What Are The Major Provision Of The 2016 CMS Medicaid Managed Care Final Rule?
What Is The Medicaid & CHIP Managed Care Final Rule?

On April 25, 2016, the federal Centers for Medicare & Medicaid Services (CMS) released the final rules for Medicaid managed care plans – Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability: RIN 0938-AS25: 42 CFR Parts 431, 433, 438, 440, 457 and 495. The rules, which were originally released in May 2015 for public comment, are a comprehensive update of the standards and provisions that govern Medicaid and CHIP managed care plans. The last time CMS updated the Medicaid managed care rules was in 2002 – more than a decade ago.

The rules apply to all at-risk managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory plans (PAHPs). PIHPs and PAHPs are at-risk health plans that provide a limited range of benefits, such as a behavioral health organization (BHO) or dental plan. Primary care case management (PCCM) programs are included in some of the final rule’s regulations, but not all.

The final rule is a comprehensive update of all Medicaid managed care provisions, including state plan services, definitions, grievances and appeals, federal financial participation, network standards, beneficiary protections, etc. This does not mean, however, that CMS has made changes to every section included in the rule – it only means that all sections of the rule have been reviewed.

CMS released these new rules due to the large changes that have occurred in Medicaid over the last decade. The rule states that in 1992 about 8%, or 2.4 million beneficiaries, were enrolled in Medicaid managed care. In 2013, 73.5%, or 45.9 million beneficiaries, were enrolled in Medicaid managed care. Additionally, the agency cites the increased use of managed long-term services and supports (MLTSS) as a reason for the rule. Finally, the rules work to align Medicaid managed care with private health plans and Medicare Advantage plans. Key provisions of the final rule include:

1. The partial end of IMD exclusion
2. The minimum mandatory medical loss ratio
3. The Medicaid quality rating system
4. MLTSS provisions
5. Network adequacy standards

CMS has granted some flexibility to states in how these provisions are implemented – more with some provisions than others. CMS also plans to issue additional guidance on some of the provisions at a later date.
Does The Rule Repeal IMD Exclusion?

Under current regulations, state Medicaid programs may not provide services to adults age 21-64 who receive services in an institution for mental disease, commonly known as the IMD exclusion. An IMD is a facility with more than 16 beds in which more than half of beds are occupied by individuals diagnosed with a mental disease and receiving care for that disease. A mental disease includes both mental impairments and substance use disorders. IMD is not a facility type and therefore depending on the state an IMD can be a free-standing psychiatric hospital, substance abuse treatment facility, assisted living facility, or nursing home.\(^1\)

Under the new rule, CMS has partially repealed IMD exclusion for managed care enrollees. MCOs can receive still the capitated rate for an adult age 21-64 who receives services in an IMD, if their stay is 15 days or less. IMD services will be covered as an in lieu of service and therefore comes with a specific set of regulations.

What are in lieu of service?

In lieu of services are cost-effective and medically appropriate alternate services or services in an alternative setting to services in the Medicaid state plan. In order for MCOs to provide in lieu of services, such as IMD services, the state must first list it as a possible in lieu of service in its state plan and the MCO must include the in lieu of service in their managed care contract with the state.\(^2\) Even if the in lieu of services are included in the MCO’s contract, the MCO may choose whether or not to offer the in lieu of services to specific enrollees and the enrollee has the right to refuse in lieu of services with no penalty.\(^3\)

Why are stays limited to 15 days?

Stays in the IMD are limited to 15 days a month because CMS does not have the authority to completely repeal the IMD exclusion rule (it would require action from Congress). 15 days was chosen because the average length of stay in an IMD, under the Medicaid Emergency Psychiatric Demonstration was 8.2 days and a scan of Medicaid claims data from 2013 found that 90% of mental health inpatient stays were 15 days or shorter and 90% of substance abuse stays were 10 days or shorter.\(^4\) In response to opposition to the fifteen day limit, CMS states that if more than 15 days of care are needed, an IMD is probably not a medically appropriate treatment.\(^5\)

How do I know which facilities are IMDs?

CMS acknowledges that determining whether a facility qualifies as an IMD is not always apparent. Additionally, they acknowledge that states have different definitions and regulations for facilities that may qualify as IMDs, such as sub-acute facilities and crisis residential centers. To help clarify the confusion over what facilities qualify as IMDs, CMS may release sub-regulatory guidelines.\(^6\)
What Is The Minimum Mandatory Medical Loss Ratio?

The new rule sets a minimum medical loss ratio (MLR) of 85% for all at-risk Medicaid managed care plans. Managed care plans will be required to calculate, report, and use the MLR to determine actuarially sound capitation rates. The minimum MLR aligns with Medicare Advantage plans and large group employer plans in the commercial marketplace. The purpose of the MLR is to ensure that actuarially sound capitation rates are in place and that Medicaid dollars are being used in a fiscally responsible way.

Will managed care plans be penalized if they do not meet the MLR?

States are encouraged by CMS to collect remittances from managed care plans that do not meet the MLR, but are not required to do so. The final rule provides no guidance on appropriate remittances or how the remittances must be calculated. If the state collects remittances, the federal government must receive their portion of the remittances.

Is there a maximum MLR?

The final rule does not implement a maximum MLR and states have the ability to set the MLR at higher than 85% at their discretion.

How will the MLR be calculated?

The calculation of the MLR is the sum of the managed care plans incurred claims, expenditures on activities that improve health care quality, and other specified activities divided by the adjusted premium revenue collected. Due to the nature of the populations served by Medicaid, service coordination, case management, and community integration of individuals with complex needs are considered activities that improve health care quality. The denominator is the adjusted premium revenue collected including the credibility adjustment, which takes into account the managed care plan’s enrollment.

