American Hospital Association®

Regulatory Advisory

April 29, 2016

CMS Issues Final Rule on Managed Care for Medicaid and CHIP

At a Glance

At Issue:

On April 25, the Centers for Medicare & Medicaid Services (CMS) issued a long-awaited final rule to modernize the Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. The rule, which is the first major update to Medicaid and CHIP managed care regulations in more than a decade, attempts to better align them with existing commercial, Health Insurance Marketplace and Medicare Advantage (MA) regulations. The final rule will be published in the Federal Register on May 6.

There are two important changes in the final rule: the treatment of provider supplemental payments and the time-line for implementation.

- Beginning in 2027, CMS prohibits states from directing a portion of the managed care plan capitation payment to providers, such as hospitals, nursing facilities and physicians, as supplemental payments. To allow states and providers time to adjust to this new policy, the final rule provides a 10-year phase-out of these payments, now defined as "pass-through" payments.
- CMS allows states to implement certain requirements of the final rule (other than "pass-through" payments) on a phased-in basis between the date of publication in the Federal Register and the managed care contract cycle that begins in 2019. This affects provisions such as the state managed care quality rating system, external quality review, and some elements of the state capitation rate setting process.

Other significant provisions of the final rule closely adhere to the proposed rule in:

- requiring greater transparency in how states set their managed care capitation rates, including a new CMS rate certification process to ensure more agency oversight;
- adding new requirements for medical loss ratios (MLR) for managed care plans;
- expanding requirements for managed care provider networks, including time and distance standards, quality measures, external quality review, and beneficiary rights and protections;
- permitting states with flexibility to use managed care to increase mental health services for enrollees aged 21 to 64 in short-term inpatient or sub-acute institutions for mental disease;
- requiring states to develop a Medicaid managed care quality rating system for health plans; and
- implementing improvements for existing managed long-term care services and support programs.

Our Take:

On balance, the rule is an important step in bringing Medicaid managed care into closer alignment with MA and private insurance, particularly private insurance sold in the Health Insurance Marketplace. The AHA, however, is very disappointed that CMS will prohibit supplemental payments to be made to hospitals through the managed care payment system. However, we believe the 10-year transition will be helpful to hospitals and other providers as they continue to meet the challenge of caring for vulnerable Medicaid patients.

In addition, we are pleased that CMS looks to standardize requirements such as MLR and state capitation rate setting, while granting states a fair amount of flexibility in adapting their current programs to the new requirements. A number of the policy changes align with AHA's advocacy efforts over the last several years such as an MLR requirement, provider network adequacy standards, and strategies for quality improvement.

The impact of the final rule for hospitals, hospitals that participate in Medicaid managed care provider networks and hospitals and health systems with Medicaid managed care plans will be highly dependent on how each state has constructed its Medicaid managed care program.

What You Can Do:

- ✓ Work with your senior leadership in Medicaid managed care for your hospital, hospital system, or health plan to assess the impact of this final rule.
- ✓ Work with your state hospital association to assess how the final rule will affect your state Medicaid managed care program.

Further Questions:

For more information, contact Molly Collins Offner, director for policy development, at mcollins@aha.org.

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BACKGROUND

On April 25, the Centers for Medicare & Medicaid Services (CMS) issued a long-awaited final rule to modernize the Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. The rule, which is the first major update to Medicaid and CHIP managed care regulations in more than a decade, attempts to better align them with existing commercial, Health Insurance Marketplace and Medicare Advantage (MA) regulations. The final rule will be published in the Federal Register on May 6.

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In addition, we are pleased that CMS looks to standardize requirements such as MLR and state capitation rate setting, while granting states a fair amount of flexibility in adapting their current programs to the new requirements. A number of the policy changes align with AHA's advocacy efforts over the last several years such as an MLR requirement, provider network adequacy standards, and strategies for quality improvement.

This advisory summarizes the key provisions of the final rule of importance to hospitals and health systems with Medicaid plans.

