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Centers for Medicare & Medicaid Services (CMS) Proposed Rule on Medicaid Managed Care: Frequently Asked Questions

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Summary

On May 26, 2015, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule (CMS-2390-P) laying out the agency's plan to update the federal regulations pertaining to Medicaid managed care, under which states contract with private health insurers to provide health care to some enrollees. The proposed rule was posted to the *Federal Register* on June 1, 2015.

The proposed rule would be the first major federal regulation impacting Medicaid managed care since 2002. In the early 1990s, states began turning to managed care to deliver benefits to enrollees. In FY2011, 49.8% of Medicaid enrollees were enrolled in comprehensive risk-based managed care. Many states rely on managed care organizations (MCOs) to deliver services to individuals newly eligible for Medicaid under the Patient Protection and Affordable Care Act's (ACA's; P.L. 111-148, as amended) Medicaid expansion. The proposed rule would influence how states structure their managed care programs going forward. As of September 2014, 39 states had contracted with MCOs to deliver care to their Medicaid enrollees. Because of the high percentage of Medicaid enrollees receiving benefits through managed care, the proposed rule likely would impact millions of Medicaid enrollees. With so many people receiving Medicaid services through managed care, CMS is updating the regulations to better align them with today's health care landscape, including the recent changes to Medicare Advantage and the private health insurance market (including the introduction of health insurance exchanges) as a result of the ACA.

This report responds to a series of frequently asked questions (FAQs) identified to address some of the major updates included in the proposed rule. The FAQs summarize provisions such as the introduction of a minimum medical loss ratio (MLR), guidance on enrolling the long-term services and supports (LTSS) population in managed care, and network adequacy. This report is not meant to be comprehensive and does not include all of the numerous technical changes CMS outlines in the proposed rule. Instead, this report provides a high-level summary of some of the major provisions in the proposed rule.

CMS is taking public comments on the proposed rule through July 27, 2015. Once the comment period closes, CMS will review the comments and make any changes before preparing a final rule. This report may be updated to include additional FAQs or more detailed answers on certain aspects of the proposed rule.

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Introduction

On May 26, 2015, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule (CMS-2390-P) that lays out the agency’s plan to update the federal regulations pertaining to Medicaid managed care, under which states contract with private health insurers to provide health care to some enrollees.¹ The proposed rule was posted to the *Federal Register* on June 1, 2015.

In general, federal agencies develop regulations to implement laws passed by Congress. CMS is responsible for creating federal regulations for the Medicaid program,² including regulations for how states deliver services to Medicaid enrollees through comprehensive risk-based managed care, the primary focus of the proposed rule. The proposed rule also addresses managed care in the state Children’s Health Insurance Program (CHIP) and third-party liability (TPL) in Medicaid, but those topics are not included in this report.

The proposed rule would be the first major federal regulation impacting Medicaid managed care since 2002, and it would influence how states structure their managed care programs going forward. Many states rely on managed care organizations (MCOs) to deliver services to individuals newly eligible for Medicaid under the Patient Protection and Affordable Care Act’s (ACA’s; P.L. 111-148, as amended) Medicaid expansion. With so many people getting Medicaid services through managed care, CMS is updating the regulations to better align them with today’s health care landscape. In developing the proposed rule, CMS took into account “private health care coverage market reforms” and “standards established for qualified health plans” in the health insurance exchanges under the ACA as well as the experience in Medicare Advantage, the managed care option available to Medicare enrollees that has “also grown significantly since 2002.”³

This report responds to a series of frequently asked questions (FAQs) identified to address some of the major updates included in the proposed rule. The FAQs summarize provisions such as the introduction of a minimum medical loss ratio (MLR), guidance on enrolling the long-term services and supports (LTSS) population in managed care, and network adequacy. This report is not meant to be comprehensive and does not include all of the numerous technical changes CMS outlines in the proposed rule. Instead, this report provides a high-level summary of some of the major provisions in the proposed rule.

Next Steps and Future Updates to This Report

CMS is taking public comments on the proposed rule through July 27, 2015. Once the comment period closes, CMS will review the comments and make any changes before preparing a final rule for review by the Office of Management

¹ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), “Proposed Rule: Medicaid Managed Care,” 80 *Federal Register* 31097, at <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>. Hereinafter referred to as CMS-2390-P.

² Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS) for a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. For more information, see CRS Report R43357, *Medicaid: An Overview*, coordinated by (name redacted)

³ CMS-2390-P, p. 31101. In the proposed rule, CMS notes that the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) brought significant changes for private health insurance including “minimum standards for treatment of appeals by covered individuals, minimum medical loss ratios for health insurance, and certain minimum coverage standards for essential health benefits and preventive services.”

and Budget (OMB). OMB review, which typically lasts up to 90 days, is the last step before an agency releases a final rule.

This report may be updated to include additional FAQs or more detailed discussions of certain aspects of the proposed rule.

