
Medicaid and CHIP Managed Care Notice of Proposed Rule Making (CMS 2390-F)
Strengthening Managed Care in CHIP

April 25, 2016

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP). The rule, which is the first overhaul of Medicaid and CHIP managed care regulations in more than a decade, advances the Administration's efforts to modernize the health care system to deliver better care, smarter spending, and healthier people. It supports state delivery system reform efforts, strengthens the consumer experience and key consumer protections, strengthens program integrity by improving accountability and transparency, and aligns key rules with those of other health coverage programs.

The Medicaid and CHIP managed care final rule aligns CHIP managed care standards with many of those of the Marketplace and Medicaid to ensure consistency across programs. The rule applies many of the same provisions it establishes for Medicaid managed care to CHIP in an effort to align the programs and modernize service delivery. In some cases, however, we retained key differences between Medicaid and CHIP due to differences in the statutory authorities governing the two programs, the flexibility states generally are afforded in operating a separate CHIP, and differences in program administration and populations served. Below is a summary of the areas of major provisions affecting CHIP in the final rule.

Improving Access

To strengthen access to care, the final rule sets forth requirements for states when setting and monitoring network adequacy standards in both Medicaid and CHIP managed care programs while leaving states flexibility to set the actual standards. In particular, the final rule provides that states develop and implement time and distance standards for primary and specialty care providers and assess and certify the adequacy of a managed care plan's provider network at least annually, and whenever there is a substantial change to the program design.

Enhancing Quality

The final regulation establishes a framework that provides states with tools to ensure CHIP beneficiaries receive high quality care. Largely adopting the quality framework developed for Medicaid managed care, the final rule focuses on promoting transparency, supporting states in contracting with health plans that offer higher-value care, and improving consumer and stakeholder engagement. The final rule establishes authority to develop and implement a Medicaid and CHIP managed care quality rating system (QRS), similar to the QRS that exists for the Marketplace, to enable states to better measure and manage the quality of care and to help consumers to shop for plans. Several components of the QRS will be established by CMS and states have the ability to request an approval of an alternative rating system.

Improving Care Coordination and Management

To improve health outcomes and beneficiaries' overall care experience, the final rule creates standards for care coordination, assessments, and treatment plans for CHIP managed care. Under the rule,

Medicaid and CHIP managed care plans will be required to coordinate and facilitate transition of services between settings of care, make every effort to complete an initial health risk assessment within 90 days of enrollment for all new beneficiaries, and ensure that enrollees with special health care needs receive an assessment and treatment plan that is regularly updated.

Strengthening Program Integrity

The final rule strengthens the fiscal transparency and program integrity in CHIP managed care in several ways. The final rule applies nearly all of the Medicaid managed care program integrity provisions to CHIP managed care, including the requirement that state CHIP programs screen and enroll all network providers, which will result in administrative and cost efficiencies by eliminating the need for each managed care plan to conduct duplicative screening activities as part of the credentialing process. It also expands managed care plan program integrity responsibilities by requiring that plans:

- Adopt administrative and managerial procedures to prevent, monitor, identify, and report potential fraud, waste or abuse;
- Report potential changes in an enrollee's circumstances that may impact eligibility as well as changes in circumstances that may impact that provider's participation in the plan's network; and
- Suspend payments to a network provider when the state determines a credible allegation of fraud exists.

Modernizing Communications

The final rule provides states and CHIP managed care plans multiple options to communicate with beneficiaries. Specifically, the final rule:

- Advances plans' abilities to communicate with beneficiaries by permitting states and managed care plans to use a range of electronic communication methods, including email, texts, and website posting for the dissemination of required information, while ensuring that beneficiaries are able to obtain paper materials upon request and at no cost;
- Ensures that information is accessible to individuals with limited English proficiency by providing that enrollee materials (such as provider directories, member handbooks, appeal and grievance notices, and other informational notices) include taglines in each state's prevalent languages explaining the availability of oral interpretation services or written translation if requested; and
- Makes information about providers and prescription drugs more available and accessible to all consumers by requiring that additional information be included in the provider directory (such as provider's group/site affiliation, website URL and physical accessibility for enrollees with physical disabilities) as well as certain information about the managed care plan's drug formulary.

Requiring Calculation and Reporting of Medical Loss Ratio (MLR)

Medicaid and CHIP are currently the only major health benefits programs in which an MLR standard does not apply to managed care plans, although some states have adopted their own MLR standard or similar measure of health plans' administrative expenditures and profits. An MLR measures how much a managed care plan spends on the provision of covered services compared to the total revenue it receives in capitation payments from the state. While allowing for unique features of CHIP program, the final rule establishes that CHIP managed care plans must calculate an MLR according to standards that

are similar to Medicare Advantage and the private market, and that rates must be developed in a manner to meet the target MLR. Use of a similar standard across programs and the private market will allow comparability across states, facilitate more accurate rate setting, and reduce the administrative burden on managed care plans that operate in multiple states or have multiple product lines.

The final rule is available at <https://www.federalregister.gov/>.

For more information, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>