SUMMARY

Current federal Medicaid law grants states significant flexibility in the design of their managed care programs. As such, Medicaid managed care can include financing and delivery arrangements that vary from state to state. Despite these variations, there are three basic types of Medicaid managed care arrangements that are referenced in the final rule:

- comprehensive risk-based managed care plans, known as managed care organizations (MCO);
- primary care case management (PCCM) programs that use a gatekeeper to manage care; and
- limited-risk benefit plans, such as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs), that allow states to "carve out" certain services that might not be available in the broader MCO market.

The final rule applies the same managed care standards to MCOs, PIHPs and PAHPs. As such, for purposes of this advisory, the term "plan" refers to MCOs, PIHPs and PAHPs, unless otherwise specified.

Standards for Actuarial Soundness, Capitation Rate Development, and Rate Certification (Sections 438.3-438.7)

The final rule requires that states adhere to greater transparency standards in developing actuarially sound Medicaid managed care capitation rates. These transparency standards include detailed documentation of how states set capitation rates, including trend factors and adjustments.

Through this final rule, CMS has increased its oversight role by requiring that it certify the capitation rates set by the states. Previously, CMS's oversight was limited to reviewing and approving the state's contracts with each plan. As part of the rate certification process, the final rule specifies that CMS will examine whether the plans' provider payment rates are sufficient to support the obligations of the managed care plans and ensure access to services for enrollees.

Actuarial Soundness. The final rule modernizes the rate setting framework using actuarial soundness principles reflected in the practice standards established by the American Academy of Actuaries. Central to these principles are the concepts that capitation rates should be appropriate and sufficient for the population and covered services, and the resulting capitation payments should promote goals such as quality of care, improved health and cost containment. In addition to requiring that states develop rates in accordance with generally accepted actuarial principles and practices, CMS requires that rates are:

- appropriate for the populations covered and the services furnished in the contract;
- specific for each rate cell without cross-subsidization across rate cells (rate cells could be based on age or sex, or care setting);
- certified by an actuary; and
- developed in such a way that plans can reasonably achieve an MLR of 85 percent for the rate year.

Required Rate Cells and Prohibited use of Rate Ranges. The final rule requires that states certify their capitation rates based on rate cells, and not rate ranges. CMS defines a rate cell as a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment. Enrollee characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the plan contract (such as acute medical services or long-term services and supports (LTSS)).

Prior to this final rule, states were permitted to certify capitation rates based on rate ranges. Rate ranges allowed states to make adjustments to the contract's

capitated rate during the contract year, even after the capitation rate was submitted for actuarial certification. Use of rate ranges have also allowed some states to make adjustments in capitation rates to provide additional funds to support certain providers or to implement programmatic changes or initiatives. However, while CMS now prohibits the use of rate ranges under the guise of greater rate setting transparency, the agency will permit states to make small programmatic changes in the certified capitation rate cells. CMS recognizes the administrative burden imposed by requiring states to submit any small adjustment to the capitated rate cell for review and certification. Therefore, states will be permitted to increase or decrease a rate cell by 1.5 percent, which results in a 3 percent rate range, without submitting a revised rate certification for CMS approval. CMS estimates that 27 states, including the District of Columbia, currently certify rate ranges for at least one managed care program in their state.

Capitation Rate Development Standards. CMS adds new definitions for states to use in their rate development standards, as well as lays out the steps states will be required to follow in setting actuarially sound capitation rates. The new definitions are for such terms as: budget neutrality; risk adjustment; prospective risk adjustment; and retrospective risk adjustment.

CMS proposes that states follow six steps in establishing sound rates:

- collect or develop appropriate base data from historical experience;
- develop and apply appropriate and reasonable trends to project benefit costs for the rating period;
- develop appropriate and reasonable cost estimates for non-benefits costs for the period;
- make appropriate and reasonable adjustments to the historical data, trends or other rate components to establish actuarially sound rates;
- consider historical and projected MLRs for the plans; and
- select an appropriate risk-adjustment methodology applied in a budget-neutral manner to make adjustments to plan payments for those programs using risk adjustment.