Background on Medicaid Managed Care

There are two main service delivery models that states use for Medicaid: fee-for-service (FFS) and managed care. Managed care differs from the traditional FFS arrangement in how states pay providers for their services. Under FFS, states pay providers directly for the services they deliver to Medicaid enrollees, with the state assuming the financial risk for health care spending. Beginning in the early 1990s, states began turning more and more to managed care to deliver benefits to enrollees.⁴ In FY2011, 49.8% of Medicaid enrollees were enrolled in comprehensive risk-based managed care.⁵ Because of the high percentage of Medicaid enrollees receiving benefits through comprehensive risk-based managed care (delivered primarily through managed care organizations [MCOs]), the proposed rule is likely to impact millions of Medicaid enrollees.⁶ As of September 2014, 39 states had contracted with MCOs to deliver care to their Medicaid enrollees.⁷ Enrollment has increased over time as states have sought out managed care because it can make costs more predictable through capitation and may improve care for beneficiaries, for example, through better care coordination.

Risk-based managed care can include a comprehensive set of benefits or a more limited set of benefits. Under comprehensive risk-based managed care, states contract with MCOs to deliver a comprehensive set of services. The state pays the MCO a fixed amount for each enrollee, called a *capitation payment*, and the MCO pays the providers. The MCO assumes the financial risk for spending. Federal regulations provide guidance to states on delivering care through MCOs, including requirements and standards for contracts and for setting capitation rates.

Under a more limited risk-based arrangement, states contract with limited-benefit health plans called Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs).⁸ These plans typically deliver a limited benefit package, sometimes limited to a single benefit such as dental coverage, in return for a capitated payment from the state Medicaid program.

In the past, managed care generally has been used to provide coverage to healthier populations, but more and more states are using it for people who need LTSS.⁹ *Managed LTSS (MLTSS)* refers

⁴ CMS-2390-P, p. 31099.

⁵ MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2014, p. 120, at https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf.

⁶ *Comprehensive risk-based managed care* refers to a system in which a state contracts with an MCO to deliver care to Medicaid enrollees in exchange for a fixed per-person payment called a *capitated payment*. In some cases, other entities such as Prepaid Inpatient Health Plans (PIHPs) or Prepaid Ambulatory Health Plans (PAHPs) also deliver care on a capitated basis but for a limited benefit. For that reason, there are references in this report and throughout the proposed rule to “MCOs, PIHPs, and PAHPs.” In many instances throughout the proposed rule, the same standards are applied to all three entities because they all rely on capitated payment models.

⁷ CMS-2390-P, p. 31099.

⁸ MACPAC, *Report to the Congress: The Evolution of Managed Care*, June 2011, p. 12, at https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_June2011_web.pdf.

⁹ *LTSS* refers to services and supports for people with functional and cognitive limitations who need help with routine daily activities. LTSS can be delivered either in an institution or in a home- or community-based setting. For more information, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name redacted)

to the delivery of LTSS benefits through managed care. MLTSS can be provided through MCOs, PIHPs, or PAHPs that receive a capitated payment from the state Medicaid program.¹⁰ In response to the significant growth in the number of states with MLTSS programs over the past decade, CMS released guidance in May 2013 for states to use in setting up an MLTSS program.¹¹ The proposed rule would codify that guidance. It addresses MLTSS with LTSS-specific changes and also includes MLTSS in changes more broadly applicable to all managed care programs.¹²

Frequently Asked Questions

Below are several FAQs on some of the major updates in the proposed rule. The questions and the responses to them explain and summarize some of the updates proposed by CMS related to Medicaid managed care. For ease of reference, the FAQs are organized by the major subsections of the Medicaid managed care portion of the proposed rule:¹³

- Alignment with Other Health Coverage Programs
- Standard Contract Provisions
- Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs
- Other Payment and Accountability Improvements
- Beneficiary Protections
- Modernize Regulatory Requirements
- Implementing Statutory Provisions

The relevant references to Title 42 of the *Code of Federal Regulations* (42 C.F.R.) appear under each section heading. Along with each FAQ is the page(s) in the proposed rule where the relevant provision is located.

Alignment with Other Health Coverage Programs

(42 C.F.R. §§431.200, 431.220, 431.244, 438.104, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.424, 438.4, 438.5, 438.8, and 438.74)

In the proposed rule, CMS proposes to better align the Medicaid managed care regulations with regulations governing other health coverage markets, such as Medicare Advantage and the health insurance exchanges established under the ACA.¹⁴

¹⁰ CMS-2390-P, p. 31141.

¹¹ CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs*, May 20, 2013, at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

¹² CMS-2390-P, p. 31141.

¹³ The last subsection of the proposed rule, Definitions and Technical Corrections, is not discussed in this report because of its technical nature.

¹⁴ For more information on Medicare Advantage, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted) .

Why is CMS proposing to better align Medicaid managed care with other health coverage programs?

(CMS-2390-P, pp. 31102-31113)

CMS is proposing to better align Medicaid managed care with the standards in the private market and in Medicare Advantage to improve Medicaid beneficiaries' experiences and ease the administrative burden on health insurance issuers and regulators.¹⁵ In establishing guidance regarding alignment with other programs, CMS took into account the significant changes that have occurred since Medicaid managed care regulations were last published in 2002, including the passage of the ACA and significant enrollment growth in Medicare Advantage, the "managed care component of the Medicare program."¹⁶ CMS considered the standards and market reforms established under the ACA in developing the proposed rule. The ACA established health insurance exchanges and qualified health plans (QHPs) to provide health care coverage to millions of Americans. QHPs are the only health plans that can be offered on the exchanges, and they are the only plans for which the premium tax credits and reduced cost sharing established under the ACA are available to enrollees.¹⁷ CMS sees greater alignment between Medicaid MCOs and QHPs as providing an easier transition for enrollees who may experience changes in income, causing them to move between the two sources of coverage.¹⁸

Along with these new health plans, the ACA established new standards and market reforms for the private health insurance market, such as standards for coverage of preventive services and essential health benefits as well as minimum medical loss ratios (MLRs) for health insurance.¹⁹ CMS views application of the private market and Medicare Advantage standards to Medicaid managed care as a way to protect beneficiaries and ease the administrative burden on health insurance issuers and regulators.²⁰

How would the proposed rule align Medicaid managed care with other health coverage programs in terms of marketing?

