

Issue brief: Medicaid managed care final rule

Overview

In the past decade, the Medicaid managed care landscape has changed considerably in terms of the number of beneficiaries enrolled in managed care and the scope of services provided by managed care organizations (MCOs). To date, 38 states and the District of Columbia use risk-based, comprehensive managed care to manage the delivery of health care services to Medicaid beneficiaries. Nationally, about 70 percent of Medicaid beneficiaries – 45.9 million people – receive care through MCOs. States continue to expand their reliance on MCOs and, for that reason, capitated payments to MCOs represent the fastest growing share of Medicaid spending.

On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued its [final rule](#) on managed care in the Medicaid program, the first major update to the federal program requirements in almost 15 years. The regulations run the gamut of managed care issues, covering oversight, operation, contracting and payment to Medicaid MCOs. CMS explains that four overall goals guide the approach taken in the updated regulations:

- Support state efforts to advance delivery system reform and improve the quality of care;
- Strengthen the beneficiary experience of care and key beneficiary protections;
- Strengthen program integrity by improving accountability and transparency; and
- Align key Medicaid and CHIP managed care requirements with other health coverage programs.

The final rule will directly impact state Medicaid departments and MCOs and, given the increasingly prominent role played by MCOs in Medicaid, will have downstream impact on nearly all physicians who treat Medicaid patients. The final rule is likely to prompt significant changes to the Medicaid realm, and physicians should look for opportunities to work with their state Medicaid agency and legislatures to determine how best to implement the new federal requirements.

Below is a summary of major provisions and issues of importance to physicians. This summary does not include provisions specific to long-term services and supports (LTSS) or the Children's Health Insurance Program (CHIP).

Contract requirements

As in the proposed rule, the final rule sets new minimum requirements for contracts between states and MCOs. Contracts must be approved by CMS, but CMS did not finalize a proposed enforcement mechanism that would have given the agency the authority to withhold a portion of federal matching funds if a state fails to meet particular contract requirements.

Actuarial soundness and rate development

States must pay MCOs capitation rates that are actuarially sound for the services included in the contract and the populations served. Capitation rates must be adequate to meet the network adequacy, access and care coordination requirements for the plan. Rates must be based only on services covered by the state plan and

services necessary to comply with federal mental health parity requirements. The final rule establishes a process for certifying actuarial soundness and requires that rates be reviewed and approved by CMS.

Under the prior rules, states could modify the exact amount of capitation payments paid within certified rate ranges without needing additional approval from CMS. The rule bars that practice. Going forward, rates must certify the final rate paid to each plan, but may modify payments by 1.5 percent without submitting a new certification to CMS. The rule also bars cross-subsidization across rate cells.

Contracts must describe, when applicable, all risk-sharing and incentive arrangements. Incentive payments remain, as under current law, capped at 105 percent of the approved capitation amount and must be conditioned on specific activities, metrics, or outcomes that support initiatives under the state's quality strategy. Withhold arrangements must be actuarially sound taking into consideration the MCO's operating needs and capital reserve requirements.

Medical loss ratio

As was proposed, the final rule requires plans to calculate and report their medical loss ratio (MLR) and requires states to develop capitation rates in such a way that MCOs can reasonably achieve a MLR of at least 85 percent for the rate year.

In the preamble, CMS explains that the obligation falls to the state to comply with the MLR provisions as the agency does not believe it has the statutory authority to subject MCOs to a mandatory minimum MLR. Plans that do not meet the 85 percent MLR will have their capitation rates adjusted for future contract years, but the rule does not otherwise provide an enforcement mechanism. States have the option to require MCOs to provide remittance if the MLR is not achieved and/or set their own minimum MLR requirements at or above 85 percent.

The MLR is calculated as the ratio of the expenditures the Medicaid managed care plan makes or incurs for claims, health care quality activities to the adjusted premium revenue the plan receives. The Medicaid MLR calculation differs from marketplace MLR requirements in that the numerator may include the cost of external quality review and plans may subtract regulatory fees and taxes from the denominator. CMS did not finalize a proposal to allow plans to include in the MLR numerator expenses related to fraud prevention, which is consistent with MLR requirements on private plans.