CMS further requires that states include in their base data the following: validated encounter data, fee-for-services (FFS) data, and the three most recent and complete audited financial reports (prior to the rating period) that demonstrate the utilization and price data for the populations served by the health plans. An exception process is available for states that are unable to provide three years of data.

CMS also requires that states use the annual medical loss ratio (MLR) calculation as part of developing capitation rates for future years. For example, if the health plan has not met the 85 percent MLR in prior years, the state would use that information in the development of future capitation rates for the plan. CMS notes that using the historical MLR data would better assist states in setting capitation rates for future years so that plans would reasonably be expected to achieve at least an 85 percent MLR.

Rate Certification. CMS expands its oversight role through a new agency-level rate certification process. This certification is in addition to its current review and approval process for all managed care contracts. It requires that states submit to CMS the following documentation for every managed care plan that includes: detailed information on base data, trend factors, non-benefit components of the rate (i.e., administration, taxes, licensing and regulatory fees), material and non-material adjustments, and risk-adjustment methodologies. States also must include a description of any special contract provisions related to payment (see description below), the rates paid under the contract, and additional information upon CMS's request. CMS will require states, through their actuaries, to certify the final rates paid under each risk contract and document its underlying data, assumptions and methodologies.

Special Contract Provisions Related to Payments (Sections 438.6(a) - (d))

Phase-down of Pass-through Payments to Hospital, Physicians and Nursing Facilities. The final rule creates a new definition of pass-through payments for hospitals, physicians, and nursing facilities within plan contracts and also prohibits the use of these pass-through payments after a transition period. Specifically, CMS defines pass-through payments as any amount required by the state to be added to the plan's capitation rate and paid directly to the providers. The pass-through payments are analogous to supplemental payments made in Medicaid fee-for-service (FFS).

CMS contends that these pass-through payments are not directly related to the utilization, delivery or outcome of services that are part of the plan contract and they do not align with managed care payments to support improved care delivery or delivery innovations. CMS bases its decision to terminate pass-through payments after a transition period on its long-standing policy that prohibit states from making direct payments to providers in a managed care setting.

CMS acknowledges that many states have used pass-through payments in the move from FFS to managed care to ensure a consistent payment stream for critical safety-net hospitals, physicians and nursing facilities long providing care to the Medicaid population. As such, the AHA advocated that states should be allowed to continue these types of hospital payments to support a variety of state specific objectives. While we are disappointed the agency did not do so, the final rule does allow states time to transition these pass-through payments to other forms of value-based payment structures permitted by the final rule through a phased down approached over a specified period of time. Specifically, because of the size, number, and complexity of hospital pass-through payments, CMS provides for a 10-year transition period, beginning in 2017 and ending in 2027, with annual milestones. Physicians and nursing facilities will be accorded a five-year transition period, beginning in 2017 and ending in 2022.

Hospital Pass-through Payment Transition and Base-Year Calculation. The base amount calculations for the hospital pass-through payment are analogous to the Upper Payment Limit (UPL) calculations states make for FFS payments. States

can initiate hospital pass-through payments any time between 2017 and 2026, but must comply with the scheduled payment reductions. To calculate the base amount for the pass through payment allowed each year, the state first calculates a base amount by:

1. identifying inpatient and outpatient hospital services (hospital services) provided under the plan contract for the rating period; and
2. calculating the difference, for hospitals services identified in Step 1, between what Medicare FFS* would have paid for hospital services two years prior to the rating period and actual Medicaid payments for hospital services two years prior to the rating period. (*Similar to the UPL calculation for FFS.)

The base amount is calculated on an annual basis and recalculated annually to account for changes in enrollment, fee schedules, and service mix. Pass-through payments may not exceed a percentage of the base amount, beginning with 100 percent for contracts starting on or after July 1, 2017, and decreasing by 10 percentage points each successive year. To illustrate, the available hospital pass-through payment for contracts beginning in July 2018 is 90 percent of the base amount. By 2026 only 10 percent of the base amount remains for pass-through payments. By 2027 all hospital pass-through payments will cease.