(CMS-2390-P, p. 31102)

Current regulations established in 2002 include certain limitations for MCOs related to marketing. For example, the regulations provide that in an MCO's contract with the state, the MCO is prohibited from "cold-call marketing activities."²¹ However, because the regulations were written prior to the ACA's passage, they do not address marketing by insurance carriers that are operating QHPs in addition to MCOs. As a result, the proposed rule would revise the definition of marketing to exclude communications from a QHP to a Medicaid beneficiary, even if the issuer of the QHP also is providing Medicaid managed care. Further, the proposed rule would clarify that Medicaid marketing rules do not prohibit a carrier that offers both a QHP and

¹⁵ CMS-2390-P, p. 31101.

¹⁶ Ibid. See also CMS, "Medicare Advantage enrollment at all-time high; premiums remain affordable," press release, September 18, 2014, at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-18.html>.

¹⁷ CMS-2390-P, p. 31101.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ 42 C.F.R. §438.104(b)(1)(v).

an MCO from marketing these products and that unsolicited emails or text messages from MCOs, PIHPs, or PAHPs for marketing purposes are prohibited.²²

What are some of the changes the proposed rule would make to the appeals and grievances process for Medicaid beneficiaries?

(CMS-2390-P, pp. 31102-31107)

The proposed rule generally would modify the appeals and grievances process to make it more streamlined across different health insurance markets. For example, the proposed rule would set the standard time frame for beneficiaries to file an appeal at 60 days. CMS notes that beneficiaries in a Medicare Advantage plan and enrollees in the private market have 60 days to request an appeal.²³ Currently, states have the option to choose a time frame between 20 days and 90 days for an enrollee to file an appeal. The proposed rule also would establish that a grievance can be filed at any time.

The proposed rule would limit an MCO's internal appeal process for beneficiaries to one level of appeal. (By contrast, existing regulations allow multiple levels of appeal.) Once that single level is exhausted, a beneficiary could request a state fair hearing. This limit is consistent with the limits in regulations that apply to the individual market and to Medicare Advantage health plans, and it is "designed to ensure that the MCO, PIHP or PAHP process would not be unnecessarily extended by having more than one level of internal review."²⁴

The proposed rule would shorten the time frame that MCOs have to make a decision about an enrollee's "standard (non-expedited) appeal" from 45 days to 30 days. It also would change the time frame that MCOs have to make a decision after receiving a request for expedited review of an appeal from "3 working days" to 72 hours to be consistent with standards in Medicare Advantage and the private market.²⁵ The proposed rule generally would make the appeals and grievance process applicable to PAHPs, except those PAHPs that provide only nonemergency medical transportation.²⁶

Would the proposed rule establish a minimum medical loss ratio for Medicaid managed care organizations?

(CMS-2390-P, pp. 31107-31113)

Yes, the proposed rule would establish a minimum medical loss ratio (MLR) of 85% as part of the process of setting capitation rates to ensure that those rates are actuarially sound and "based on reasonable expenditures on covered services" for enrollees.²⁷ The *minimum MLR* refers to the amount of premium revenue that a health plan spends on the delivery of care or on improvements

²² CMS-2390-P, p. 31102.

²³ CMS-2390-P, p. 31104.

²⁴ Ibid.

²⁵ CMS-2390-P, p. 31105.

²⁶ CMS-2390-P, p. 31103.

²⁷ Current regulations found at 42 C.F.R. §438.6(c)(i) define *actuarially sound capitation rates* as rates that 1) have been developed in accordance with generally accepted actuarial principles and practices; 2) are appropriate for the populations to be covered and the services to be furnished under the contract; and 3) have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

to the quality of care as opposed to administrative costs or profits.²⁸ The ACA established minimum MLRs for the private health insurance market and Medicare Advantage.²⁹ Under the proposed rule, states have flexibility in how they set their MLRs and incorporate them into their contracts with MCOs. For example, states can set MLRs higher than 85%. States also are not required to collect a remittance from the MCO if it falls below the minimum threshold, but CMS encourages states to include contract provisions that will “drive MCO, PIHP and PAHP performance in accordance with the MLR standard.”³⁰ In addition, CMS encourages states to take into account whether the MCO, PIHP, or PAHP has met the minimum 85% threshold in the past, when setting future capitation rates. CMS chose 85% as the “appropriate minimum threshold” because it believes that consistency across Medicaid, Medicare Advantage, and the private market will lead to administrative efficiency for state Medicaid programs and health insurance issuers, and a minimum threshold of 85% is the standard for Medicare Advantage and for large employers in the private market.³¹ This new standard would be incorporated into all state contracts with MCOs starting on or after January 1, 2017.³² Some state Medicaid programs may have minimum MLR requirements for MCOs already in place. In 2010, 10 states and the District of Columbia had minimum MLR requirements for Medicaid MCOs.³³

Standard Contract Provisions

(42 C.F.R. §438.3, 438.6)

This section of the proposed rule would reorganize the standards currently in place for contracts between states and MCOs, PIHPs, and PAHPs. In some cases, it would make changes to those standards. In addition, this section would modify the exclusion on Medicaid payments for coverage in an institution for mental disease (IMD).

