



Medicaid and CHIP Managed Care Notice of Proposed rulemaking (CMS-2390-F):

Overview of the NPRM

Centers for Medicaid & CHIP Services



CMS-2390-P

- Notice of Propose Rulemaking (NPRM)
- Federal Register display on May 25, 2015;
Federal Register publication on June 1, 2015
- Comments due no later than 5 p.m. on July 27, 2015. May be provided by:
 - Electronically at <http://www.regulations.gov>
 - Regular mail
 - Express or overnight mail
 - By hand or courier

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 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
- Request comment whether category for activities that improve health care quality accommodates care coordination and case management activities

Alignment:

Appeals and Grievances Proposals

- Definitions and timeframes for resolution of appeals would be more consistent with the commercial market and Medicare Advantage (MA)
 - 60 days for an enrollee to file an appeal
 - 30 days for managed care plans to resolve standard appeal
 - 72 hours to resolve an expedited appeal
- 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 and 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
 - 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)

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

The proposed rule would:

- Set standards for transition plans when a beneficiary moves into a new managed care plan
- Ensure that managed care plans coordinate services between settings of care and services received across delivery systems
- Set standards for managed care plans to make best effort to conduct health risk assessments within 90 days of enrollment
- Broaden ongoing source of care requirement beyond primary care

Principle: Modernizing & Improving Quality of Care

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

Examples

- Network Adequacy
- Information Standards
- Provisions for Indians, IHCPs, and IMCEs
- 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

Information Requirements

- Enrollee materials would include taglines in each prevalent non-English language explaining the availability of written materials in those languages and interpreter assistance if requested
- Managed care plans would be required to post provider directories online and in a machine readable format
 - Updating schedule: paper – monthly; electronic - 3 business days
- Managed care plans would be required to post drug formularies online and in a machine readable format

Provisions for Indians, Indian Providers, and Indian Managed Care Entities

The proposed rule would implement provisions in section 5006(d) of the American Reinvestment and Recovery Act (ARRA) of 2009 (section 1932(h) of the Social Security Act):

- Define Indian, Indian Health Care Provider (IHCP), Indian Managed Care Entity (IMCE) consist with statutory and existing regulatory definitions
- Permit Indian enrollees to choose an IHCP that participates in the managed care network as their primary care provider
- Permit Indian enrollees to obtain services from out-of network IHCPs

Provisions for Indians, Indian Providers, and Indian Managed Care Entities

- Specify that managed care plans would demonstrate there are sufficient IHCPs participating in the network. If there are no or few IHCPs in the State:
 - Indian enrollees would be permitted to access out-of-State IHCPs, or
 - The state could treat this as good cause reason for Indian enrollees to disenroll from the managed care program
- Clarifying payment standards for IHCPs that may or may not be part of the network
 - State must provide a supplemental payment to meet the applicable rate under the State plan

Provisions for Indians, Indian Providers, and Indian Managed Care Entities

We request comment on:

- Whether these proposals are adequate to ensure that Indian enrollees have timely access to covered services
- How to facilitate a coordinated approach to care for Indian enrollees who receive services from an out-of-network IHCP and may need a referral to a specialty provider in the managed care network
- The potential barriers for IHCPs to contract with managed care plans and what technical assistance and resources might be helpful, e.g. I/T/U contract addendum

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 proposes 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



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