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VNAA Summary:
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability
Proposed Rule

On Monday, June 1, 2015, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that would update the federal regulations governing state contracting with managed care entities for purposes of delivering services through the Medicaid and Children's Health Insurance Programs. This proposed rule is the first in more than a decade updating the standards states must follow when negotiating with managed care entities, including commercial managed care organizations, pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs), and primary care case management entities. While the rule would largely align standards across the Medicaid and CHIP programs, where they deviate we focus our summary on the Medicaid program.

In many respects, the rule would codify policies that CMS has implemented in states already using managed care via its oversight vehicles, e.g., the Special Terms and Conditions (STCs) of Section 1115 waivers. Below we provide an overview of rule's major provisions. In the following section, we provide additional detail on those provisions that may impact home-based care providers. For purposes of this rule, home health and other services provided in the home are considered "long term services and supports" or "LTSS." Hospice services, not a mandatory Medicaid benefit, are generally not considered LTSS but this may vary by state.

Selected Major Provisions of the Proposed Rule

CMS proposes that states:

1. Establish a minimum loss ratio (MLR) of no less than 85%, consistent with marketplace and Medicare Advantage plans;
2. Submit sufficient information to CMS to replicate the calculation of MCO rates to certify that the rates are actuarially sound;
3. Establish minimum network adequacy standards, including standards designed for LTSS services provided in the home;
4. Implement robust beneficiary protections, including a 14-day period during which beneficiaries will be served through traditional fee-for-service Medicaid while selecting a managed care plan and the

implementation of beneficiary support services, such as counseling on how to choose among managed care plans;
5. Provide beneficiaries with a minimum amount of information to assist them in selecting a plan, using their benefits, and resolving any issues that arise;
6. Streamline enrollment processes for beneficiaries;
7. Have the option to require that plans engage in value-based purchasing initiatives with providers and/or participate in other delivery system and payment reform initiatives, such as multi-payer initiatives;
8. Incorporate standards specific to LTSS throughout the regulations to ensure appropriate access to the full range of LTSS services;
9. Establish robust oversight policies and procedures, including screening and enrollment of providers, independent audits of plan encounter and financial data, and public posting of contracts and plan performance data;
10. Establish a quality strategy for its Medicaid program;
11. Establish a quality rating system for Medicaid health plans that aligns with the existing rating systems in Medicare Advantage and the Marketplace; and
12. Support the adoption and meaningful use of health information technology, including through the option for states to pay providers meaningful-use incentives to provider types excluded from the HITECH program.

Selected Provisions of the Proposed Rule that May Impact Home-based Care Providers

Below we provide an overview of the provisions in the proposed rule that may impact home-based care providers. We have separated the provisions into two categories: those with more significant, direct impact on home health providers, and those that are important to be aware of but have less direct implications for home health.

Provisions with Direct Impact

1. Standards for Long Term Services and Supports (§438.208(c))

Current managed care regulations were written at a time when the managed care delivery system was not often responsible for LTSS. With the changing marketplace—and increased flexibility in the Medicaid program to provide home and community-based services (HCBS)—this rule would codify previous guidance for managed long-term supports and services. In addition, the rule proposes mechanisms for comprehensive identification and assessment of enrollees by the state or the plan and the development of a person-centered treatment plan by the provider.

CMS has integrated throughout the rule key principles for a strong MLTSS program. These elements include:

- Adequate planning: including standards for enrollee and potential enrollee materials; standards for provider directories; and requiring plans to provide information on covered benefits.
- Stakeholder engagement: including the development of state-level stakeholder advisory groups.
- Enhanced provision of HCBS: including robust implementation of the Americans with Disabilities Act (ADA) and Olmstead.
- Alignment of payment structures: including that states include MLTSS program elements in their annual summary reports to CMS.
- Support for beneficiaries: including choice counseling, training to plans and providers on available community-based resources, education on and support for the appeals and grievance process.
- Person-centered processes: including a comprehensive needs assessment of medical and non-medical needs.
- Comprehensive, integrated service package: including mechanisms to enhance care coordination and transitions of care, and coordination with services received through traditional fee-for-service Medicaid.
- Qualified providers: including stringent new network adequacy provisions for LTSS providers.
- Participant protections and high quality: including standards for a state's entire managed care program, and MLTSS-specific quality measures

2. Stakeholder Engagement when LTSS is Delivered Through Managed Care (§438.70)

The rule would require states to create and maintain a stakeholder advisory group that consists of beneficiaries, providers and other stakeholders to discuss the design and implementation of the MLTSS program.

3. Network Adequacy (§438.68)

States must develop and enforce network adequacy standards, and plans must annually document the availability of covered services and the provider network. For most providers, the rule would require that states use time and distance standards for most providers. For LTSS providers that travel to the enrollee to deliver services, including home-based care providers, the state must use standards in addition to time and distance. In the preamble to the rule, CMS offers timeliness as a possible alternative standard. The rule does not propose specific time, distance, or timeliness standards that plans must meet; states have discretion to develop the specific standards. The rule also includes "consumer choice of providers" as an important factor in network adequacy but does not define a standard.

