



Medicaid and CHIP Managed Care Proposed Rule CMS-2408-P

Overview of Proposed Revisions

Center for Medicaid and CHIP Services



Facts & Figures

- NPRM Publication Date: 11/14/2018
- Public Comments Due: 01/14/2019
- Annual Burden Reduction: 120k hours & \$31M
- Link to Federal Register:
 - <https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-plan-managed-care>
- Link to Regulations.gov:
 - <https://www.regulations.gov/document?D=CMS-2018-0140-0001>

Submitting Public Comments

Comments must be submitted in one of the following two ways:

1. Electronically through <http://www.regulations.gov>
2. By Mail:

Regular Mail	Express or Overnight Mail
Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS-2408-P P.O. Box 8016 Baltimore, MD 21244-8013	Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS-2408-P Mail Stop C4-26-05 7500 Security Boulevard Baltimore, MD 21244-1850

CMS Goals for the NPRM

The NPRM is designed to achieve several key goals:

1. Promoting Flexibility
2. Strengthening Accountability
3. Maintaining and Enhancing Program Integrity

Maintaining Key Components of the Rule

CMS did not change certain key provisions of the regulation:

- **Program Integrity**

- We are maintaining the current regulatory framework for program and fiscal integrity;

- **Screening and Enrollment**

- The 21st Century Cures Act codified this provision of the 2016 managed care regulations; and

- **Medical Loss Ratio (MLR) Standards**

- We are maintaining the current regulatory framework for the MLR requirements that was included in the 2016 managed care regulations.

Length of Stay in an Institution for Mental Disease (IMD)

- Current regulation:
 - Allows federal funding for payments to managed care plans when the stay in the IMD is for no more than 15 days in the month
- What we found:
 - Legal theory that supported 2016 regulation has not changed, and CMS needs to comply with the statutory IMD payment exclusion
 - No new data sources than those that supported 15 days
 - Concern with regard to potential cost shifting to the federal government
- What we are proposing:
 - Maintain 15 day policy, while asking for public comments on additional IMD data that CMS should review
 - Continue encouraging states to apply for SUD demonstration
 - Develop new pathways for state to expand access to mental health treatment capacity

Setting Actuarially Sound Capitation Rates

- Current regulation:
 - Requires certification of a precise capitation rate per rate cell
- What we found:
 - Measured steps to allow greater flexibility are appropriate, without a wholesale return to the prior structure that put federal spending at risk
- What we are proposing:
 - Permit states to develop and certify a rate range of 5 percent within certain limitations & when both ends of range are certified as sound
 - Maintain ability to adjust rates up or down by 1.5 percent without new certification for states not utilizing the rate range option
 - Codify requirements for CMS to issue annual sub-regulatory guidance to help streamline rate review processes and to address updates or developments in the rate review process to reduce state burden and facilitate prompt actuarial reviews
 - Protect against federal cost shifting by explicitly prohibiting states from retroactively adding or modifying risk-sharing mechanisms and strengthening the regulatory requirements that any differences among capitation rates cannot link to differences in federal financial participation

Pass-Through Payments / State Directed Payments

- Current regulation:
 - Generally prohibits and phases out pass-through payments in managed care
- What we found:
 - This may have created an unintended barrier to moving populations into managed care delivery systems since supplemental payments are not prohibited in FFS
- What we are proposing:
 - Allow states newly transitioning Medicaid populations or services from FFS to managed care a three year transition period where they can require managed care plans to make pass-through payments at an amount that is less than or equal to the amount of existing supplemental (UPL) payments under fee-for-service
 - Permit directed payments that utilize a State Plan approved fee schedule to be implemented without prior approval
 - Allow multi-year approval (instead of annual approval) in certain circumstances
 - Acknowledge more types of directed payment arrangements and remove the prohibition on specifying the amount and frequency of payments
 - Other minor changes to acknowledge the complexity and variation of these state directed payment arrangements and permit states to effectively negotiate these complex payment arrangements

Network Adequacy Standards

- Current regulation:
 - Requires that states develop and enforce time and distance standards for specified provider types and defines which provider types for which states were required to establish standards
- What we found:
 - Time and distance standards did not translate well for all services and failed to adequately account for alternative access points like telemedicine
- What we propose:
 - Replace the requirement for states to establish time and distance standards with a more flexible requirement that states establish quantitative network adequacy standards
 - Clarify that states have the authority to define “specialists” in the most appropriate way for their programs
 - Continues to apply to CHIP

Appeals and Grievances

- Current regulation:
 - Requires that an enrollee must follow-up an oral appeal request with a written, signed appeal; allows a 120 calendar day timeframe for enrollees to request a state fair hearing; and requires managed care plans to send a notice to beneficiaries for every claim denial
- What we found:
 - These requirements did not align with Medicaid FFS or created unnecessary administrative burdens
- What we propose:
 - Eliminate the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted
 - Change the timeframe for enrollees to request a state fair hearing to no less than 90 calendar days and no greater than 120 calendar days to better align with Medicaid FFS requirements
 - Revise the definition of an adverse benefit determination to exclude administrative claim denials and thus eliminate the requirement for unnecessary written notices to enrollees

Requirements for Beneficiary Information

- Current regulation:
 - Includes a number of prescriptive requirements associated with the communication of beneficiary information
- What we found:
 - Many of these requirements were overly burdensome, did not account for modern communication methods, failed to align with other federal protections, and did not add value to the program
- What we propose:
 - Replace the requirement for taglines to be in 18-point font with the adoption of the “conspicuously-visible” font size standard as used by the HHS Office for Civil Rights
 - Eliminate the requirement to print taglines on all written materials and instead only require taglines on materials that are critical to obtaining services
 - Permit paper provider directories to be updated quarterly rather than monthly if the managed care plan offers a mobile-enabled provider directory
 - Provide managed care plans more flexibility by permitting notices of provider terminations to be sent by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of a termination notice

Quality Rating System (QRS)

- Current regulation:
 - Allows states to adopt the Medicaid and CHIP QRS currently being developed by CMS, or to develop an alternative QRS. Alternative QRS proposals must be approved by CMS and yield substantially comparable information on plan performance as the federal QRS.
- What we found:
 - States were faced with significant uncertainty with regard to the standards for substantial comparability and were concerned with its application given the significant variation in state program design.
- What we propose:
 - Add to the QRS framework development process a requirement for CMS to develop a minimum set of mandatory performance measures that will apply equally to the federal QRS and alternative QRS. CMS will continue to align the QRS and this minimum set with the Medicaid Scorecard initiative and other CMS managed care rating systems, as appropriate.
 - Eliminate the requirement that a state receive approval from CMS prior to implementation of an alternative QRS while maintaining CMS oversight authority.
 - Make more explicit that CMS will consult with states and other stakeholders in developing the QRS including sub-regulatory guidance on the “substantially comparable” standard for an alternative QRS.
 - Continues to apply to CHIP.

Application to CHIP

- CHIP continues to align with Medicaid when appropriate
- CHIP adopts many of the proposed revisions to 42 CFR 438, including:
 - Network adequacy standards, medical loss ratio standards, quality rating system and other quality standards, and appeals and grievances
- Additional CHIP proposals to 42 CFR 457, subpart L:
 - Technical edits where CHIP inadvertently adopted inappropriate cross-references to a Medicaid requirement
 - Edits to clarify certain requirements, including the application of managed care appeals and grievances requirements to CHIP

Questions

