BRIEF

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CMS PROPOSES NEW RULES FOR MANAGED MEDICAID

(HELLO, RED TAPE)

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On May 27, the Centers for Medicare and Medicaid Services (CMS) issued proposed new rules for Medicaid. The new rules – the first CMS has proposed in more than a decade – aim to ease the financial burdens the program creates for states, alleviate certain challenges involving coverage and access, and align Managed Medicaid to Medicare Advantage (MA) and market standards.

The rules are still a proposal; the Department of Health and Human Services will accept comments on them through the end of July prior to issuing the final rules. While it is true that final responsibility for accepting or rejecting the rules rests with the states, we believe that CMS's proposed changes will have a significant impact on all stakeholders in the Medicaid space.

What follows is a summary of the proposed rules written from the perspective of the health plan. (We will discuss the impact on healthcare providers and the states in additional, forthcoming publications.) Because Medicaid is largely a procurement business – with states purchasing services from managed care organizations – we expect the new rules to have an impact on state requirements for procurement. Health plans will need to be thoughtful about how the regulations will impact current contracts, as well as those that are due for renegotiation.

RULES COVERING REIMBURSEMENT/RATE SETTING

MEDICAL LOSS RATIO (MLR) FLOOR: We saw this one coming

Under the proposed rules, Managed Medicaid plans will need to maintain an MLR floor of no less than 85 percent commencing in 2017. The rule is similar to provisions in the Affordable Care Act (ACA) covering large group, small group and small individual plans, but, unlike ACA, the proposed Medicaid rules do not mandate a payback to the state should the MLR floor not be achieved. The states will use the MLRs in setting rates and to monitor MCO-specific MLRs over time. Depending on what counts as a medical cost and what as an administrative cost, this rule could limit an MCO's ability to provide services to the most specialized/needy populations (given the increased support and care coordination requirements for this population).

ACTUARIAL SOUNDNESS PROVISIONS: Good-bye unpredictable state pricing

The new rules define standards of actuarial soundness that states should use in setting rates. Capitation rates should be sufficient and appropriate, and rates should cover reasonable non-medical costs. In addition, the rules specify that an actuarially sound rate should promote goals such as quality of care and improved health. Finally, the rules require the states to submit a rate certification that provides sufficient detail of the data used in setting rates, and mandates a transparent rate review and approval process based on actuarial practices. This proposed requirement should alleviate the irrational pricing swings that have caused some Medicaid markets to become unattractive due to state-driven changes in reimbursement rates.

RECEIPT OF CAPITATED PAYMENTS FOR INDIVIDUALS SPENDING LESS THAN 15 DAYS IN AN INSTITUTION FOR MENTAL DISEASE (IMD): Good-bye to a barrier to care for the mentally ill

The old regulations do not allow MCOs to receive any sort of Federal Financial Payment (FFP) for individuals receiving care at an IMD. The proposed rules will permit MCOs to receive a capitation payment from the state for an enrollee (aged 21 to 64) who spends a portion of the month in an IMD, as long as the facility is a hospital providing psychiatric or substance abuse inpatient care, or a sub-acute facility providing residential services for psychiatric disorders or substance abuse. Capitation payment is provided only for an IMD stay of less than 15 days a month. CMS explains that this proposed rule was included to alleviate some of the access issues that have confronted patients requiring short-term inpatient or sub-acute psychiatric or substance abuse treatment. While capitated payments for this population will benefit health plans, MCOs will need to ensure they can manage these individuals appropriately to reap the rewards of the proposed payment.

PROPOSED RULE	IMPLICATIONS FOR MCOs	RATIONALE
MLR Floor	Negative	• Achieving profitability in Medicaid requires attention to the whole person, including needs that go beyond traditional medical expenses (this could make providing care to specialized populations more challenging) • MCOs will need to carefully consider what is classified as medical cost vs. administrative cost going forward
Actuarial Soundness	Positive	• Actuarial soundness should promote the setting of appropriate rates across states
IMD Capitation Payment	Positive	• Receiving capitated payments for these individuals could present a lucrative opportunity • This will create greater access to care and lower burden/hassle to beneficiaries with mental illness • However, MCOs will need to ensure they can manage individuals suffering from substance abuse/psychiatric disorders appropriately

RULES ON COVERAGE AND MEMBER MANAGEMENT

MANAGED CARE ENROLLMENT: Choose your plan within 14 days

The proposed rules require states to have an enrollment system for a voluntary managed care program. States have several alternatives under the rule: they may establish an enrollment period during which eligible individuals may actively elect to enroll in managed care, or they may employ a passive enrollment process in which the State selects an entity for a potential enrollee but provides a period of time for the potential enrollee to decline the entity selected. States are also being asked to provide at least 14 calendar days of FFS coverage to provide members with the opportunity to actively elect to receive covered services through their choice of managed care plan. Prior to the 14 day period, states have to provide appropriate informational materials to help individuals make their choice. States will be allowed to enroll members into a qualified plan (applicable for both voluntary and mandatory managed care plans), should they fail to make a choice during the enrollment period. Finally, states may limit individuals' ability to disenroll from a managed care program without cause, starting 90 days post enrollment. While this is a net positive for health plans (disenrollment without cause can create substantial disruption) the level of member communication that may be required during the 14-day choice period could be overwhelming.

