Medicaid and CHIP Managed Care Notice of Proposed Rulemaking (CMS-2390-P)

Overview of NPRM

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Background

This NPRM is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002

- Today, the predominant form of Medicaid is managed care using capitated, risk-based arrangements
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2011, 39 million (58%) of Medicaid beneficiaries received Medicaid through capitation managed care plans

Principles for Change

This NPRM supports the agency's mission of better care, smarter spending, and healthier people

Key NPRM Principles

- Alignment with Other Insurers
- Delivery System Reform
- Payment and Accountability Improvements
- Beneficiary Protections
- Modernizing Regulatory Requirements and Improving the Quality of Care

Principle:
Alignment with Other Insurers

- Aligning Medicaid and CHIP managed care requirements with the Marketplace or Medicare Advantage (MA) requirements to:
  - Smooth beneficiary coverage transitions
  - Ease administrative burdens of managed care plans that participate across publicly-funded programs and the commercial market
- Examples
  - Medical Loss Ratio (MLR)
  - Appeals and Grievances
  - Marketing

Alignment: Medical Loss Ratio Proposals

- Managed care plans would be required to calculate and report their MLR experience for each contract year
- Actuarially sound rates would be set to achieve a MLR of at least 85%
- States would have the flexibility to set a standard higher than 85% and/or impose a remittance requirement
- Expenditures for program integrity activities (subject to a cap) would be included in the numerator for the MLR calculation

Alignment: Appeals and Grievances Proposals

- Definitions and timeframes for resolution of appeals would be more consistent with the commercial market and the Medicare Advantage (MA) program
- Managed care plans would perform one level of internal appeal. For any additional appeal, the enrollee would proceed to a State Fair Hearing
- Would extend requirements to Pre-paid Ambulatory Health Plans (PAHPs)

Alignment: Marketing Proposals

- Propose to revise definitions for terms related to marketing so that Marketplace qualified health plans may communicate with Medicaid enrollees without implicating the Medicaid marketing rules
- Proposal is consistent with the FAQs on Medicaid marketing rules that were released in January

Principle: *Delivery System Reform*

To support state and federal delivery system reforms, the NPRM:

- Strengthens existing quality improvement approaches; and
- Provides flexibility for States to adopt payment reform goals or value-based purchasing models for provider reimbursement

Examples

- Value-Based Purchasing (VBP)
- Withhold Arrangements
- Capitation Payments for Enrollees with a Short-Term Stay in an Institution for Mental Disease

Delivery System Reform: Payment Reform Proposals

- Would permit States to set minimum fee schedules or direct managed care plans to operate provider incentive programs tied to outcomes
- Acknowledges that States may require managed care plans to engage in VBP initiatives
- Would establish requirements for withhold arrangements to incentivize managed care plan performance for States that choose to include such arrangements

Delivery System Reform: IMD Change Proposal

NPRM would permit the State to make a monthly capitation payment to the managed care plan for an enrollee that has a short term stay in an IMD

- The facility must be an inpatient hospital facility or a sub-acute facility providing short term crisis residential services
- A short term stay is one lasting no more than 15 days

Principle: *Payment and Accountability Improvements*

The NPRM retains State flexibility to meet State goals and reflect local market characteristics while:

- Ensuring rigor and transparency in the rate setting process
- Clarifying and enhancing State and health plan expectations for program integrity

Examples

- Better defining Actuarial Soundness
- Transparency in the Rate Setting Process and Approval
- Refined Deferral and/or Disallowance of FFP for Non-Compliance
- Program Integrity
- Encounter Data

Payment and Accountability: Actuarially Sound Capitation Rates

- Proposes standards for the documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification
- Would require certification of specific rates rather than a rate range
- Proposes that actuarially sound rates may not have provider reimbursement requirements that differ based on the FMAP attributable to covered populations
- Would permit certain mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval

Payment and Accountability: Program Integrity Proposals

- Would require managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse
- Network providers would be screened and enrolled as done in FFS
  - Approach would not require network providers to participate in the FFS program
- Would require managed care plans to retain recoveries of overpayments when the plan makes the recovery
  - Such recoveries would be taken into account in rate setting