4. Provider discrimination prohibited (§438.12)

Plans are neither required to contract with all providers nor with more providers necessary to meet the needs of its enrollees. If a plan declines to include individual or groups of providers in its network, it must provide the affected providers with written notice for its decision.

5. Plan Provider Directories (§438.10(h))

The regulations would require states to ensure that a robust set of plan information is readily available to beneficiaries. Types of communication mechanisms addressed in the rule include member handbooks, appeal and grievance notices, and provider directories. The information contained in these communications must be accessible to beneficiaries, including through the use of tools such as oral interpretation, large font, and auxiliary aids and services, as well as the availability of materials in common languages besides English.

The rule would expand the information required to be included in the provider directory and the frequency with which the directory must be updated. The provider directory must be available both electronically and in paper form. The directory must include the following information for long term service and support providers, as well as other types of providers: name and any group affiliation; street address; telephone number(s); website URL; specialty (if appropriate); whether the provider is accepting new enrollees; the provider's cultural and linguistic capabilities; and whether the provider's office is accessible for people with disabilities.

The provider directory must be updated regularly. The plan must update the paper directory at least monthly and the electronic directory no later than three business days after receiving changes in provider information.

6. Delivery System and Provider Payment Initiatives (§438.6(c))

If codified, states would be permitted to require plans to contract with providers on a value basis or participate in other payment and delivery system reform initiatives. Under this provision, states would also be permitted to set a fee schedule to which the plans would be required to adhere.

To the extent the state directs plans to spend part of the capitation rate in a specific way, e.g., through defined rates, the state must obtain federal approval for its approach. The state must be able to demonstrate that all monies being directed are based on the utilization and delivery of services, that the approach expects to advance the state's comprehensive quality strategy, that the state will evaluate its effectiveness, that the program does not automatically review, and that the program is implemented equally for public and private providers, among other conditions.

7. Primary Care Case Management (§438.2; §438.3; §438.35; §438.350)

Primary care case managers (PCCM) who engage in intensive care management or enhanced care coordination models are considered "PCCM entities" and their enhanced set of services will be recognized. These entities will have the same operational responsibilities and financial incentives as managed care plans, absent the financial risk for medical services.

Provisions with Indirect Impact

8. Medical Loss Ratio (§438.8)

A medical loss ratio (MLR) is a standardized tool to assess the proportion of premium revenue a plan spent on clinical services and quality improvement. CMS proposes that states must calculate managed care capitation rates taking into account an MLR of no less than 85%.

9. Quality Strategy (§431.500; §431.504)

The rule extends a comprehensive written quality strategy to all state Medicaid programs, including LTSS, to monitor the delivery of quality health care to Medicaid beneficiaries. CMS will provide technical assistance to states that do not already have a managed care quality strategy in place. States will state their goals and objectives for quality improvement, and identify specific quality metrics and performance targets used to measure performance. Specific quality metrics, such as for network adequacy and availability of services standards, will be included as part of the managed care elements of the comprehensive quality strategy. States will develop their quality strategies in partnership with state stakeholders with review from CMS; a final product will be publicly posted.

10. Beneficiary Choice of Plan (§438.52)

The rule reiterates current policy that states must ensure beneficiaries have the choice of at least two plans with an exception for residents in rural areas. The rule however would change the definition of "rural" for purposes of this provision. CMS proposes to define "rural area" as "any county designated as 'micro,' 'rural,' or 'County with Extreme Access Criteria' in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year. This change would increase the number of counties defined as rural and therefore may increase the geographic areas where providers would only have one plan with which to contract to serve Medicaid beneficiaries.

11. Managed Care Enrollment (§438.54)

States may either mandate or make voluntary enrollment in managed care. The rule would require states to provide enrollees with at least 14 days of traditional, fee-for-service coverage during

which the potential enrollee could select to participate in managed care (in a voluntary scenario) or choose a plan (in both mandatory and voluntary scenarios).

In cases where an individual does not select a plan, the state would be required to choose a plan for the beneficiary. The rule outlines criteria the state would need to follow for enrolling such individuals into plans: the states must consider a plan's capacity to serve the beneficiary, whether the beneficiary has an existing relationship with a plan, and whether the beneficiary has an existing relationship with a particular provider within a plan. The state would be permitted to consider additional criteria. Once the criteria are exhausted, the state would be required to distribute any remaining beneficiaries equitably among the plans.

12. Disenrollment: Requirements and limitations (§438.56(d)(2)(iv))

If a state does not let an enrollee switch plans at any time, it would be required to let enrollees disenroll and switch plans if the enrollee's MLTSS provider leaves their network and, as a result, the enrollee would experience a disruption of services to their residence or institution.

13. State Monitoring Standards (§438.66)

States would develop monitoring standards and collect data from plans as plans enter the market or contract with the state to enroll Medicaid beneficiaries for the first time. This includes data on provider networks and network adequacy.

14. Beneficiary Support System (§438.71)

States would be required to develop and implement a beneficiary support system to provide beneficiaries information about various health plans, and to provide support before and after enrollment, including providing support to beneficiaries who would like to receive LTSS. States may design their programs and define who can provide the counseling but the parties must be independent and free of conflict of interest. In other words, the support system may not have a financial relationship with any MCO entity. States may expand programs that already exist under Medicaid to include support for MLTSS plans.