The state may choose to have managed care plans calculate a separate MLR for each population covered or the state may choose to have the managed care plan calculate an aggregate MLR. Additionally, states may choose to exempt new managed care plans from MLR reporting during the first year of their operation in the state. The MLR will be calculated for a 12 month period and must be reported within 12 months of the end of the period. CMS has chosen to allow states to select the timeframe for the 12-month period because not all managed care contracts operate on a calendar year schedule.
When does the minimum MLR go into effect?

The minimum MLR rules goes into effect nationwide for contracts that begin after July 1, 2017. When managed care plans begin tracking the MLR will be dependent upon when their contract is renewed by the state. In accordance with the rule that MLRs must be reported within 12 months, the first publically available reports on Medicaid MLRs will be 2018.
What Is The Medicaid Quality Rating System?

The final rule creates a Medicaid managed care quality rating system (MMC QRS) in order to increase transparency about managed care performance and help Medicaid beneficiaries select a managed care plan. The rating system will use the same framework as the health insurance marketplace, which rates plans on three categories: clinical quality management, member experience, and plan efficiency, management, and affordability. The individual measures will differ with in each category will be tailored towards Medicaid and may differ from the marketplace. States will be required to update managed care plan ratings annually and publish the results of the ratings prominently online.

Will all states implement the same quality rating system?

After consideration of stakeholder comments, CMS will allow states to implement an alternative quality rating system. However, the alternative rating system must be comparable to the national rating system. Additionally, the alternative rating system will require approval by CMS.¹⁴

What measures are included in the quality rating system and how will ratings be calculated?

At this time CMS has not developed the quality rating system. The individual measures and methodology for calculating plan ratings will be developed through an extensive process involving stakeholders. The proposed measures and methodology will be released as a federal register notice with an opportunity for comments.¹⁵

When will the rating system be implemented?

CMS expects to release guidance about the quality rating system in 2018 and states would then have three years to implement the rating system.¹⁶
What Are The Provision Related To MLTSS?

The final rule addresses managed long-term service and support (MLTSS) programs through the 2013 CMS framework that laid out principles for state operation of MLTSS programs. The ten provisions in the framework include:

1. Adequate Planning
2. Stakeholder Engagement
3. Enhanced Provision of Home and Community-Based Services
4. Alignment of Payment Structures and Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive, Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

For specific guidance about each of the ten principles see CMCS Informational Bulletin Long-Term Services & Supports Delivered Through Medicaid Managed Care Programs Guidance.

Does the ruling provide a specific definition for MLTSS services?

The final rule does not provide a definition of the specific services covered, but it does provide a definition for the scope of services that MLTSS programs must cover. According to the final rule, “long term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual’s home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.” Note that this rule only applies to MLTSS programs in section CFR 42 438 and does not apply to other section of CFR 42.

What protections are afforded to Medicaid MLTSS enrollees?

A Medicaid beneficiary must be allowed to disenroll from their MCO if their residential, institutional or employment support provider is terminated from the provider network and the termination results in a disruption in residency or employment. The state may require the beneficiary to enroll in a different MCO or receive services through the FFS delivery system.
The ruling also states that the state must implement a managed LTSS stakeholder group, MCOs must include a representative portion of LTSS enrollees on their member advisory board, and that beneficiaries must be provided with information on all covered benefits and a provider directory.\textsuperscript{19}

**What provisions effect LTSS providers?**

The final rule requires that the state credential and re-credential all LTSS providers regardless of the types of services they provide. States set their own credentials per provider type and credentials can vary to be appropriate for each provider type.\textsuperscript{20} The rule also explicitly states that states must ensure adequate managed LTSS networks, however states are given broad flexibility in how to define network adequacy.
What Standards For Network Adequacy Are Set By The Final Rule?

In the final rule, CMS declined to set specific network adequacy standards and instead has given states the flexibility to set their own standards. State standards should be consistent with other state Medicaid program and private market standards. The rule specifies that separate network standards must be set for:

1. Primary care (adult and pediatric)
2. OB/GYN
3. Behavioral health (adult and pediatric)
4. Specialist (adult and pediatric)
5. Hospital
6. Pharmacy
7. Pediatric dental

States may set additional network adequacy standards for provider types not included in the above list. The state’s minimum network adequacy standards must be posted online and accessible to all individuals.

What are the specific provisions that states must consider when setting their standards?

CMS sets broad standards for states to consider when setting network adequacy including:

1. Anticipated Medicaid enrollment
2. Expected utilization of services taking into account the characteristics and health needs of the covered population
3. Number and types of health care professionals needed to provide covered services
4. Number of network providers that are not accepting new Medicaid patients;
5. Geographic location and accessibility of the providers and enrollees
6. Telehealth, e-visits, triage lines, and other available technological advances in providing health care services

States are expected to use time and distance measurements to provider organizations as the first measurement of network adequacy. Provider to enrollee ratios and other measurements of network adequacy may be used as secondary measures. Additionally, states may vary network standards based on different geographic areas in the state.
When do network adequacy standards go into effect?
States must establish network adequacy standards before the rating period for Medicaid managed care contracts starting on or after July 1, 2018. A rating period is "a period of 12 months selected by the atate for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS." This means that network adequacy standards will be made available later in some states than others, depending on the state’s managed care contracting timeline.
Sources


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OPEN MINDS | Market Intelligence Report | May 2016


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