Phase-Out of Hospital Pass-Through Payments	
Date	**% of Base Amount Allowed**
2017	100%
2018	90%
2019	80%
2020	70%
2021	60%
2022	50%
2023	40%
2024	30%
2025	20%
2026	10%
2027	0%

Physician and Nursing Facility Pass-through Payment Transition. States can make pass-through payments for physicians and nursing facilities from 2017 through 2021 and terminate by 2022. The final rule does not stipulate a base year amount nor a scheduled payment decline over the five-year transition period. States are accorded the maximum flexibility to transition these types of pass-through payments. CMS explains that because these types of pass-through payments are much smaller compared to hospital payments, the state can transition these provider payments on a shorter timeframe.

Provider Payments Supporting Delivery System Restructuring. The special contracting provisions in the final rule allow states to direct plans to participate in multi-payer delivery system reform or performance improvement initiatives, or implement value-based purchasing models, pay for performance, bundled payments, or other provider reimbursement initiatives. CMS argues that its objective is to allow states to direct plans to participate in value-based purchasing models that support its overall goal to move Medicare and Medicaid provider payment to more value-based reimbursement.

CMS provided states with added flexibility to direct 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. States that pursue these delivery system payment arrangements through their plan contract must seek CMS's approval and demonstrate in writing that the payment arrangement:

- is based on utilization and delivery of services;
- directs expenditures equally using the same terms of performance for a class of provider type;
- expects to advance one goal or objective in the state's quality strategy
- has an evaluation plan;
- does not condition participation on the network provider entering into an intergovernmental transfer agreement;
- makes participation in value-based initiatives or delivery system reform initiatives available to a specific class of provider type;
- uses a common set of performance measures across all payers and providers;
- does not set the amount or frequency of the expenditures; and
- does not require recoupment of any unspent funds allocated for these arrangements.

As advocated by AHA, the final rule does provide more flexibility for states, plans and providers to enter into these special contracting arrangements.

In addition, the special contracting provisions provide states and plans some flexibility to explore risk sharing and incentive-based payment arrangements. CMS encourages states to use health plans as partners in achieving delivery system and payment reform, as well as performance improvements. As such, CMS modified special contract standards related to risk-sharing mechanisms, financial incentive arrangements and withhold arrangements to encourage such partnerships. According to the final rule, all such payment arrangements would have to be described in the contract, including any risk-related mechanisms such as risk-sharing, reinsurance, risk corridors or stop-loss limits. Contracts with incentive arrangements could not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

States, according to the rule, will have to ensure that plan contracts that include withhold arrangements – where a portion of the capitation rate is withheld from the plan and all or a portion will be paid to the plan once specified targets in the plan's contract are met – meet the test for actuarially sound capitation rates. In addition, the special contract provisions require that such payment arrangements must be for a fixed period of time, cannot be renewed automatically, must be made available to both public and private contractors under the same terms of performance, and cannot be conditioned on intergovernmental transfer agreements.

Special Initiatives Such as Advancing Population Health or Health IT. In the proposed rule, CMS outlined other special contract initiatives that states could utilize. In the final rule, CMS chose not to codify these initiatives, but instead allows states the flexibility to pursue them. Examples included in the proposed rule were patient-centered medical home initiatives, low-birth weight baby initiatives and provider health information exchanges. In addition, states also could make available incentive payments that support interoperable health information exchange by health plan network providers not otherwise eligible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The EHR incentive payments could be for long-term care, post-acute care, behavioral health and home- and community-based providers.

Medical Loss Ratio Standards (MLR): Calculation, Reporting and State Oversight (Sections 438.8, 438.74)

As advocated by the AHA, the final rule requires states to impose a new, national uniform MLR standard for Medicaid and CHIP managed care plans. The MLR measures the proportion of the managed care plan's premium that is spent providing covered services. States have the flexibility to establish a minimum MLR, but it can be no lower than 85 percent. According to CMS, the new MLR standard better aligns Medicaid and CHIP managed care with MA and the private insurance market. The agency estimated, in the proposed rule, that 28 states currently have MLR standards for Medicaid managed care.

