MEDICAID MANAGED CARE RULE OVERHAUL: FIRST PROPOSED REVISIONS IN OVER A DECADE

Health care providers and practitioners in most states are well aware that most Medicaid and CHIP enrollees are members of managed care organizations ("MCOs"). As states have increasingly contracted with and relied on MCOs for their growing Medicaid and CHIP populations, including enrollees who need and use long-term care services, the Centers for Medicare & Medicaid Services ("CMS") has worked to maintain adequate oversight of the states' administration of the program in the rapidly changing environment. In its Notice of Proposed Rulemaking ("NPRM") published in the Federal Register earlier this week, CMS outlines its regulatory response to this new environment, proposing substantial modifications to the Medicaid managed care rule for the first time in more than a decade. In the NPRM, CMS states its view that a number of significant laws have passed since the last revision, making parts of the current regulatory framework, in its view, inadequate. CMS, in particular, emphasizes that the Affordable Care Act ("ACA") makes coordination and alignment between the Medicaid plans and the private insurance market increasingly important as individuals move between sources of health care coverage. In developing the proposed revisions that would strengthen and clarify existing regulations or establish new standards, CMS considered the ACA's recent market reforms, the standards established for Qualified Health Plans on the ACA Marketplaces and CMS's experience with Medicare Advantage plans.CMS's proposal includes a broad range of modifications to the Medicaid managed care rule. We believe our health care provider and system clients will be most interested in the proposals highlighted and summarized in this Health Law News.

PROVIDER NETWORK ADEQUACY STANDARDS

Relying on a 2014 study by the Office of the Inspector General, CMS has concluded that the states' standards for access to care vary widely and that a state's standards are often not specific to certain types of providers or to areas of the state. As a result, CMS is proposing a new regulation that would require states to develop and enforce network adequacy standards. *At a minimum*, a state must develop time and distance standards for the following provider types (if covered under its contract with an MCO):

- Primary care, adult and pediatric
- OB/GYN
- Behavioral health
- Specialist, adult and pediatric
- Hospital
- Pharmacy
- Pediatric dental
- Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards

The network standards must include all geographic areas covered by the contract between the state and the MCO. States are permitted to have varying standards for the same provider type based on geographic areas. Furthermore, in developing network adequacy standards, a state must consider the following elements:

- The anticipated Medicaid enrollment
- The expected utilization of services
- The characteristics and health care needs of specific Medicaid populations covered in the MCO contract
- The numbers and types (in terms of training, experience and specialization) of network health care professionals needed to furnish the

contracted Medicaid services

- The numbers of network health care professionals who are not accepting new Medicaid patients
- The geographic location of health care professionals and Medicaid enrollees, considering distance, travel time and the means of transportation ordinarily used by Medicaid enrollees
- The ability of health care professionals to communicate with limited English proficient enrollees in their preferred language
- The ability of health care professionals to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for Medicaid enrollees with physical or mental disabilities

MEDICAL LOSS RATIO

Noting Medicaid and CHIP are the only health benefit coverage programs not utilizing a minimum Medical Loss Ratio for managed care plans, CMS believes the MLR calculation and reporting are important tools to ensure that capitation rates set for Medicaid managed care programs are actuarially sound. CMS proposes an MLR of at least 85 percent, calling it the appropriate minimum threshold and the industry standard for Medicare Advantage and large employers in the private health insurance market. CMS would direct states to consider the MLR as part of the rate setting process to ensure that program dollars are being spent on health care services, covered benefits and quality improvement efforts.

VALUE-BASED PURCHASING AND DELIVERY SYSTEM REFORM

As proposed by CMS, states would be prohibited from directing an MCO's expenditures. A state, however, could require MCOs to implement one or more of the following:

- Value-based purchasing models for provider reimbursement. These models could include pay-for-performance arrangements, bundled payments or "other service payment models intended to recognize value or outcomes over volume of services."
- Multi-payer delivery system reform or performance improvement initiative. As examples, CMS cites patient-centered medical homes, efforts to reduce the number of low birth weight babies and broad-based provider health information exchange projects.
- Adopt a minimum fee schedule (or provide a uniform dollar or percentage increase) for all providers that provide a particular service under the contract between the state and the MCO.

With regard to value-based purchasing models and multi-payer delivery system reform or performance improvement initiatives, a state would set the capitation rates for such efforts, but the MCOs would have control over the amount and frequency of the payments. Under the proposed rule, a state could not implement any of the three programs described above without prior written approval from CMS.

CHOICE OF MCOS (EXPANDING THE RURAL EXCEPTION)

Under the current regulations, enrollees in a mandatory Medicaid managed care program must be given a choice of at least two MCOs, except for enrollees who reside in "rural" areas. Enrollees who reside in rural areas may be served by a single MCO with certain opportunities to receive care outside of the MCO's network. CMS defines "rural" to mean any area other than an "urban" area as defined by the U.S. Office of Management and Budget ("OMB"). Believing that the current definition of "rural" is too narrow (and not accommodating MCOs' financial models), CMS is proposing to expand the number of areas that would be considered "rural," which could limit enrollee access to a single MCO in those areas. As proposed by CMS, any *county* with an OMB designation other than "large metro" or "metro" would be considered a "rural" area for purposes of the MCO choice rule.

LIMITED IMD EXCLUSION

CMS proposes that a state may make a monthly capitation payment to an MCO for enrollees 21 to 64 years of age receiving inpatient treatment in an institution for mental diseases, so long as the facility is:

- An inpatient hospital facility or
- A sub-acute facility providing "crisis residential services" and
- The length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment.

CAPITATION RATE SETTING

When developing the modifications to the rate setting process and standards, CMS emphasized the need for a transparent rate setting process. CMS relied on the following principles as it developed its modifications to the rate setting regulations:

- Capitation rates should be sufficient and appropriate for the anticipated service utilization of the populations and services covered under the contract and provide appropriate compensation to the health plans for reasonable non-benefit costs.
- Actuarially sound rates should result in appropriate payments for payers and should promote program goals such as quality of care, improved health, community integration of enrollees and cost containment.
- Actuarial rate certification should provide sufficient detail, documentation and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final capitation rate.
- A transparent and uniformly applied rate review and approval process based on actuarial practices should ensure that both the state and the federal government act effectively as fiscal stewards and in the interests of beneficiary access to care.

In the proposed rule, CMS provides that actuarially sound capitation rates must provide for all reasonable, appropriate and attainable costs that are required under the contract, including an adequate network that provides timely access to services and ensures coordination and continuity of care. CMS's review of the rate certification could include a determination of whether the provider rates are sufficient to support the MCO's obligations.The NPRM includes other important proposals that, with those summarized above, will be analyzed and debated as the many stakeholders develop their comments on the proposed rule. Comments on the NPRM are due to CMS by July 27, 2015. A copy of the proposed rule is available here.If you have any questions or would like additional information about this topic, please contact:

- Timothy W. Kennedy at (317) 977-1436 or tkennedy@hallrender.com;
- Laura J. Leitch at (612) 499-3084 or lleitch@hallrender.com;
- Adele Merenstein at (317) 752-4427 or amerenst@hallrender.com; or
- Your regular Hall Render attorney.

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