

ACR Summary of Medicaid Managed Care Proposed Rule

On November 8th, 2018 the Centers for Medicare and Medicaid Services (CMS) issued the [Medicaid Program; Medicaid and Children's Health Insurance Program \(CHIP\) Managed Care](#). This proposed rule aims to increase state flexibility, enhance program integrity, and reduce administrative burden. This proposed rule comes after the 2016 Managed Care final rule that aimed to align Medicaid Managed Care with other health insurance coverage programs, strengthen the consumer experience among other consumer protection provisions. In 2016, 54.6 million beneficiaries were enrolled in Medicaid managed care plans. The number of beneficiaries enrolled in Medicaid managed care plans is expected to continue to rise. Comments on these proposals are due to CMS by January 14th, 2019.

Setting Actuarially Sound Capitation Rates

Prior to the 2016 final rule being published, CMS considered any capitation rate paid to a managed care plan that fell anywhere within the certified rate range to be actuarially sound. In the 2016 final rule, CMS required that states develop and certify as actuarially sound each individual rate paid per rate cell to each MCO, PIHP, or PAHP with enough detail to understand the specific data, assumptions, and methodologies behind that rate. To address stakeholder concerns that requirement to certify a capitation rate per rate cell, rather than to certify a rate range, has the potential to weaken states' ability to obtain the best rates when contracts are completed through competitive bidding.

CMS is proposing to allow states to develop and certify a rate range per rate cell within specified parameters. The proposed rate range option would allow states to certify a rate range per rate cell subject to specific limits and would require the submission of a rate recertification if the state determines that changes are needed within the rate range during the rate year. Under CMS' proposal, an actuary must certify the upper and lower bounds of the proposed rate range as actuarially sound.

Under this proposal, CMS would require the following parameters for the use of rate ranges:

1. the rate certification identifies and justifies the assumptions, data, and methodologies specific to both the upper and lower bounds of the rate range;
2. the upper and lower bounds of the rate range are certified as actuarially sound consistent with the requirements of part 438;
3. the upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05;
4. the rate certification documents the state's criteria for paying MCOs, PIHPs, and PAHPs at different points within the rate range;
5. and compliance with specified limits on the state's ability to pay managed care plans at different points within the rate range.

In the 2016 final rule, CMS set standards that capitation rates must meet to be approved as actuarially sound capitation rates eligible for FFP. In response to stakeholders, CMS is not changing existing regulatory standard, but is proposing that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations.

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This proposal is intended to eliminate any ambiguity in the regulation and clearly specify CMS' intent that variation in the assumptions, methodologies, and factors used to develop rates must be tied to actual cost differences and not to any differences that increase federal costs and vary with the rate of FFP. CMS is requesting public comments on these proposals and specifically asks for comments on the value of the additional state flexibility described in these proposals.

Pass Through Payments

Since implementation of the 2016 and 2017 final rules, CMS has worked with several states that have not transitioned some or all services or eligible populations from the FFS delivery system into a managed care program. Based on analysis, CMS concluded that pass-through payments are not consistent with CMS' standards for actuarially sound rates since they do not tie provider payments with the provision of services. Some states have told CMS that they would like to transition some services or eligible populations from FFS to managed care, but would like to continue to make supplemental payments to hospitals, physicians, or nursing facilities.

CMS is proposing that states may require managed care plans to make pass-through payments to network providers (hospitals, nursing facilities, or physicians) when Medicaid populations or services are initially transitioning or moving from a Medicaid FFS delivery system to a Medicaid managed care delivery system. Under this proposal CMS is requiring that the following requirements are met:

1. the services will be covered for the first time under a Medicaid managed care contract and were previously provided in a Medicaid FFS delivery system prior to the first rating period specified pass-through payment transition period;
2. the state made supplemental payments to hospitals, nursing facilities, or physicians for those specific services that will be covered for the first time under a Medicaid managed care contract during the 12-month period immediately 2 years prior to the first rating period of the pass-through payment transition period;
3. the aggregate amount of the pass-through payments that the state requires the managed care plan to make is less than or equal to the payment amounts attributed to and actually paid as FFS supplemental payments to hospitals, nursing facilities, or physicians during the 12-month period immediately 2 years prior to the first rating period of the pass-through payment transition period for each applicable provider type.

State Directed Payments

Since publication of the 2016 final rule, CMS has reviewed and approved directed payment arrangements submitted by states. CMS states that they have observed that the regulation does not explicitly address some types of potential directed payments that states have sought to implement. In the proposed rule, CMS is proposing to eliminate the prior approval requirement for payment arrangements that are based on state plan approved rates.



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Network Adequacy Standards

To provide increased state flexibility, CMS is proposing to change requirements for states to set time and distance standards. CMS is proposing to allow states to set a quantitative minimum access standard for specified health care providers and LTSS providers. CMS believes that this change would allow states to choose from a variety of quantitative network adequacy standards that meet the needs of their respective Medicaid programs in more effective ways. Additionally, CMS clarifying with this proposal that states have the authority under the final rule to define “specialist” in a way they deem most appropriate for their programs.

Quality Rating System (QRS)

In the 2016 final rule, CMS established the authority to require states to operate a Medicaid managed care quality rating system (QRS). The regulation states that CMS, in collaboration with other stakeholders, will develop a QRS framework, including the identification of performance measures and methodologies that states could adopt. CMS is proposing that they develop a minimum set of mandatory performance measures that will apply equally to the federal QRS and alternative QRS. Furthermore, CMS is proposing to eliminate the requirement that a state receive approval from CMS prior to implementation of an alternative QRS while maintaining CMS oversight authority.

Appeals and Grievances

CMS is proposing to eliminate the written and signed appeal requirement for enrollees after an oral appeal is submitted. Additionally, CMS is proposing to require enrollees to request a state fair hearing in no less than 90 calendar days and no greater than 120 days to align with Medicaid FFS requirements.