What are some of the changes the proposed rule would make regarding contracts between states and MCOs?

(CMS-2390-P, pp. 31113-31118)

Under existing regulations, CMS lays out requirements for states that contract with MCOs, PIHPs or PAHPs. For example, CMS must review and approve all MCO, PIHP, and PAHP contracts.³⁴

²⁸ CMS-2390-P, p. 31109. The proposed rule describes the calculation of the MLR as “the sum of the MCO’s, PIHP’s, or PAHP’s incurred claims, expenditures on activities that improve health care quality, and activities specified under proposed §438.6089a(1) through (5), (7), (8), and (b) (subject to the cap in §438.8(e)(4)), divided by the adjusted premium revenue collected, taking into consideration any adjustments for MCO, PIHP, or PAHP enrollment (known as a credibility adjustment).” Further, CMS notes that the calculation of the MLR under the proposed rule “uses the same general calculation as the one established in 45 CFR 158.221 (private plan MLR) with proposed differences to what is included in the numerator and the denominator to account for differences in the Medicaid program. The proposal also calculates the MLR over a 12-month period rather than a 3-year period.”

²⁹ In particular, the ACA requires an annual, minimum 80% MLR for individual and small group insurance plans, and an annual, minimum 85% MLR for large group plans. For more information on the minimum medical loss ratio established under the ACA, see CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by (name redacted).

³⁰ CMS-2390-P, p. 31109.

³¹ CMS-2390-P, p. 31107.

³² CMS-2390-P, p. 31108.

³³ Kaiser Family Foundation, *Quick Take: Medicaid MCOs and Medical Loss Ratio Requirements*, April 13, 2012, at <http://kff.org/medicaid/fact-sheet/medicaid-mcos-and-medical-loss-ratio-mlr/>.

³⁴ 42 C.F.R. §438.6.

The proposed rule would give CMS the regulatory flexibility to set procedural rules in sub-regulatory materials related to the time frames and processes that states must use for submitting contracts to CMS. It would set a new standard that requires states to submit a contract to CMS for review and approval “no later than 90 days before the planned effective date of the contract.”³⁵

Would the proposed rule remove the Medicaid exclusion for institutions for mental disease, under certain circumstances?

(CMS-2390-P, p. 31116)

Yes, the proposed rule would remove the institutions for mental disease (IMD) exclusion for Medicaid enrollees between the ages of 21 and 64 who are receiving coverage in an IMD for less than 15 days and have managed care coverage for that month.

Under current law, states are prohibited from making capitated payments to MCOs for coverage in an IMD for enrollees aged 21 to 64 who are patients in an IMD.³⁶ Under current Medicaid managed care regulations, there potentially are some options for states to provide coverage of IMD services to individuals aged 21 to 64. However, it is unclear whether any states are using these options.

Under the proposed rule, states would be allowed to make capitated payments to MCOs that provide coverage in an IMD as long as the enrollee’s stay is less than 15 days in any given month and “so long as 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.”³⁷ CMS notes that it is making this change “in light of the flexibility that managed care plans have had historically to furnish care in alternative settings that meet an enrollee’s needs ...” and because of “access issues for short-term inpatient psychiatric and SUD treatment.”³⁸

Setting Actuarially Sound Capitation Rates for Medicaid Managed Care

(42 C.F.R. §438.2, 438.4, 438.5, 438.6, 438.7)

This section seeks to improve consistency and transparency in the rate-setting process across Medicaid managed care programs.³⁹ It would establish standards for states to use in setting actuarially sound payment rates for capitated payments to MCOs. States are required in statute to set capitation rates that are actuarially sound.⁴⁰ Title 42, Section 438.6(c)(i) of the *Code of Federal Regulations* defines *actuarially sound capitation rates* as rates that 1) have been developed in accordance with generally accepted actuarial principles and practices, 2) are appropriate for the populations to be covered and the services to be furnished under the contract, and 3) have been certified by an actuary who meets the qualification standards established by the

³⁵ CMS-2390-P, p. 31114.

³⁶ For more information, see CRS In Focus IF10222, *Medicaid’s Institutions for Mental Disease (IMD) Exclusion*, by (name redacted) and (name redacted)

³⁷ CMS-2390-P, p. 31116.

³⁸ Ibid.

³⁹ CMS-2390-P, p. 31119.

⁴⁰ §1903(m)(2)(A)(iii) of the Social Security Act.

American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

What are some of the standards that the proposed rule would establish for setting actuarially sound capitation rates?

(CMS-2390-P, pp. 31118-31126)

Under existing law, states are required to set actuarially sound capitation rates within broad parameters such as appropriateness for the population covered, but CMS does not lay out more specific criteria that states must follow in setting those rates. The proposed rule would establish standards that all states must meet in setting capitation rates for MCOs to ensure that the rates are actuarially sound. CMS proposes to create a new section (§438.4) to establish these standards. In some cases, the proposed rule restates an existing provision of law within the new section, without changing the substantive meaning. For example, one of the standards included in the new section restates an existing rule that rates must be appropriate for the populations to be covered and the services to be provided under the managed care contract.⁴¹ The proposed rule would establish a new standard that capitation rates must be specific to the payment attributable to each rate cell under the contract.⁴² CMS would apply these standards during the review and approval process of the state's capitation rates.