Payment and Accountability: Encounter Data Proposals

- Pursuant to the ACA, States would only be eligible to claim federal matching payments for timely, accurate and complete encounter data
- Through managed care contracts, States would require that managed care plans:
  - Collect and submit encounter data sufficient to identify the provider rendering the service
  - Submit all encounter data necessary for the State to meet its reporting obligation to CMS
  - Submit encounter data in appropriate industry standard formats (i.e., ASC X12N 837, ASC X12N 835, NCPDP)

Payment and Accountability: Deferral or Disallowance of FFP

- Would permit partial deferrals and/or disallowances for non-compliant contracts or rate certifications
- Would permit partial deferrals/disallowance for non-compliance with the regulations
- Would permit partial deferrals/disallowance for incomplete, inaccurate, untimely encounter data

Principle: *Beneficiary Protections*

Ensuring beneficiary protections that promote the delivery of quality care

Examples

- Enrollment Process
- Beneficiary Support System, Including Choice Counseling
- Managed Long-Term Services and Supports (MLTSS)
- Care Coordination and Continuity of Care

Beneficiary Protections: Enrollment Process Proposals

- NPRM adds a new section on enrollment.
- Proposed requirements for mandatory and voluntary programs:
  - States would need to provide at least 14 calendar days of fee-for-service coverage to allow enrollees time to select a plan
  - States would send informational notices to beneficiaries at least three days before the 14-day choice period
  - Enrollment cannot be effective until the sooner of the end of the 14-day period, or the enrollee notifies the state of his/her choice

Beneficiary Protections: Beneficiary Support System Proposals

- Would require the State to offer personalized assistance before/after enrollment to:
  - Help beneficiaries understand materials and information provided by managed care plans and the State
  - Answer questions about available options
  - Facilitate enrollment
- Assistance to be available via phone, internet or in-person and include:
  - Choice Counseling
  - Training for network providers on community-based resources and supports
  - Assistance for enrollees in understanding managed care and assistance for enrollees who use or receive LTSS

Managed Long Term Services & Supports Proposals

- NPRM would implement the requirements for Managed Long Term Services & Supports (MLTSS) set forth in the May 2013 guidance
- The 10 elements incorporated into the NPRM reflect best practices identified in existing programs, ensure adequate beneficiary protections, and provide clear guidance for States

Care Coordination & Continuity of Care Proposals

- Proposed standards for transition plans when a beneficiary moves into a new MCO, PIHP, or PAHP, or from FFS into a managed care plan
- Would ensure there is more accurate and timely data gathering and sharing
- Would include enrollees with LTSS needs in the identification, assessment, and service planning processes in a person-centered manner

Principle: *Modernizing & Improving Quality of Care*

Recognizes advancements in State and managed care plan practices and federal oversight interests

Examples

- Network Adequacy
- Information Standards
- Quality of Care

Modernizing & Improving Quality: Network Adequacy Proposals

- States would develop and use time and distance standards for:
  - primary care - adult and pediatric;
  - specialty care - adult and pediatric;
  - OB/GYN; behavioral health;
  - hospital; pharmacy; and
  - pediatric dental
- States would develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- Managed care plans would certify the adequacy of the networks at least annually

Modernizing & Improving Quality: Information Standards Proposals

- States would need to operate a website that provides specific managed care information including each managed care plan's handbook and provider directory
- States would develop definitions for key terms and model handbook and notice templates for use by the managed care plans
- States and managed care plans may provide required information electronically if the information is available in paper form upon request

Modernizing & Improving Quality: Quality of Care Proposals

- Would establish a public notice/comment process to determine a core set of performance measures and performance improvement projects for managed care plans
- Would implement a state review/approval process for health plans based on performance vis-à-vis standards of a CMS-recognized private accreditation entity
- Would expand the Medicaid managed care quality strategy to all delivery systems (FFS and managed care)
- Would add a new external quality review activity to validate network adequacy
- Would extend the external quality review to PAHPs

Modernizing & Improving Quality: Quality Rating System Proposal

The NPRM proposed that the State establish a quality rating system (QRS) for managed care plans:

- State would report performance information on all health plans
- The QRS would align with existing rating systems like those of Medicare Advantage and the Marketplace
- The QRS would be developed using a robust public engagement process
- The standards for the Medicaid QRS would be refined over a period of three to five years

Questions