Provider payment

The final rule codifies previous CMS guidance limiting the authority of states to direct how MCOs pay providers. Under the final rule, states may only direct payment under four circumstances: to implement value-based purchasing models, to support delivery system reform or quality improvement initiatives, to adopt a minimum or maximum fee schedule, or to require a certain dollar or percentage increase. "Pass-through" payments to hospitals, physicians and nursing facilities are to be phased out over the next 5 to 10 years.

Incentive arrangements with providers must be specific with respect to time and performance, cannot be renewed automatically and must be available to public and private contractors. CMS declined to require plans to submit additional information about physician payment rates during the rate setting process.

Network adequacy

For the first time, all states with managed care programs will have to develop and implement time and distance standards for primary care services (adult and pediatric), specialty care services (adult and pediatric), behavioral health services (adult and pediatric), obstetrical and gynecology services, hospital services, pharmacies and pediatric dental services. States may vary standards by geographic area within the state. The final rule does not require any other network adequacy standards, such as provider-to-patient ratios and appointment wait times, though states may elect to develop additional network adequacy standards.

At a minimum, state must consider the following when developing network adequacy standards:

- Anticipated Medicaid enrollment and expected utilization of services;
- Characteristics and health care needs of covered populations;
- Number and types of providers required;
- Number of providers who have closed panels;
- Geographic location of providers and enrollees, considering distance, travel time and the means of transportation used;
- Ability of providers to communicate with limited English proficient enrollees in their preferred language;
- Ability of providers to ensure physical access, reasonable accommodations, culturally competent communication and accessible equipment for enrollees with physical or mental disabilities; and
- Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits and/or other evolving and innovative technological solutions.

CMS does not define how use of telemedicine and other innovative technology may be applied with relation to network adequacy.

MCOs must maintain written agreements with their network providers and plan contracts must ensure networks are sufficient in scope to deliver all contracted services, with timely coverage of out-of-network care “if the provider network is unable to provide necessary services.” States must also publish network adequacy standards on the state’s website.

Under the previous regulations, MCOs were required to submit documentation to the state to demonstrate network adequacy and states were required to provide assurances to CMS that the contracts provide an adequate network. The final rule adds that the submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO related to its provider network. Additionally, The External Quality Review Organization (EQRO) will be required to validate managed care plan network adequacy during the preceding 12 months for compliance. However, the final rule provides states the option to seek an exemption for certain provider types, subject to approval by CMS and ongoing access monitoring.

Provider discrimination

The final rule specifies that MCOs may not discriminate against a provider for purposes of a provider’s participation, reimbursement, or indemnification of any provider acting within the scope of his or her license or certification under state law on the basis of race, color, national origin, disability, age, or sex. The preamble to the final rule explains that MCOs must comply with anti-discrimination provisions in Title VI, Title IX, the Age Discrimination Act, the Rehabilitation Act, the Americans with Disabilities Act and section 1557 of the Affordable Care Act (ACA). MCOs must also not discriminate against providers who serve high-risk populations or provide high-cost treatments.

Benefits

MCO contracts must identify each covered service and specify the amount, scope and duration of contractual coverage. Each contract must specify the extent to which the plan is responsible for covering services that address:

- The prevention, diagnosis and treatment of an enrollee’s disease, condition and /or disorder that results in health impairments and disability;
- The ability for an individual to achieve age-appropriate growth and development;
- The ability for an enrollee to attain, maintain and retain functional capacity; and
- The opportunity for an enrollee receiving LTSS to have access to the benefits in the setting of their choice.

To the extent that MCO contracts cover outpatient drugs, MCOs may develop and use their own formularies, but must cover any drug deemed medically necessary after a prior authorization review even if it is not on the formulary. MCOs must also report drug utilization data that is necessary for states to bill manufacturers under the Prescription Drug Rebate Program.

Services Offered ‘In Lieu Of’

The final rule expands the ability of MCOs to offer alternative services from those covered under the state plan. States may contract with MCOs to provide services “that are in lieu of services or settings covered under the State plan” so long as the services are medically appropriate and cost-effective substitute. “In lieu of” services must be identified in the contract, calculated into the capitation rate and voluntary for members.

Under the prior regulations, federal funding was not available for services provided to beneficiaries ages 21 to 64 in an institution for mental disease (IMD). CMS finalized its proposal to permit payment to IMDs in lieu of other covered services under certain conditions: the enrollee must not stay in the IMD for more than 15 days during the capitation period and the IMD must meet provider participation standards.