Also in the proposed rule, CMS would establish six new rate-development standards to be used in the process of setting capitation rates, listed below:

- “Collect or develop appropriate base data from historical experience;
- Develop and apply appropriate and reasonable trends to project benefit costs in the rating period, including trends in utilization and prices of benefits;
- Develop appropriate and reasonable projected costs for non-benefit costs in the rating period as part of the capitation rate;
- Make appropriate and reasonable adjustments to the historical data, projected trends, or other rate components as necessary to establish actuarially sound rates;
- Consider historical and projected MLR of the MCO, PIHP, or PAHP; and
- For programs that use a risk adjustment process, select an appropriate risk adjustment methodology, apply it in a budget neutral manner, and calculate adjustments to plan payments as necessary.”⁴³

Would the proposed rule modify the contract requirements related to payments to MCOs?

(CMS-2390-P, pp. 31122-31125)

Yes, the proposed rule would add a new standard to the regulations currently found in Section 438.6(c)(5)(iii) governing incentive arrangements. Incentive arrangements occur when an MCO

⁴¹ CMS-2390-P, p. 31120.

⁴² CMS-2390-P, p. 31120. *Rate cells* are “distinct payment amounts” that are used for different Medicaid populations. For more information, see Office of the Assistant Secretary for Planning and Evaluation, *Medicaid and CHIP Managed Care Payment Methods and Spending in 20 States*, December 2012, at <http://aspe.hhs.gov/health/reports/2012/medicaidandchipmanagedcarePayments/rpt.cfm>.

⁴³ CMS-2390-P, p. 31121.

may receive additional funds above what it was paid through its capitation rate for meeting a target specified in the contract with the state Medicaid program.⁴⁴ The proposed rule would require that incentive arrangements “be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes.”⁴⁵

The proposed rule also would provide, for purposes of delivery system and payment reform, that states may specify in their contracts with MCOs that the MCOs must adopt “value-based purchasing models for provider reimbursement.”⁴⁶ In addition, states would be able to require that MCOs participate in “multi-payer or Medicaid specific initiatives” including “patient-centered medical homes” and “efforts to reduce the number of low birth weight babies.”⁴⁷

Other Payment and Accountability Improvements

(42 C.F.R. §438.60, 438.230, 438.600, 438.602, 438.604, 438.606, 438.608, 438.610, 438.807, 438.808)

This section focuses primarily on improving program integrity in managed care, including improvements to provider screening and enrollment processes. *Provider screening and enrollment* refers to the process that states are required to use to enroll all providers as participating providers under the Medicaid program.

Does the proposed rule address program integrity in Medicaid managed care?

(CMS-2390-P, pp. 31127-31131)

Yes, CMS considers the current managed care program integrity regulations to be limited in scope and uses the proposed rule to take a “broader approach to rethinking Medicaid managed care program integrity provisions.”⁴⁸ In the proposed rule, CMS identifies two main concerns related to program integrity: 1) fraud committed by MCOs and 2) the vulnerability of Medicaid funds to fraud by network providers.⁴⁹

There have been significant changes in program integrity since CMS last issued Medicaid managed care regulations in 2002. These changes include passage of the Deficit Reduction Act (P.L. 109-171), which created the Medicaid Integrity Program, and passage of the ACA, which enhanced the Secretary of the Department of Health and Human Services’ (HHS’s) program integrity authority and established new requirements around screening providers.⁵⁰ CMS issued

⁴⁴ 42 C.F.R. §438.6(c)(iv).

⁴⁵ CMS-2390-P, p. 31123.

⁴⁶ CMS-2390-P, p. 31124. *Value-based purchasing* in the proposed rule refers to approaches that “prioritize achieving health outcomes rather than simply the delivery of services.”

⁴⁷ CMS-2390-P, p. 31124. A patient-centered medical home is a model of primary care that encompasses comprehensive care, patient-centered and coordinated care, accessible services, and quality and safety. See U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “Patient Centered Medical Home Resource Center,” at <http://pcmh.ahrq.gov/page/defining-pcmh>.

⁴⁸ CMS-2390-P, p. 31127. Program integrity in Medicaid encompasses efforts to combat fraud, waste, and abuse in Medicaid. For more information, see [Medicaid.gov](http://www.medicaid.gov), “Program Integrity,” at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html>.

⁴⁹ CMS-2390-P, p. 31128.

⁵⁰ §6401 of the ACA created §1902(kk) of the Social Security Act, which contains requirements around screening providers.

final regulations implementing the ACA provisions.⁵¹ However, those regulations excluded Medicaid managed care providers.⁵² CMS has heard from states and the HHS Office of the Inspector General (OIG) about a lack of consistency in provider screening and enrollment procedures “applicable to FFS providers in states’ managed care programs” that could leave state and federal Medicaid dollars vulnerable to fraud.⁵³ As a result, CMS would use the proposed rule to bolster provider screening and enrollment processes by adapting those requirements to MCOs.

How would the proposed rule seek to improve provider screening and enrollment processes in Medicaid managed care?

(CMS-2390-P, pp. 31127-31131)

In the proposed rule, CMS addresses the provider screening and enrollment processes that states are required to use to enroll all “ordering or referring physicians or other professionals” as participating providers under the Medicaid program.⁵⁴ Existing regulations regarding screening and enrollment do not apply to providers that only refer or deliver services in a risk-based managed care environment. According to the proposed rule, CMS has received feedback from state program integrity reviews and from the HHS OIG that the inconsistent application of provider screening and enrollment provisions potentially leaves Medicaid programs vulnerable to fraud.

CMS proposes to put all state responsibilities associated with program integrity in one section of the regulation. The proposed rule would require states to enroll all MCO network providers that are not otherwise enrolled to provide services to FFS Medicaid beneficiaries.

The rule also would require states to post their contracts with each MCO on the state’s website. In addition, states would have to post encounter data submitted by MCOs to the state and the results of independent audits of encounter and financial data submitted by MCOs to the state. (See also “What is enrollee encounter data?”)

Beneficiary Protections

(42 C.F.R. §438.54, 438.56, 438.71, 438.210, 438.420, 438.62, 438.208, 438.2, 438.3, 438.70, 438.71, 438.214, 438.816)

In the proposed rule, CMS addresses several aspects of a beneficiary’s experience with Medicaid managed care, including enrollment and disenrollment standards, establishment of a beneficiary support system, and coordination of care. CMS also responds to the growth in MLTSS programs by codifying the principles of a “strong MLTSS program” that CMS previously outlined in guidance to states released in May 2013.⁵⁵

⁵¹ CMS, “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers,” 76 *Federal Register*, February 2, 2011, at <https://www.federalregister.gov/articles/2011/02/02/2011-1686/medicare-medicaid-and-childrens-health-insurance-programs-additional-screening-requirements>.

⁵² CMS-2390-P, p. 31127.

⁵³ *Ibid.*

⁵⁴ §1902(kk)(7) of the Social Security Act, added by §6401 of the ACA.

⁵⁵ CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs*, May 20, 2013, at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

What are some of the beneficiary protections that would be added by the proposed rule?

(CMS-2390-P, pp. 31133-31141)

The proposed rule would establish federal regulations around enrollment in managed care plans. According to CMS, existing regulations only address the default enrollment process and do not provide basic federal standards for enrollment that states can follow when enrolling Medicaid beneficiaries in managed care.⁵⁶ The proposed rule would establish a requirement that states must provide an enrollee at least 14 days of FFS coverage while the enrollee chooses an MCO. This standard would apply to both voluntary (where enrollment in managed care is voluntary for the beneficiary) and mandatory (where enrollment in managed care is required) managed care programs.⁵⁷

The proposed rule would establish a beneficiary support system that states would set up to provide support to Medicaid beneficiaries before and after they enroll in managed care. The system must provide at least the following four functions:

- Making choice counseling available to all beneficiaries;
- Providing training for MCO, PIHP, and PAHP staff and network providers on the “type and availability of community based resources and supports”;
- Assisting all beneficiaries in understanding managed care; and
- Providing assistance for enrollees who receive or desire to receive LTSS.⁵⁸

Within the beneficiary support system, CMS proposes four elements that states should establish that are specific to “beneficiaries who use, or desire to use, LTSS”:

- “An access point for complaints and concerns about enrollment, access to covered services, and other related matters;
- Education on enrollees’ grievance and appeal rights, the state fair hearing process, and rights and responsibilities;
- Assistance, upon request, in navigating the grievance and appeal process and appealing adverse benefits determinations made by a plan to a state fair hearing; and
- Review and oversight of LTSS program data to assist the state Medicaid Agency on identification and resolution of systemic issues.”⁵⁹

The proposed rule also clarifies that a beneficiary’s right to a 90-day without-cause disenrollment period is limited to “the first 90 days of an enrollee’s *initial* enrollment into any MCO.”⁶⁰ The proposed rule would allow only one 90-day without-cause disenrollment per enrollment period. CMS notes that this regulation represents current state practice and is consistent with the intent of statute.

⁵⁶ CMS-2390-P, p. 31133.

⁵⁷ CMS-2390-P, p. 31134.

⁵⁸ CMS-2390-P, p. 31137.

⁵⁹ *Ibid.*

⁶⁰ CMS-2390-P, p. 31136.

How would the proposed rule incorporate previous CMS guidance on managed long-term services and supports programs?

(CMS-2390-P, pp. 31141-31144)

Managed long-term services and supports (MLTSS) refers to the delivery of LTSS benefits through managed care.⁶¹ MLTSS can be provided through MCOs, PIHPs, or PAHPs that receive a capitated payment from the state Medicaid program.⁶² The number of states with MLTSS programs has grown significantly over the past decade. Only 8 states had MLTSS programs in 2004, compared with 16 states in 2012.⁶³ In response to this growth, CMS released guidance in May 2013 for states to use in setting up an MLTSS program through a 1915(b) waiver or a Section 1115 demonstration.⁶⁴ The proposed rule would codify that guidance. The May 2013 guidance outlined 10 key elements for high-quality MLTSS programs, which can be found in the proposed rule.⁶⁵

CMS's Key Elements for MLTSS Programs⁶⁶

- Adequate Planning – includes a “thoughtful and deliberative planning process with a clear vision for the program”
- Stakeholder Engagement – includes “engaging stakeholders regularly in the ongoing monitoring and oversight of the MLTSS program”
- Enhanced Provision of Home- and Community-Based Services⁶⁷ – the proposed rule states that “all MLTSS programs must be implemented consistent with the Americans with Disabilities Act and the Supreme Court’s *Olmstead* ... decision”⁶⁸
- Alignment of Payment Structures and Goals – the proposed rule states that “payment to MCOs, PIHPs, and

⁶¹ LTSS benefits include services for individuals with physical and mental disabilities who need assistance with routine daily activities. LTSS can be delivered either in an institution or in a home- or community-based setting. For more information, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name redacted)

⁶² CMS-2390-P, p. 31141.

