The Centers for Medicare & Medicaid Services (CMS) Nov. 8 released a proposed rule that would make changes to the Medicaid and Children's Health Insurance Program (CHIP) managed care regulations and, specifically, to a number of provisions contained in the agency’s 2016 final rule. CMS has indicated that the proposed changes are intended to grant state Medicaid and CHIP agencies greater flexibility to tailor their managed care programs to meet the needs of each state’s population.

The 2016 final rule modernized the Medicaid and CHIP managed care regulations to bring Medicaid managed care into closer alignment with Medicare Advantage plans and private insurance, particularly private insurance sold in the Health Insurance Marketplaces. Since the implementation of the 2016 final rule, state Medicaid agencies have urged CMS to address issues of state flexibility and administrative burden.

To that end, CMS formed a working group that included the National Association of Medicaid Directors and state Medicaid directors. Many of the proposed rule’s policy changes were recommendations made by this CMS working group.

Select highlights of the proposed rule follow.

**Key Takeaways**

CMS’s proposed rule would:

- Grant state Medicaid programs more flexibility in determining actuarially sound capitation rates for Medicaid managed care plans.
- Permit states moving to Medicaid managed care to transition their Medicaid provider supplemental payments over a three-year period.
- Grant states greater flexibility in directed payments to providers in managed care settings.
- Replace the current provider network adequacy time and distance standard with a requirement that states establish quantitative network adequacy standards, among other changes.
- Develop minimum mandatory performance measures to apply to federal Quality Rating Systems and alternative QRS standards.
- Not change the 15-day limit for Medicaid managed care enrollees in IMDs, but seek comment on the agency’s IMD policy.

**Provider Payments in a Managed Care Setting**

Pass-through payments for states with new managed care programs. The 2016 final rule allowed certain states that were newly adopting managed care to transition their fee-for-service (FFS) provider supplemental payments into their managed care
contracts with the managed care entity simply acting as the conduit over a specified period. In a subsequent rule, the agency clarified that no new pass-through payment programs could be established beyond July 5, 2016. Supplemental payments, by nature, are payments rooted in the FFS payment system. States new to managed care and looking to transition supplemental payments like Upper Payment Limit (UPL) programs into their managed care programs were no longer able to take advantage of the pass-through payment policy. This impacted a number of states: while many states already rely on managed care for most Medicaid enrollees, in 2016, 26 states still had more than 20 percent of the Medicaid populations under FFS and three states had 100 percent of their populations in FFS. In this rule, CMS proposes to allow states new to Medicaid managed care the opportunity to transition their FFS-based supplemental payments to managed care if they meet certain criteria. The pass-through amounts would be less than or equal to the amount of the existing FFS UPL supplemental payments. States would be allowed a three-year transition period for these pass-through payments.

Directed provider payments. The 2016 final rule allowed states to direct managed care plans to support high-quality, integrated care through setting minimum reimbursement standards or fee schedules for providers, and raising provider rates in an effort to enhance access to quality services. CMS notes that, since the 2016 final rule, many states have sought to implement “directed provider payment arrangements” and have based those payment arrangements on the rates approved in the state plan. To address issues and questions regarding the direct payment arrangements, CMS proposes several changes. The proposed rule would:

- Define “state plan-approved rates” as the amounts calculated on a per unit price of services.
- Define supplemental payments as the amounts paid by the state in its FFS system to providers described and approved in their state plan or waiver and would not constitute a state plan approved rate.
- Allow states more flexibility on directed payment arrangements to enable states to experiment with new payments models by allowing the use of cost-based rates, a Medicare equivalent rate, a commercial rate or other market-based rates for network providers.
- Allow states to direct the amounts and frequency of directed payments.
- Allow multi-year approval in certain circumstances.
- Allow directed payment arrangements that use state plan approved rates without prior approval.