Care coordination

MCOs must make a “best effort” to conduct a health screening of enrollees within the first 90 days of enrollment. MCOs must also ensure that each provider maintains and shares, as appropriate, enrollee health records in accordance with professional standards.

The final rule requires states to have a transition of care policy to ensure continued services during a beneficiary’s transition from fee-for-service (FFS) to managed care and between managed care plans when, in absence of continued services, the beneficiary would suffer serious determinant to health or be at risk of hospitalization. New enrollees must be permitted to retain their current provider for a period of time even if the provider is out of network.

Enrollee experience and protection

Information requirements

The final rule requires states and MCOs to make a wide variety of information available to beneficiaries before and after enrolling in a plan. Information must be made accessible in terms of language and disability.

States must provide online access to plans' handbook, provider directory and formulary, though the rules allow the state to link to the MCO's website rather than provide the information in full on the state website. Provider directories must be in a machine readable format and MCOs must update online directories within 30 calendar days after the plan receives updated provider information. Paper directories must be updated monthly.

MCOs must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

States must also provide a beneficiary support system to supply support counseling, assistance with navigating the managed care system and facilitate enrollment. Choice counseling is to be unbiased and cannot be provided by an entity with a financial interest in the enrollee's choice.

Enrollment and dis-enrollment

The final rule allows states to use passive enrollment, meaning beneficiaries may be assigned to plans by the state. States must, however, provide a period of time for the beneficiary to make an active choice to select a different plan. During passive enrollment, beneficiaries will receive information about enrollees' choices and information about how to dis-enroll from a plan, with cause or without. Default enrollment is also permissible when a beneficiary does not choose a plan.

Passive enrollment and default enrollment must preserve existing provider-beneficiary relationships and relationships with providers that have traditionally serviced Medicaid beneficiaries to the extent possible, but the rule does not specifically define how this requirement is to be met. Passive enrollment should take into consideration family preference, previous plan assignment, quality performance, procurement evaluation elements, accessibility for people with disabilities and other reasonable criteria.

In the proposed rule, CMS proposed a 14-day choice period between when a beneficiary is deemed eligible for Medicaid and when that beneficiary chooses a managed care plan. During that time, the state would have provided Medicaid services on a FFS basis. CMS dropped the proposal in the final rule, but left states the option to offer an initial choice period.

MCOs may dis-enroll beneficiaries, but not because of changes in enrollee health status, use of services, diminished mental capacity, or uncooperative or disruptive behavior related to special needs. Enrollees may choose to dis-enroll if they move out of the plan's service area, need services not covered by the plan's network (the regulation gives the example of a caesarean section coupled with a tubal ligation), or because the plan excludes covered services on moral or religious grounds.

Non-discrimination against beneficiaries

The final rule prohibits MCOs from discriminating for enrollment purposes against beneficiaries on the basis of race, color, national origin, sex, sexual orientation, gender identity and disability. The non-discrimination rules extend to any policy or practice that has the effect of discrimination. These provisions align with the non-discrimination provisions contained in the ACA.

Coverage authorizations

The final rule shortens the timeframe during which plans must make coverage determinations: 14 days for standard coverage determinations and 72 hours when an expedited determination is needed. The rule

specifies that practice guidelines must be based on valid and reliable clinical evidence or consensus among specialty providers, be adopted in consultation with network providers and reviewed and updated periodically.

Grievances and appeals

In the final rule, CMS aims to align grievances and appeals processes with those in Medicare and exchange plans.

The definition of an adverse benefit determination is expanded to include determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit. Appeals are also permitted for disputes over cost-sharing; however, CMS did not elect to allow an appeal of an MCO's denial of choice of provider or out-of-plan service requests except for enrollees in rural areas with only one MCO option.

Enrollees must exhaust internal MCO appeals before appealing to a state fair hearing. Importantly, however, the rule limits MCOs to only one level of internal appeal. If the MCO fails to take action within the timelines prescribed in the rule, the enrollee will be deemed to have exhausted internal appeals and may proceed to a state fair hearing. States may elect to offer enrollees an independent external review, but the external review may not extend timelines for the appeal process which requires MCOs to resolve standard appeals within 30 days and expedited appeals within 72 hours and gives enrollees 120 days to appeal an adverse determination to a state fair hearing.