⁶³ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *How Have Long-Term Services and Supports Providers Fared in the Transition to Medicaid Managed Care?*, p. v, December 2013, at <http://aspe.hhs.gov/daltcp/reports/2013/3LTSStrans.pdf>.

⁶⁴ §1115 of the Social Security Act authorizes the Secretary of the Department of Health and Human Services to approve experimental, pilot, or demonstration projects that are consistent with the goals of the Medicaid program. §1115 provides states with additional flexibility in designing their Medicaid programs. For more information, see Medicaid.gov, “Section 1115 Demonstrations,” at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>. §1915(b) of the Social Security Act provides options that states can use to waive certain federal Medicaid requirements when setting up their managed care programs. For example, under §1915(b)(1), states are allowed to restrict the types of providers available to managed care enrollees. For more information, see Medicaid.gov, “1915(b) Managed Care Waivers,” at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/Managed-Care-1915-b-Waivers.html>.

⁶⁵ CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs*, May 20, 2013, at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

⁶⁶ These elements can be found on pp. 31142-31144 of the proposed rule.

⁶⁷ *Home- and community-based services* refers to the provision of LTSS in a home or community-based setting, enabling the beneficiary to receive services in his or her home or community rather than in a facility such as a nursing home. For more information, see <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>. See also CRS Report R43804, *Medicaid Home and Community-Based Settings Final Rule: In Brief*, by (name redacted) .

⁶⁸ See the Americans with Disabilities Act of 1990 at http://library.clerk.house.gov/reference-files/PPL_101_336_AmericansWithDisabilities.pdf and the Supreme Court’s 1999 *Olmstead* Decision at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/community/olmstead_decision.pdf.

PAHPs should support the goals of MLTSS programs to improve the health of populations, support the beneficiary’s experience of care, support community integration of enrollees, and reduce costs”

- Support for Beneficiaries – the proposed rule states that “support and education, including enrollment and disenrollment assistance and advocacy support services, are critical for all beneficiaries in a MLTSS program”
- Person-Centered Processes – the proposed rule states that “ensuring that beneficiaries’ medical and non-medical needs are met and that they have the quality of life and level of independence they desire within a MLTSS program starts with person-centered processes including comprehensive needs assessments and service planning policies”
- Comprehensive, Integrated Service Package – where “a state managed care program divides services between contracts or delivery systems, it is important that there is robust coordination and referral by the managed care plan to ensure that the beneficiary’s service plan ... is comprehensive and person-centered”
- Qualified Providers – the proposed rule states that “MCOs, PIHPs, and PAHPs in a MLTSS program must have an adequate network of qualified providers to meet the needs of their enrollees”
- Participant Protections – the proposed rule states that “participant health and welfare is an important tenet in a program providing LTSS”
- Quality – the proposed rule states that “a quality system for MLTSS is fundamentally the same as a quality system for a state’s entire managed care program, but should include MLTSS-specific quality elements” including “mechanisms to assess the quality and appropriateness of care provided to LTSS enrollees”

Does the proposed rule include changes specific to MLTSS?

Yes, the proposed rule would make changes that are specific to MLTSS. For example, within the beneficiary support system established in the proposed rule, CMS proposes four elements for states that are specific to “beneficiaries who use, or desire to use, LTSS”:

- “An access point for complaints and concerns about enrollment, access to covered services, and other related matters;
- Education on enrollees’ grievance and appeal rights, the state fair hearing process, and rights and responsibilities;
- Assistance, upon request, in navigating the grievance and appeal process and appealing adverse benefit determinations made by a plan to a state fair hearing; and
- Review and oversight of LTSS program data to assist the state Medicaid Agency on identification and resolution of systemic issues.”⁶⁹

It also proposes that states set specific time and distance standards for MLTSS, as part of the Qualified Providers element, which is one of the key elements of an MLTSS program listed in the box above and included in CMS’s 2013 guidance. CMS proposes that states establish time and distance standards that are specific to MLTSS programs to recognize that MLTSS beneficiaries are high utilizers of services that are obtained from providers outside the traditional doctor’s office.⁷⁰ Time and distance standards refer to standards that states must establish related to the travel time and distance from an enrollee’s residence to a provider.

⁶⁹ CMS-2390-P, p. 31137.

⁷⁰ CMS-2390-P, p. 31143.

Does the proposed rule define LTSS?

