Medicaid and CHIP Managed Care Notice of Final Rulemaking (CMS-2390-F)

Overview of CHIP Provisions

Centers for Medicaid & CHIP Services
This final rule 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 service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) adopted key Medicaid managed care provisions for CHIP
- 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 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs
Goals of the Final Rule

This final rule advances the agency’s mission of *better care, smarter spending, and healthier people*

**Key Goals**

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs
Key Dates

• Publication of Final Rule
  – On display at the Federal Register on April 25th
  – Published in the Federal Register May 6th

• Dates of Importance
  – Effective date was July 5th
  – Provisions with implementation date as of July 5th
  – Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017
  – Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
  – Applicability dates/Relevance of some 2002 provisions
Resources

• Medicaid.gov – Landing and Managed Care Pages
  – Link to the Final Rule
  – 8 fact sheets and implementation timeframe table
  – Link to the CMS Administrator’s “Medicaid Moving Forward” blog
• ManagedCareRule@cms.hhs.gov
Principles for Change

This final rule advances the agency’s mission of better care, smarter spending, and healthier people.

Key Final Rule Principles

• Alignment with Other Insurers
• Delivery System Reform
• Payment and Accountability Improvements
• Beneficiary Protections
• Strengthen Beneficiary Experience of Care
• Modernizing Regulatory Requirements and Improving the Quality of Care
Topics for Today’s Presentation

- Background on CHIP managed care
- Alignment with Medicaid
- CHIP-specific provisions
- Provisions CHIP is not adopting
- Compliance dates
Background on CHIP Managed Care

- CHIPRA applied several Medicaid managed care provisions to CHIP
- Guidance was provided in two 2009 SHO letters (#09-008 & #09-013)
- This final rule supersedes and clarifies the guidance provided in the SHO letters and institutes additional changes to support principles of alignment and modernization
Background on CHIP Managed Care

• Scope of CHIP regulations is narrower than Medicaid, but aligns where appropriate

• Medicaid revised existing requirements that are new in some cases for CHIP
CHIP adopts the following Medicaid managed care provisions, as revised in the final rule:

- Medical loss ratio
- Information requirements
- Provider discrimination
- Indian Health Care providers and Managed Care entities
- Disenrollment
- Conflict of interest safeguards
- Continued services to enrollees
- Network adequacy standards
- Enrollee rights & protections
- Access standards
- Marketing activities
- MCO, PIHP, and PAHP standards
- Quality measurement and improvement
- External quality review
- Grievance system
- Program integrity
- Sanctions
Aligning with Medicaid: Medical Loss Ratio

• Medical Loss Ratio (MLR) is a tool used to assess the appropriateness of capitation rates
  – Sets target for the proportion of premium revenues spent on care and quality improvement

• New rules require MLR calculation and reporting:
  – Rates developed based on actuarially sound principles must be set to achieve a target MLR of at least 85%
  – State flexibility to set a standard higher than 85% and/or impose a remittance requirement

§457.1203, cross referencing to §438.8 and §438.74
Aligning with Medicaid: Information Requirements

• Standards for communication with beneficiaries:
  – Electronic communication
  – Language access
  – Handbooks and provider directories

• Final rule aligns Medicaid and CHIP with commercial market

§457.1207, cross referencing to §438.10
Aligning with Medicaid: Disenrollment

- Disenrollment standards ensure beneficiaries’ rights are maintained and administrative and medical inefficiencies are reduced.
- CHIP standards in the final rule:
  - include PCCM entities
  - clarify the start of beneficiary 90 day without cause disenrollment
  - express state option to accept oral or written disenrollment
  - specify additional cause for disenrollment
- Managed care contracts must specify reasons for and methods by which the plan can request that an individual disenroll.
- Beneficiary can disenroll within 90 days of enrollment or anytime with cause.
- Note: existing CHIP provisions require states to have an alternative plan or FFS delivery system for disenrolled beneficiaries.

§457.1212, cross referencing to §438.56
Aligning with Medicaid: Conflict of Interest

• Provides against conflicts of interest for employees or agents of the state

• Medicaid requirements not revised in final rule

§457.1214, cross-referencing to §438.58
Aligning with Medicaid: Continued Services to Enrollees

• States must develop Transition of Care Policy

• Ensure continuity of services for enrollees moving between plans or delivery systems

• Beneficiaries must have access to existing providers for a limited time

§457.1216, cross referencing to §438.62
Aligning with Medicaid: Network Adequacy

• Network adequacy standards ensure beneficiaries can access covered services
• Final rule aligns and CHIP standards with Marketplace
• States must develop and use time and distance standards for:
  • primary care (including pediatric);
  • specialty care (including pediatric);
  • OB/GYN;
  • behavioral health;
  • hospital;
  • pharmacy; and
  • pediatric dental
• Standards may vary based on geographic area served by plans

§457.1218, cross referencing §438.68
Aligning with Medicaid: Enrollee Rights and Protections

• Establishes requirements for plans to provide enrollees with treatment options and opportunity to participate in decision-making regarding their care