MLR Calculation. The final rule requires states to ensure that, beginning on or after Jan. 1, 2017, each plan calculates and reports its MLR. The rule describes the standards for the calculation and reporting and outlines the state responsibilities for the oversight of those standards. CMS follows the National Association of Insurance Commissioners (NAIC) standards.

The numerator of the MLR would consist of three basic categories – incurred claims of the managed care entity; expenditures for activities that improve health care quality; and expenditures for program integrity requirements. The denominator would be broadly defined as premium revenue, less any expenditures for federal, state taxes and licensing or regulatory fees. In general, the rule uses definitions for incurred claims and revenue that are outlined in federal regulations for private health insurance MLR calculations. The rule does include, however, some unique definitions for incurred claims and health care

quality expenditures. For example, provider “pass through” payments are to be expressly excluded from incurred claims figures. Payments made to state-mandated solvency funds are also to be deducted from incurred claims figures. In addition, CMS provides examples of unique Medicaid expenditures that could count for purposes of health care quality improvement activities including activities related to manage care external quality review, health IT and meaningful use.

CMS uses the NAIC credibility adjustment to take into account claims variability that may skew loss ratios, particularly for small managed care plans. This credibility adjustment is used in the private insurance markets, as well as the MA market. In addition it will base the calculation of the MLR on a 12-month period to make it consistent with the calculation period for MA and private insurance plans. CMS also grants states the flexibility to decide whether to require plan rebates to the state when the plans do not meet the minimum MLR standard of 85 percent.

MLR Reporting. CMS proposes that states require plans to report, as part of their contract, the following information:

- Total incurred claims
- Expenditures on quality improvement activities
- Expenditures related to program integrity
- Non-claims costs
- Premium revenue
- Taxes, licensing and regulatory fees
- Aggregation method
- Methodology for allocation expenditures
- Credibility adjustment applied
- MLR remittance owed to the state if applicable
- MLR calculation
- Reconciliation of information reported with audited financial reports
- Number of member months

The MLR reporting year is a period of 12 months, consistent with the rating period selected by the state. Plans are to report the above information to the state within 12 months after the end of the MLR reporting year. The state is allowed to exclude plans from the reporting requirement in their first contract year.

MLR Oversight. The rule imposes minimum standards for how states oversee plans’ implementation of the MLR standards. States are required to submit annual reports to CMS and include summary descriptions of the MLR calculations for each MCO, PIHP or PAHP. The reports also are to include information on plans’ remittances to the states. Remittances are any amounts owed by the plan to the states for the plan’s failure to meet the state minimum MLR requirement. The final rule also clarifies that the state is obligated to re-pay the federal share of any remittances the state chooses to collect from the plans.

Provider Network Adequacy Standards, and Provider Directory: (Sec. 438.68, 438.10(h))

Provider Network Adequacy Standards. As advocated by the AHA, the final rule requires that states contracting with plans establish minimum provider network adequacy standards. CMS's clear intent is to align the provider network adequacy standards for Medicaid and CHIP with network standards for quality health plans (QHPs) in Marketplaces and MA plans. States will be required to develop time and distance standards for the following provider types covered under the managed care contract:

- 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.

CMS chose not to prescribe how the time and distance standards would be measured (i.e., 30 minutes and 10 miles) leaving such determinations to each state. In addition, the final rule requires that states with managed care contracts that include coverage for LTSS develop time, distance and other network adequacy standards for LTSS provider types.

The scope of state network adequacy standards must include geographic areas covered by the state managed care program, but such standards could vary based on geography for provider types to account for the number of providers practicing in a particular area. In developing network adequacy standards, states must consider such elements as:

- the anticipated Medicaid enrollment;
- the expected utilization of services;
- the characteristics and health care needs of the specific Medicaid populations covered by the contract;
- the number and type of health care professionals needed to furnish the services under the contract;
- the numbers of network health care professionals who are not accepting new Medicaid patients;
- the geographic location of the health care providers and Medicaid enrollees;
- the ability of providers to communicate with limited English enrollees; and

- the ability of providers to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

States also will need to consider elements that support an enrollee's choice of providers, an enrollee's health and welfare, and the best interest of enrollees needing LTSS.