(CMS-2390-P, p. 31141)

Yes, the proposed rule defines LTSS as “services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual’s home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.”⁷¹

Modernize Regulatory Requirements

(42 C.F.R. §§438.206, 438.207, 438.68, 440.262, 438 subparts D and E, 438.66, 438.10, 438.52)

This section of the proposed rule addresses issues of network adequacy in Medicaid managed care as well as strategies for assessing and improving quality. *Network adequacy* refers to an MCO’s “capacity and ability to provide services” to Medicaid enrollees.⁷² Also related to network adequacy are access standards set by states for all Medicaid enrollees. States include access standards in the “quality assessment and improvement strategies” for their managed care programs that Section 1932(c)(1) of the Social Security Act requires states to develop.

How would the proposed rule address network adequacy in MCO provider networks?

(CMS-2390-P, pp. 31144-31148)

The proposed rule would set standards to “ensure ongoing state assessment and certification of MCO, PIHP and PAHP networks, set threshold standards for the establishment of network adequacy measures for a specified set of providers, establish criteria for developing network adequacy standards for MLTSS programs, and ensure the transparency of network adequacy standards.”⁷³ (See also “Beneficiary Protections”)

CMS requires states to set time and distance standards or provider-to-enrollee ratios for specific provider types (including pediatric primary, specialty, and dental providers, among others), but it defers to the state on what those standards or ratios should be.⁷⁴ Time and distance standards refer to standards that states must establish related to the travel time and distance from an enrollee’s residence to a provider.

The proposed rule would require states to consider the following elements when developing network adequacy standards:

- Anticipated Medicaid enrollment;
- Expected utilization of services;
- Characteristics and health needs of the covered population;

⁷¹ CMS-2390-P, pp. 31141-31142.

⁷² CMS-2390-P, p. 31144.

⁷³ CMS-2390-P, p. 31144.

⁷⁴ CMS-2390-P, p. 31145.

- Number and types of health care professionals needed to provide covered services;
- Number of network providers that are not accepting new Medicaid patients; and
- Geographic location and accessibility of the providers and enrollees.⁷⁵

What are some of the quality strategies in the proposed rule?

(CMS-2390-P, pp. 31148-31158)

Under current law, states are required to follow certain quality-assurance standards, including developing a quality assessment and improvement strategy and providing for an external independent review of the MCOs with which they contract. The proposed rule would require states contracting with managed care plans to establish a Medicaid managed care quality rating system for MCOs, PIHPs, and PAHPs. The proposed rule would specify minimum standards that all states would use related to oversight and evaluation of health plan performance. In developing this proposal, CMS reviewed the quality rating system established for QHPs and the five-star rating system used for Medicare Advantage and Medicare Part D Prescription Drug Plans. The quality rating system should be based on the following three indicators: clinical quality management; member experience; and plan efficiency, affordability and management.⁷⁶

The proposed rule also would extend the existing “comprehensive state quality strategy” requirement for states contracting with MCOs and PIHPs to all state Medicaid programs. Under current law, the quality strategy requires states to maintain a written strategy for “assessing and improving the quality” of services delivered by MCOs and PIHPs. Because of recent delivery system reforms, the proposed rule would extend the quality strategy to the “delivery of services to all Medicaid beneficiaries.”⁷⁷

Implementing Statutory Provisions

(42 C.F.R. §438.2, 438.242, 438.818, 438.14)

This section primarily relates to encounter data. CMS defines enrollee encounter data and establishes new standards for data reporting by states and MCOs.

What is enrollee encounter data?

(CMS-2390-P, p. 31166)

In the proposed rule, CMS defines enrollee encounter data as “the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP” that is subject to the standards of Section 438.242 (an existing regulation that requires MCOs to maintain a health information system that collects and reports data on utilization, among other things) and Section 438.818 (a new section added by the proposed rule titled “Enrollee Encounter Data”).⁷⁸

⁷⁵ CMS-2390-P, p. 31146.

⁷⁶ CMS-2390-P, p. 31153.

⁷⁷ Ibid.

⁷⁸ CMS-2390-P, p. 31166.

Why is CMS proposing new standards for enrollee encounter data and what are some of the new standards?

(CMS-2390-P, pp. 31166-31167)

In the proposed rule, CMS notes that “robust, timely, and accurate data” is necessary to “ensure the highest financial and program performance, support policy analyses, and maintain ongoing improvement that enables data-driven decision making.”⁷⁹ However, it also notes that utilization data from Medicaid managed care providers frequently is “less robust” or even “nonexistent” when compared with data from Medicaid providers that are paid on a FFS basis.⁸⁰ As a result, the proposed rule would make changes to MCO contracts and to the requirements for states.

CMS proposes new enrollee encounter data standards that would be incorporated into all MCO, PIHP, and PAHP contracts. The specific standards and level of detail will be forthcoming in guidance from CMS but likely will include “enrollee and provider identifying information” and “service, claim submission, adjudication, and payment dates,” among other requirements.⁸¹

In the proposed rule, CMS establishes a new Section 438.818 and proposes that “federal matching payments would not be available to states that do not meet established data submission benchmarks for accuracy, completeness, and timeliness.”⁸² This provision was passed in Section 6402 of the ACA.⁸³ CMS released guidance in 2013 regarding timeliness and frequency of reporting encounter data.⁸⁴

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⁷⁹ Ibid.

⁸⁰ CMS-2390-P, p. 31167.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Section 6402(c)(3) of the ACA amended Section 1903(i) of the SSA.

⁸⁴ CMS, SMD# 13-004, *Re: Transformed Medicaid Statistical Information System (T-MSIS) Data*, August 2013, at <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>.

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