INTEGRATION OF LONG TERM SERVICES AND SUPPORTS (LTSS): Important but hard

Two years ago, CMS released a set of 10 guiding principles regarding Managed Long Term Services and Supports (MLTSS) in their report titled *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for MLTSS Programs*. The proposed rules require all MCOs to comply with these principles, in addition to several other

requirements, including: network adequacy (time, distance, accommodations for disabilities, etc.), access to benefits of community living, identification and assessment of individuals who need LTSS (with reassessment on an annual basis), and elimination of any disadvantages for individuals with chronic conditions who need LTSS. Management of LTSS populations presents a lucrative opportunity for health plans, but network adequacy rules may pose challenges for providing appropriate coverage.

CONTINUITY OF CARE: Setting standards for care coordination

The proposed rules aim to align the Medicaid managed care framework with other public and private programs while improving coordination and continuity of care. Programs will be asked to set standards for transition plans when a beneficiary moves into a new plan, expand coordination efforts beyond primary care, strengthen the role of the care coordinator, ensure more accurate and timely data gathering and sharing, and build the needs of enrollees with LTSS needs into the identification, assessment, and service planning processes. The big, unanswered question: Will the rules improve care coordination or create administrative challenges?

PROPOSED RULE	IMPLICATIONS FOR MCOs	RATIONALE
Managed Care Enrollment	Positive/Neutral	• Limiting individuals ability to disenroll without cause after 90 days of enrollment will help plans manage their enrollee populations better • However, this rule also requires substantial information sharing with enrollees, which could place an administrative burden on plans
LTSS Integration	Neutral	• Network adequacy will likely pose a challenge to MCOs • Since the LTSS population is one of the most costly, better management and integration of LTSS could be an upside
Continuity of Care	Neutral	• From a population management perspective, more care coordination is better, however, meeting state-decreed standards could pose a substantial burden

RULES RELATING TO NETWORK

NETWORK ADEQUACY: Lowering barriers to access

Many Medicaid beneficiaries face access challenges. We've heard of at least one who had to travel 75 miles to see his physician. CMS believes that traditional provider-to-enrollee ratios do not adequately capture the true nature of care access in a region and proposes to require states to establish time and distance standards for certain classes of providers (including hospitals, primary care physicians, and ob-gyns). CMS suggests that states also include access rules for pediatricians, dentists, and specialists, given the number of children enrolled in

CHIP plans. Finally, states are also being asked to consider whether plans offer enough providers who speak a language other than English. These proposed time, distance, and fluency standards will cause significant challenges for MCOs and may potentially give greater bargaining power to providers.

SETTING OF STATE MONITORING STANDARDS: More hoops for provider participation

The new rule would require all MCO network providers to be enrolled with the state – though it does not require them to actually deliver FFS Medicaid services. States will be required to conduct readiness reviews of MCOs prior to start dates and submit the results of the readiness assessment to CMS for final approval. States will also be required to submit an assessment report within 150 days of the end of an MCO's period of performance. This rule may result in further narrowing of an already thin provider network, which coupled with the time and distance regulations proposed, may prove to be problematic. The MCO readiness assessment and year-end evaluation will once again add administrative burden to plans, making it more difficult to meet the proposed MLR floor requirements.

PROPOSED RULE	IMPLICATIONS FOR MCOs	RATIONALE
Network Adequacy	Negative	• Given the limited number of providers that accept Medicaid patients, meeting the network adequacy standards will be challenging • Could result in higher bargaining power for select providers
State Monitoring Standards	Neutral/ Negative	• While pre-screening of providers will be helpful in reducing fraud/abuse, this will likely further narrow an already thin provider network • Additional administrative burden for MCOs due to readiness assessments and year end assessments

RULES DEALING WITH QUALITY

SUPPORT OF VALUE-BASED CARE/PERFORMANCE IMPROVEMENT INITIATIVES: "We are the Borg. Your biological and technological distinctiveness will be added to our own. Resistance is futile"

In an effort to encourage states to incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries, the proposed rules will now allow a state to specify in its contracts that MCOs adopt value-based purchasing models for provider reimbursement. Further, under the proposed rules states can require MCOs to participate in broad-ranging delivery system reform or performance improvement initiatives (e.g. patient-centered medical homes, programs to reduce the incidence of low-birth-weight babies, health information exchanges, etc.). This rule could confer an advantage on providers that are further along in their value-based care strategy.