States that provide an exception process to provider network standards must specify the process in the contract with the plan, and it must be based on, at a minimum, the number of health care professionals in the specialty practicing in the plan's service area. States must also monitor enrollee access to providers and include findings in the required assessment report to CMS.

In addition, states must publish the network adequacy standards on their publicly available websites. CMS, through the final rule's commentary section, strongly encourages states to seek stakeholder input in the development of the provider network adequacy standards.

Provider Directory and Drug Formulary. The final rule requires that states ensure that plans and PCCM entities make available their provider directories in electronic or paper form. The directory must include a:

- provider's name and group affiliation;
- specialty (if appropriate);
- contact information (address, telephone number and website);
- information on whether the provider is accepting new patients;
- cultural and linguistic capabilities; and
- whether he/she is located in a facility that is accessible to people with physical disabilities.

These requirements for the provider directory apply to all provider types: hospitals, physicians, pharmacies, behavioral health, and LTSS providers. Plans are required to update directories monthly.

The final rule also includes requirements that the plan must make available the following information about its drug formulary:

- which medications are covered (both generic and brand);
- what tier the medication is in; and
- post the formulary on plan's public website.

***Medicaid and Institutions for Mental Disease (IMD)* §438.6(e)**

The final rule allows states greater flexibility to use managed care to improve access to mental health services for those enrollees aged 21 to 64 and subject to the IMD exclusion. Currently, the law prohibits coverage for adults aged 21 to 64

who are patients in an IMD facility, including private free-standing psychiatric hospitals with more than 16 beds. However, this rule will allow states to pay a capitation payment to managed care plans for enrollees aged 21 to 64 who have a short-term stay of no more than 15 days in an IMD, as long as the facility is an inpatient psychiatric hospital facility, substance use disorder (SUD) inpatient care, or a sub-acute facility providing psychiatric or SUD crisis residential services.

CMS notes that it is the states' choice to exercise this new flexibility and that no Medicaid patient can be required to use the services of designated IMD. CMS explains that this new IMD managed care provision does not violate the statutory IMD exclusion and is based on current rules that allow managed care plans to furnish care in alternate settings that meet an enrollee's needs. In addition, CMS states that federal matching payments will be made for these IMD services as long as they are no more than 15 days within the capitated month. CMS justifies this added flexibility based on the need for greater access to short-term inpatient psychiatric and substance use disorder treatment and notes that 7.1 percent of those aged 18–64 currently meet the criteria for a serious mental illness, while an estimated 13.6 percent of uninsured adults within the Medicaid expansion population currently have a substance use disorder.

Quality Measurement, Improvement and Review (Sections 438.330, 438.340, and 483.350)

The final rule requires that states establish a quality framework built upon the principles set forth in the Department of Health and Human Services' National Quality Strategy and the CMS Quality Strategy. The framework must include establishing a public notice and comment period to determine a core set of performance measures and performance improvement, as well as a state review and approval process for health plans. In addition, the state must develop a quality strategy and that strategy must include:

- state-defined standards for provider networks and availability of services;
- the state's goals, objectives and metrics for continuous quality improvement;
- the state's annual and external independent review process;
- the state's use of intermediate sanctions; and
- the state's assessment of performance and quality outcomes.

CMS's final rule only requires that the quality strategy apply to managed care in all states for both Medicaid and CHIP. The proposed rule would have required that state's quality strategy apply to both FFS and managed care.

In addition, the final rule requires states to establish a new Medicaid and CHIP managed care quality rating system that must include performance information on all health plans. The quality rating system will be based on clinical quality measurement, member experience, and plan efficiency, affordability and management. The quality rating system will measure and report on performance

data collected from the plan on a standardized set of measures determined by CMS. Plans serving only enrollees that are dually eligible for both Medicare and Medicaid can use the MA five-star rating system. States will be required to post on their website plan quality ratings.