• Standards address:
  – Enrollee rights
  – Provider-enrollee communications
  – Marketing
  – Liability for payment
  – Emergency and post-stabilization services

§457.1220, 457.1222, 457.1226 cross referencing §§438.100, 438.102, 438.104 (except for 438.104(c)), 438.106, 438.114.
Aligning with Medicaid: Access Standards

- Access standards ensure access to timely, adequate and coordinated care
  - Availability of services
  - Assurances of adequate capacity and services
  - Coordination and continuity of care
  - Coverage and authorization of services

§457.1230 cross referencing to §§438.206, 438.207, 438.208, 438.210 (except 438.210(a)(5) and 438.210(b)(2)(iii))
Aligning with Medicaid: Structure and Operations Standards

• Structure and operations standards for MCOs, PIHPs, and PAHPS
  – Provider selection
  – Subcontractual relationships and delegation
  – Practice guidelines
  – Health Information Systems
  – Privacy protections

§457.1233 cross referencing to §§438.214, 438.230, 438.236, 438.242 and 457.1110
Aligning with Medicaid: Quality Measurement & Improvement

• Standards are important for ensuring enrollees receive quality care through collecting, reporting and using data

• Regulations require:
  – Quality strategy
  – Quality assessment and performance improvement program
  – Posting plans’ accreditation status
  – Managed care quality rating system

§457.1240, cross-referencing to §§438.330 (except 438.330(d)(4)), 438.332, 438.334, and 438.340
Aligning with Medicaid: External Quality Review

- CMS develops protocols
- Performed annually by qualified External Quality Review Organization (EQRO)
- 4 Mandatory EQR activities
  - Validations of performance improvement projects, performance measures, and network adequacy
  - Compliance review of managed care plans
- 6 Optional EQR activities
- CHIP does not adopt §438.362 or §438.360 for Medicare review

§457.1250 cross-references to §§438.350, 438.352, 438.356, 438.358, 438.360 (in part), and 438.364
• Enhanced Title XXI FMAP applies to all CHIP administrative expenses
• Ten percent limit on total CHIP administrative expenses
Aligning with Medicaid: Grievances

• Regulations provide for streamlining the appeals and grievances process

• Final rule further aligns Medicaid and CHIP with Marketplace and Medicare Advantage, where appropriate, including:
  – Common definitions
  – Appeal timeframes
  – Processes for appeals and grievances

§457.1260, cross-referencing to §§438.400 – 438.424, except for §438.420
Aligning with Medicaid: Sanctions

• Sets forth state enforcement responsibilities when violations found

• State flexibility:
  – Defining the types of sanctions that may be imposed
  – Option to also extend sanctions to PCCMs and PCCM entities (not PIHPs or PAHPs)

§457.1270, cross-referencing to §§438.700 – 438.730
Aligning with Medicaid: Program Integrity

• Defines key state responsibilities for ensuring program integrity

• Specific areas addressed:
  – Fraud committed by managed care plans
  – Fraud committed by providers

§457.955, redesignated at §457.1280
§457.1285, cross-referencing to §§438.600 – 438.610, except for §438.604(a)(2)
CHIP-Specific Provisions

• CHIP-specific standards:
  – Contracting
  – Enrollment

• Maintain principle of alignment where appropriate.
CHIP-Specific Provisions: Contracting

• States required to submit CHIP contracts to CMS for review
• Prior approval not required
• Maintains some standards from existing CHIP regulations:
  – e.g., plan attestations regarding claims and payment data
• Adopts many Medicaid requirements
  – Prohibition on enrollment discrimination
  – Parity in mental health and substance use disorder benefits

§457.1201, including many provisions in §438.3
CHIP-Specific Provisions: Enrollment

- Sets standards for states that opt to have default enrollment process
- Default enrollment process not required
- Priority for existing enrollees at renewal
- Informational notices required for potential enrollees

§457.1210
CHIP does not adopt Medicaid provisions related to:

• Rate development
  – States must develop payment rates consistent with actuarially sound principles, however specific Medicaid rate development standards do not apply

• Plan choice at enrollment

• Provisions related to dual beneficiaries or LTSS

• Prior approval of plan contracts
# CHIP Compliance Dates

States must comply with existing regulations until new provisions are implemented

<table>
<thead>
<tr>
<th>Description</th>
<th>Compliance Date</th>
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<tbody>
<tr>
<td>Withholding of FFP for failure to comply with federal requirements (§457.204)</td>
<td>July 5, 2016</td>
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<tr>
<td>All changes to part 457, including new subpart L, except as otherwise noted: §§457.10, 457.902, 457.940, 457.950, 457.955</td>
<td>No later than state fiscal year beginning on or after July 1, 2018</td>
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<td>Mandatory EQR activity of validation of network adequacy), as applied to CHIP (§438.358(b)(1)(iv), as applied to CHIP per §457.1250)</td>
<td>No later than one year from the issuance of the associated EQR protocol (or July 1, 2018, if later)</td>
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<tr>
<td>Managed care quality rating system (§457.1240(d))</td>
<td>No later than 3 years from the date of a final notice of Medicaid/CHIP QRS framework published in the Federal Register</td>
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Questions
Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations.