviews and onsite reviews for each plan, and must be submitted to CMS for the agency’s review and approval of all MCO, PIHP, PAHP, and PCCM entity contracts.

Annual program report to CMS. States would be required to submit a report to CMS on each managed care program they operate, after each contract year. The report would have to provide information on and an assessment of the operation of the managed care program, including at a minimum: the financial performance of each risk-based plan; grievances, appeals, and state fair hearings for the program; availability and accessibility of covered services; evaluation of performance on quality measures; and other specified elements. States would be required to post the annual program report on their Medicaid managed care website, and provide it to the Medical Care Advisory Group and, if applicable, the LTSS stakeholder consultation group.

Program integrity

The proposed rule would strengthen and add to program integrity requirements for states and managed care plans. Program integrity and compliance plan requirements would be extended to PAHPs and plan subcontractors. Plans would be required, through state contracts, to submit specified data to the state, including encounter data; data related to capitation rates, assessments of compliance with the minimum MLR, and insolvency protections; and other data. All data, documentation, and information provided by plans would have to be certified by the plans’ CEO or CFO. Plans’ procedures to detect and prevent fraud, waste, and abuse would be required to include a compliance program that meets specified standards and, among other requirements, provides for mandatory reporting to the state of potential fraud or improper payments and changes that may affect an enrollee’s eligibility or a provider’s eligibility to participate (e.g., termination of the provider agreement).

States would be required to monitor plan compliance with the data, information, and documentation requirements and plan certification of all such matters, as well as plan compliance with required program integrity activities, and to make plan program integrity information, as described above, publically available on state’s Medicaid managed care website. States would also be required to screen and enroll all network providers of Medicaid managed care plans and to conduct monthly federal database checks for excluded managed care plans and subcontractors.

Encounter data. The NPRM would define enrollee encounter data and add enrollee encounter data standards that would have to be incorporated in all MCO, PIHP, and PAHP contracts. Contracts would be required to specify that enrollee encounter data include information about the provider rendering services, be submitted in compliance with CMS specifications regarding accuracy and completeness, and be submitted to the state in a format consistent with the industry standard. The rule would also add a new section to implement the

requirement that states report encounter data to CMS. CMS intends to issue future guidance about the required specificity of encounter data that plans must report.

The proposed rule would also clarify that federal matching payments would not be available for states that do not meet data submission benchmarks for accuracy, completeness, and timeliness. Under the NPRM, CMS could issue partial deferrals or disallowances of federal matching payments for failure to report enrollee encounter data, on a per-enrollee basis and based on the type of service for which the reported encounter data do not meet the requirements. Within 90 days of the effective date of the final regulation, states would be required to submit to CMS a detailed plan of their procedures for ensuring that complete and accurate enrollee encounter data are being submitted on a timely basis.

Partial deferrals and disallowances. Under a proposed new section, CMS state Medicaid agencies could defer or disallow federal matching payments for spending under a managed care contract when it does not comply with applicable statute and rules, including standards for actuarial soundness of payment rates. CMS has previously interpreted the federal Medicaid managed care statute to mean that, if a state fails to comply with any of required conditions, there could be no federal matching at all for payments under the contract, even for amounts associated with services for which there was full compliance with all requirements. CMS proposes, in the new section, to interpret the law to condition federal matching payments on a service-by-service basis, so that, for example, if a violation involved the payment amount associated with inpatient hospital costs and that was the only portion of the payment amount that was not actuarially sound, then only federal matching payments for that portion of the payment would be deferred or disallowed.

Looking ahead

The Medicaid managed care NPRM represents an effort by CMS to update the federal regulatory framework for the structure, operation, accountability, quality, and oversight of Medicaid managed care programs. The 60-day public comment period for the NPRM closes on July 27, 2015. In light of the scope of the proposed rule, CMS' solicitation of public input on numerous issues, and the diverse stakeholder interests in Medicaid managed care, the volume of comments on the NPRM is likely to be great. Based on CMS' consideration of the public comments, the final rule that is issued could reflect some rethinking or refinement of the policies set forth in the proposed rule to govern this large and growing sector of the Medicaid program.

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Endnotes

¹ 80 *Fed. Reg.* 31098-31297 (June 1, 2015), available at <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>.

² Centers for Medicare and Medicaid Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (May 2013), available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>; see also Kaiser Commission on Medicaid and the Uninsured, *Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers* (Nov. 2014), available at <http://kff.org/medicaid/issue-brief/key-themes-in-capitated-medicare-managed-long-term-services-and-supports-waivers/>.

³ 79 *Fed. Reg.* 2948-3039 (Jan. 16, 2014), available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>.