CMS recommends that, as a condition of contracting with the state, all plans undergo a performance review in accordance with standards at least as stringent as those used by recognized accreditation organizations and that is conducted at least every three years. States will be required to post each plan's quality approval status on their website.

The final rule also requires an external quality review (EQR) be performed on each plan and that the annual validation of the plans' network adequacy be performed on an annual basis. In addition, the rule expands the states required annual report on quality and access to include data from EQR activities and recommendations on how the state can better support quality, timeliness and access to services in the state's quality strategy.

Managed Long-term Services and Supports (Sections 438.70, 438.71)

The final rule allows state flexibility in the design and administration of managed LTSS, which include home and community-based services and institutional-based services provided through Medicaid managed care. The rule outlines certain best practices to better protect beneficiaries, such as requiring states to create an open and transparently managed LTSS planning process, engage stakeholders, include person-centered process for beneficiaries, establish payment methodologies to reflect goals to improve population health, and provide a beneficiary education and grievance process.

Beneficiary Protections (Sections 438.54, 438.104, 438.210, 438.3, 438.114, 438.230)

The rule has several provisions to enhance beneficiary protections. For example, states are required to ensure that enrollees are able to affirmatively exercise their right to select a plan and must establish standards for voluntary and mandatory managed care enrollment processes. The final rule also clarifies additional criteria a state could use in its default enrollment process to facilitate plan assignments that best meet enrollees' needs.

Another protection relates to plan marketing. Specifically, CMS allows issuers that offer both Medicaid and Marketplace QHPs to market their QHP plan product to Medicaid enrollees in the event the enrollee loses his or her Medicaid eligibility. This change is viewed as an improvement in access to coverage for a low-income population that may be moving from Medicaid to subsidized coverage through the Marketplace. Another enhanced protection includes new standards for plans regarding coverage authorizations if the plan proposes to reduce or eliminate treatment. Under this provision, plans are required to adhere to Medicaid's long-standing requirements that treatments be reasonable in amount, duration and

scope, and not arbitrarily discriminate based on conditions such as chronic conditions or the need for LTSS. Plans are required to expedite authorization decisions from the three working days to 72 hours.

Grievance and Appeals Process. The rule also makes changes to the grievance and appeals process for beneficiaries to better align these processes with those found in MA and private insurance. For example, it requires the enrollee to exhaust one internal plan appeal before seeking review of an adverse benefit determination in a state fair hearing. The rule requires plans to provide, free of charge and upon request, the basis for an adverse coverage decision. CMS choose not to include in the final rule its proposal to allow providers to appeal a coverage decision on behalf of the enrollee without the written consent of the enrollee. Although the AHA strongly supported this proposal, we are pleased that states will retain the discretion to designate providers as authorized representatives of enrollees.

Prescription Drug Coverage. CMS requires states to cover any outpatient drugs that are excluded from the managed care contract through FFS. Plans are also required to respond to drug authorization requests within 24 hours and provide a 72-hour emergency supply of drugs prior to authorization.

Subcontractual Relationships and Delegation. The final rule requires that states stipulate that the managed care plans are accountable for complying with all terms of the contract with the state. CMS, through the rule, applies MA standards with regard to subcontractual relationships and delegation of service delivery to first tier, downstream and related entities. In addition, CMS requires that any plan that delegates activities or obligations under the contract to another individual or entity is ultimately responsible for ensuring that the individual or entity complies with all applicable laws, regulations, sub-regulatory guidance and contract provisions.

Care Coordination. CMS, through the final rule, strengthens care coordination standards imposed on states when a beneficiary moves into a new managed care plan or is in need of LTSS. Specifically, states must have a transition of care policy to ensure continued access to services during a transition from FFS to a managed care plan, or from one plan to another, when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The rule requires that a state's transition care policy needs to ensure that the enrollee has access to services consistent with the access he or she previously had; is able to retain his or her current provider for a period of time; and is referred to appropriate in-network providers of services.

FURTHER QUESTIONS

For more information, contact Molly Collins Offner, director for policy development, at mcollins@aha.org.