QUALITY INITIATIVES: Stars for Medicaid

The proposed rules aim to strengthen quality measurement and improvement efforts by focusing on transparency, alignment with other systems of care, and consumer and stakeholder engagement. CMS wants states to adopt a quality rating system, similar to Medicare Advantage's Star Rating system. Quality ratings must be based on clinical quality management, member experience, and plan efficiency, affordability, and management. The measures will be identified by CMS, with states being given the option to report on additional measures. States may also opt (with CMS's approval) for an alternative system. For MCOs serving dual-eligibles, states may elect to use the MA Star Rating system. The administrative implications for health plans are substantial – as evidenced by the effort that goes into reporting and maintaining MA star ratings.

PROPOSED RULE	IMPLICATIONS FOR MCOs	RATIONALE
Support of Value-Based Care/ Performance Improvement	Neutral	• States will be able to dictate MCO participation in select initiatives • The rule may advantage providers who are further along in their value-based care agenda
Quality Initiatives	Negative	• It is well documented that achieving high star ratings for the dually eligible populations is very difficult given their specialized care needs and socio-economic challenges – the system will need to be designed with Medicaid in mind • The administrative burden of such ratings can be substantial

ADMINISTRATIVE SERVICES

PREVENTION OF FRAUD & ABUSE: Cut as much unnecessary cost as possible

Historically, the Medicaid program has been rife with fraud and abuse, with states being billed for services that enrollees never received. The proposed rules include provisions to conduct periodic independent audits of plan data, screen and periodically re-evaluate providers, and make the results of audits and other data checks publicly accessible. Finally, plans will be required to maintain compliance with federal standards, report changes in enrollee/provider circumstances, and report any fraud or abuse to a central program integrity unit. While avoidance of fraud and abuse is a good thing, the administrative processes involved may hinder other efforts.

DRUG UTILIZATION AND REBATE REPORTING: Ensuring states get their cut of the drug traffic

Federal regulations require drug manufacturers to enter into a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of a company's drugs. These rebates are sizeable (ranging from 17 to 23 percent, depending on the type of drug in question). But it is up to the states to collect them, and many states are lax in following through. The proposed rules would require MCOs to report drug utilization data to enable states to collect these rebates. The rules also include language that would avoid double drug discounts (i.e. 340b pricing and Medicaid rebates). Finally, the rules propose moving drug utilization programs under the purview of MCOs, with associated standards around prior authorization response times (by telephone/ telecommunication device, within 24 hours of the request, etc.).

CMS DISALLOWANCE: Line-item rejection of FFP

The proposed rules allow CMS to defer or disallow Federal Financial Participation (FFP) for expenditures under an MCO contract with the state, if it determines that the contract does not comply with set standards. CMS can decree whether a particular service would be eligible for FFP or not on a much more granular level, based on compliance with predetermined standards. These standards include whether final capitation rates are actuarially sound, as mentioned earlier.

APPEALS/GRIEVANCES: A clear grievance process is good. Large process and administrative burdens are bad

The proposed rules would modify the appeals and grievances processes to align more closely with Medicare, and to align CHIP more closely with the Medicaid grievance and appeals process. It should be noted that the rules recommend establishment of a grievance system, and requires MCOs to record the appeals and grievances that are filed against them. The administrative implications of the new process will likely be significant for MCOs.

PROPOSED RULE	IMPLICATIONS FOR MCOS	RATIONALE
Prevention of Fraud and Abuse	Negative	• This rule would provide MCOs with greater ability to manage fraud and abuse • The administrative burden of maintaining compliance and reporting data will likely be significant
Drug Utilization and Rebate Reporting	Neutral	• Initiatives that put money back in state coffers is a good thing for plans; however, the administrative burden of drug utilization reporting will be substantial • Similarly, while placing DUR under the purviews of MCOs is the right thing to do, administrative expenses of running the program and reporting data may impact the MLR floor
CMS Disallowance	Negative	• Substantial administrative burden due to compliance standards
Appeals/Grievances	Negative	• Substantial administrative burden

CONCLUSION
Well intentioned, but will likely cause an increase in administrative hassles

In conclusion, although the rules are rooted in good intentions, the administrative burden that these changes would place on plans is not insignificant. When considered in light of the MLR floor, these new regulations could become particularly onerous and could make caring for specialized populations impractical – which would be an unfortunate reversal of recent progress. Plans will need to carefully manage the additional administrative costs that arise as a result of these changes to ensure they are able to maintain financial success while also meeting the MLR requirements.

It should be noted that health plans that primarily focus on Medicaid are accustomed to the administrative requirements that accompany the program – and have already achieved (or bettered) the MLR floor requirements in order to ensure profitability in their segment. Interestingly enough, while this paper presents a view of the administrative burden that will be faced by MCOs, it should be noted that the administrative hassles faced by states as a result of these proposed rules is not likely to be any better – in fact, some are positing that the states will face a worse burden than the health plans, given the standardization, monitoring, and rate setting requirements.

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