November 30, 2018

Medicaid Managed Care Proposed Rule

Summary

Internal

On Nov. 14, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that makes changes to the 2016 Medicaid managed care final rule. CMS notes that it made these changes to respond to feedback from stakeholders and specifically referred to a workgroup of state Medicaid directors. Although many expected a larger overhaul of the rule, this proposed rule makes smaller scale changes to give states a bit more flexibility in the areas of rate setting, pass through payments, information requirements and network adequacy. Some of the proposed changes apply only to managed care under Medicaid, while others also apply to managed care under the Children's Health Insurance Program (CHIP). The following summary highlights those changes most likely to be of interest to children's hospitals.

Children's hospital feedback on these proposed revisions rule should be sent to Aimee Ossman by COB, Dec. 14. CHA will incorporate that feedback into a draft comment letter, which it will share with hospitals on Dec. 21. Comments are due to CMS by COB Jan. 14. Please contact Aimee Ossman if you have any questions on the proposed rule.

Issue	Key Proposed Provision Changes	Hospital Feedback
Medicaid Managed Care - Actuarial Soundness §438.4	• Provides an option for states to develop and certify a rate range per rate cell within specified parameters, rather than certifying a capitation per rate cell. Specified parameters include: o Rate certification identifies and justifies the assumptions, data and methodologies specific to the upper and lower bounds of the rate range. o Upper and lower bounds of the rate range are certified as actuarially sound consistent with other requirements of the rule. o The upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05. o The rate certification documents the state's criteria for paying health plans at different points within the rate range. o The state cannot use as criterion for paying managed care plans at different points within the rate range based on the willingness or the	

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	amount of funding the managed care plans or network providers enter into/provide through Intergovernmental Transfers agreements. • States choosing to certify a rate range would also need to get approval from CMS of their capitation rates prior to the rating period and not modify these rates unless the state provides a revised rate certification to CMS. • Clarifies 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 federal financial participation (FFP) and requires an evaluation of the entire managed care program that includes all managed care contracts for all covered populations. o Would not allow use of higher contractually obligated fee schedules and/or minimum levels of provider reimbursement that exceeds those same reimbursements for a covered population or a contract with the lowest average FFP.	
Medicaid Managed Care - Special Contract Provisions Related to Payment §438.6	**Supplemental/Pass Through Payments:** States may require Medicaid managed care plans to make pass through payments to network providers (hospitals, nursing facilities or physicians) for each rating period up to 3 years, when Medicaid populations or services are initially transitioning from fee-for-service (FFS) to managed care. • Option only available to states: o Covering these populations/services for the first time under managed care. o That ensure payments are not more than the supplemental payments paid under FFS for these populations/services. All other provisions related to supplemental payments provided through Medicaid managed care plans would remain the same as in previous rule, including phase-out requirements.	

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	Risk-sharing Mechanisms: Requires any risk-sharing mechanisms (reinsurance, risk corridors, stop-loss limits, etc.) to be documented in the state's contract and rate certification submissions. States are not allowed to modify or add retrospectively new mechanisms. **Directed Payments**: Allows two new directed payments by states to managed care in addition to those allowed under the 2016 final rule. States may: • Require plans to pay at least the FFS rates in the state plan, excluding supplemental payments, without seeking approval from CMS. • Require plans to adopt a cost-based, Medicare-equivalent, commercial payer-equivalent, or other market-based rate.	
Rate certification submission §438.7	CMS would annually release guidance that describes: • Federal standards for capitation rate development. • Documentation required to determine that capitation rates are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of the contract. • Documentation required to determine that capitation rates have been developed in accordance with the regulation. • Any updates or developments in the rate review process to reduce state burden and facilitate prompt actuarial reviews. • Documentation necessary to demonstrate that capitation rates competitively bid through a procurement process have been established consistently with regulatory requirements. According to CMS, this provision codifies its current practice to show commitment to efficient review and approval process.	
Information Requirements: Language and Format §438.10(d)	CMS proposes to replace the final rule tagline requirements with more limited requirements. Specifically, the proposed rule: • Requires taglines only on materials for potential enrollees that "are critical to obtaining services," rather than on "all written materials."	

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CHIP **§457.1207**	• Replaces the final rule's definition of "large print" as "no smaller than 18-point" with a "conspicuously visible" standard for taglines. Under the proposed rule, taglines are required to be large print when they explain the availability of written translation or oral interpretation, how to request auxiliary aids and services for individuals who have limited English proficiency or a disability, and the toll-free phone number of the entity providing choice counseling services.	
Network Adequacy Standards **§438.68** **CHIP** **§457.1218**	CMS proposes to replace the final rule's requirement that states develop time and distance standards for specific adult and pediatric specialists and long-term services and supports (LTSS) providers with a more flexible quantitative standard. Specifically, states would be: • Required to develop quantitative network adequacy standards for adult and pediatric specialists and LTSS providers. Standards could include, but are not limited to time or distance, percentage of providers accepting new patients, office hours, or provider/enrollee ratios • Allowed to determine which adult and pediatric specialists for which it will set network adequacy standards. CMS encourages, but does not require, states to adopt multiple quantitative standards for each provider type and to solicit stakeholder input in the development of their network adequacy standards.	
Enrollee Encounter Data **§438.242** **CHIP** **§457.1233**	• Maintains the final rule's requirement that states collect and validate encounter data from plans (Medicaid and CHIP) and provide this data to CMS. • Clarifies that the required data that states must submit includes "allowed amount and paid amounts" of claims.	
Medicaid managed care - Quality ratings system **§438.334**	• Revises current requirements for states that are developing their own Quality Rating System (QRS) to give them additional flexibility. Specifically: o An alternative state QRS must generate ratings which are "substantially comparable to the federal QRS to the extent feasible, taking into account	

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CHIP **§457.1240**	such factors as differences in covered populations, benefits, and stage of delivery system transformation." o CMS will work with states and other stakeholders to develop sub-regulatory guidance on the meaning of "substantially comparable" and how a state would demonstrate it meets this standard. • Proposes to include mandatory performance measures in the QRS, which states must adopt in their own QRS. o The federal QRS framework would align, to the extent possible, with the Qualified Health Plan QRS and the Medicare Advantage Star Rating System. o CMS also plans to align the Medicaid/CHIP scorecard initiative with performance measures included in QRS framework. o CMS plans to release the framework with a public comment period. o States would not need CMS pre-approval of their QRS framework, but would be required to make certain information available to CMS upon request.	
Exemption from external quality review (EQR) **§438.362**	Requires states to post on their website which health plans are exempt from EQR and for what time period.	
Handling of grievances and appeals **§438.402 and 438.406** **CHIP** **§457.1260**	Eliminates the requirement that enrollees submit a written signed appeal after an oral appeal is submitted.	
CHIP **Part 457**	Makes technical and clarifying changes to CHIP, which primarily address issues related to the application of rules governing Medicaid managed care in the areas of information requirements, quality measurement and improvement and grievance system and sanctions.	