An enrollee request for the continuation of benefits must be submitted before the expiration of the original authorization, but benefits must continue for the duration of the appeal. This is a departure from the prior rules which allowed plans to discontinue benefits after the original authorization period. However, enrollees may be held financially liable to continued benefits if the final appeal decision is adverse to the enrollee. Policies for financial responsibility must be consistent between the FFS and managed care delivery systems within the state.

Providers may only pursue an appeal on the behalf of an enrollee with the enrollee's consent and only when state law permits the provider to act as the enrollee's representative.

State monitoring and oversight

States are required to develop and establish a monitoring system for all managed care programs that addresses at least the following:

- Administration and management;
- Appeals and grievances;
- Enrollee materials, marketing and customer services;
- Finance, including the MLR;
- Medical management and claims processing
- Information systems, including encounter data reporting;
- Program integrity;
- Provider network management, including provider directory standards;
- Availability and accessibility of services, including network adequacy; and
- Quality.

States must assess the readiness of each managed care plan prior to the implementation of a new managed care program, when a plan has not previously contracted with the state and when a plan contracting with the state will cover new populations. The readiness review will include on-site review and must be started at least 90 days prior to the effective date of the triggering event.

States must submit an annual program report on each managed care program 180 days after each contract year. The program report must be posted online and provided to the state medical care advisory committee and a LTSS stakeholder consultation group.

Quality review

The final rule requires states to develop and implement a managed care quality strategy to assess and improve the quality of care provided by MCOs. The quality strategy must include, among many other things, a plan to identify, evaluate and reduce health disparities, mechanisms to identify beneficiaries in need of LTSS or who have special healthcare needs and validation of network adequacy. MCOs will continue to be subject to review by an EQRO. States will post several items on the state's website including the state's quality strategy, performance measures, progress and the results of EQRO reviews. The rule does not require states to accredit plans or develop an accreditation process, but states must post plan accreditation information on the website.

The final rule introduces a quality rating system (QRS) to Medicaid which is intended to align with Marketplace systems. CMS intends to develop the QRS system over the next five years by issuing a proposed methodology and seeking stakeholder input prior to developing the specific requirements for a state QRS.

Program integrity

The final rule increases the program integrity requirements and compliance standards on states and MCOs to prevent waste, fraud and abuse. Among the numerous new requirements, states must address the treatment of provider overpayments in their contracts with MCOs. States will also have to post on the state website the managed care plan contracts, audit results and information about the availability of services and network adequacy. Additionally, states may, but are not required to, impose sanctions against non-compliant MCOs for:

- Failing to substantially provide medically necessary services required under its contract;
- Imposing excessive cost-sharing on enrollees not permitted under the program;
- Discriminating against enrollees based on health status or wrongful disenrollment;
- Misrepresenting information to a current or potential enrollee or a provider;
- Failing to comply with incentive plan requirements; or
- Distributing false or misleading marketing materials.

Provider enrollment

In the final rule, CMS finalized its proposal to require all MCO network providers to be independently screened and enrolled by the state Medicaid agency using the same standards as the FFS screening and enrollment process. Previously, some states required only that the MCO screen network providers. The move puts the responsibility on the state for screening and enrolling all Medicaid-participating providers, regardless of the delivery system through which they see Medicaid patients. However, CMS has stated that states may delegate the responsibility to MCOs. The final rule also establishes a 120 day grace period during

which time providers may participate in the MCOs network while the state completes the provider's screening and enrollment process. Network providers will not be required to participate in FFS.

Subcontractors and network providers

The final rule clarifies that providers are not to be considered subcontractors – which are subject to broader compliance obligations – merely by joining the plan's network, though a network provider may become a subcontractor if he or she contracts with the MCO to perform the MCO's obligations, such as accepting risk for or managing utilization of enrollees.

With regard to network providers, the final rule requires MCOs to have a process in place to notify the state of changes to a provider's eligibility to participate in the Medicaid program, verify provider utilization and suspend payment to providers for which there is a credible allegation of fraud. MCOs must also have a mechanism for providers to report and return overpayment within 60 calendar days.

For additional information about the final rule and state implementation of the final rule, please contact Annalia Michelman, senior legislative attorney, Advocacy Resource Center, at annalia.michelman@ama-assn.org or (312) 464-4788.