Provider network adequacy

Adequacy standards. The 2016 final rule required that states contracting with managed care plans establish minimum provider network adequacy standards. States are currently required to develop time and distance standards for provider types covered under the managed care contract including: primary care (adult and pediatric); OB/GYN; behavioral health, including mental health and substance use disorder (adult and pediatric); specialists (adult and pediatric); hospitals; pharmacy; pediatric dental; and any additional provider type determined by CMS. The proposed rule would replace the requirement that states establish time and distance standards with a requirement to develop a process where any network inadequacy is identified and resolved in a timely manner.
distance standards with a more flexible standard that states establish quantitative network adequacy standards. CMS further suggests quantitative standards states could use such as minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; and hours of operation requirements (for example, extended evening or weekend hours). CMS also encourages states to use combinations of quantitative measures. The proposed rule further clarifies that the state has the authority to define adult and pediatric specialist for purposes of provider network adequacy.

Provider directories. The proposed rule would make two changes to the current requirements for managed care plan provider directories. The first proposed change would require provider directories to list provider cultural competency, a provision that aligns with the provider directory requirements in the 21st Century Cures Act. Under this proposed change, the directories would need to list cultural and linguistic capabilities of the provider but would remove the reference as to whether the provider completed cultural competency training. The second proposed change would allow managed care plans to update the paper version of their provider directory on a less frequent basis if they offer enrollees a mobile-enabled electronic directory in addition to the web-based provider directory.

Quality Rating Systems

The 2016 final rule established that CMS, in consultation with states and other stakeholders, would develop a quality rating system (QRS) framework, including the identification of performance measures and methodologies, which states could adopt. According to the 2016 final rule, states have the option to use the CMS-developed framework or establish a state-specific QRS producing substantially comparable information about plan performance subject to CMS approval of the alternative system. CMS has yet to finalize the CMS-developed QRS framework. The proposed rule changes the requirement that the information yielded be substantially comparable to give states greater flexibility by allowing states to meet this standard to the extent feasible to enable meaningful comparison across states. In addition, the proposed rule reaffirms CMS’s commitment to engage with states and other stakeholders in developing sub-regulatory guidance on what it means for an alternative QRS to yield substantially comparable information, and how a state would demonstrate it meets the standard.

Standards for Capitation Rate Development

The 2016 final rule required that states adhere to greater transparency standards in developing actuarially sound Medicaid managed care capitation rates. These transparency standards included detailed documentation of how states set capitation rates, including trend factors and adjustments. States had raised issues with CMS regarding administrative burden and lack of flexibility in the standards set for developing capitation rates for managed care plans. Chief among these concerns was the use of rate ranges and rate cells. The current rules require that states certify their capitation rates based on rate cells, and not rate ranges. CMS has long been concerned that the use of rate ranges allows states to increase managed care plan
capitation rates without changing the obligations in the underlying contract or basing the increase on the plan’s actual expenses.

In the proposed rule, CMS would allow states to use rate ranges under certain circumstances. Specially states can develop and certify a rate range of 5 percent within certain parameters. In addition, the proposed rule clarifies that states adjusting capitation rates within the permissible 1.5 percent range would not have to submit a revised rate certification or actuarial justification. The proposed rule also would codify requirements for CMS to issue on an annual basis guidance to help streamline the rate review process and allow for more accelerated review. States also would be prohibited from retroactively adding or modifying risk-sharing mechanisms to protect against cost-shifting to the federal government. Lastly, the proposed rule would clarify that differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of federal Medicaid match rate associated with covered populations such as expansion populations.

**Changes the Proposed Rule Does Not Make**

**Institutions for Mental Disease (IMD).** The proposed rule would not make changes to the current regulation that limits to 15 days stays for managed care beneficiaries in an IMD. [CMS seeks comment on its IMD policy](#).

**Medical Loss Ratios (MLR).** CMS did not propose any changes to the current regulation that states must establish a minimum MLR no lower than 85 percent. The proposed rule would make several technical corrections to the MLR requirements.

**Next Steps**

Comments are due Jan. 14. If you have further questions, please contact Molly Collins Offner, director of policy, at mcollins@aha.org at 202-626-2326.