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Updating Medicaid managed care

A new CMS rule for quality, transparency, and integrity

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CMS update affects Medicaid and Children's Health Insurance Programs.

Background: Landmark CMS Medicaid and CHIP Managed Care Rule

As of March 2016, 38 states were offering comprehensive Medicaid managed care (MMC) as part of their Medicaid program. These programs cover more than 55 million Medicaid members, which represents greater than one-sixth of the population of the United States.[1] MMC has broad coverage across Medicaid populations, takes diverse forms in how Managed Care Entities (MCEs) are operated, and has been undergoing rapid transformation in recent years. For these reasons, the framework for MCE regulation and oversight at both the state and federal levels had become outdated.

In the spring of 2016, the Centers for Medicare & Medicaid Services (CMS) finalized a landmark regulation governing Medicaid and Children's Health Insurance Program (CHIP) managed care programs. This rule represents a major update to requirements for how state governments contract with and oversee MCEs that offer Medicaid and CHIP products.

The governing objective of these regulations embodies CMS's triple aim—increasing access to care, improving the quality of care delivered, and containing cost. In particular, the rule bolsters access to care for Medicaid recipients by requiring states to develop time and distance standards when developing network adequacy requirements and adding requirements around plan-to-member communications. With a strong focus on quality, the rule requires states to develop quality rating systems for managed care organizations (MCOs) and tightens requirements around quality review audits. The rule also strengthens the financial responsibilities of states and MCEs by requiring a medical loss ratio (MLR) calculation, increasing rate setting transparency, and fortifying program integrity for managed care.

1. Henry J. Kaiser Family Foundation, Total Medicaid MCO Enrollment, http://kff.org/other/state-indicator/total-medicaid-mco-enrollment/.

Overview of the key provisions

The final rule addresses the following key provisions:

— **Calculating a minimum MLR and increasing transparency:** States will now be required to calculate and report MLRs to CMS for MMC plans. In addition, CMS has established a minimum MLR of 85 percent while allowing states to require manage care plans to pay remittances if the 85 percent standard is not met. Subsequently, states would be required to return the federal share of any remittances back to CMS. The rule also requires states to submit actuarially sound rates to CMS with sufficient detail for CMS to monitor the specific data, assumptions, and methodologies behind each state-developed rate. Under the new rule, states will need to certify specific managed care rates per premium rate cell as opposed to rate ranges in their reporting to CMS.

— **Establishing network adequacy requirements:** State Medicaid programs must establish and make publicly available network adequacy standards, including time and distance standards for specific provider types. CMS defers the establishment of the managed care network adequacy standards to the states, but mandates broad parameters for how these standards must be developed. The rule also requires that states improve plan-to-member communication processes by requiring health plans to post provider network lists on their Web sites. Health plans must also ensure that this information be up to date and accessible for members with visual impairment or limited English proficiency.

— **Incentivizing transformation through care delivery and payment models:** States now have significant flexibility to use MMC programs to implement initiatives to improve and integrate care, enhance quality, and reduce costs. CMS has given states the authority to require and incentivize managed care plans to transition to value based purchasing (VBP) models. The rule also clarifies that states can require MCEs to develop and participate in broad-ranging delivery system reform or performance improvement initiatives (e.g., patient-centered medical homes, provider health information exchange, and access initiatives). MCEs can be strong partners for states during transformation efforts as they can provide flexibility in how programs are implemented without requiring changes to Medicaid state plans or waivers.

— **Strengthening program integrity:** The rule adds several components to strengthen Medicaid and CHIP, program integrity to monitor, prevent, identify, and respond to suspected fraud. All providers in Medicaid that render services under a managed care program are now required to be screened and enrolled by the state, as is done in current Medicaid fee-for-service (FFS) programs. In tandem, states will be required to report to CMS encounter data that are complete, timely, accurate, and independently audited in order to receive federal matching payments.

— **Bolstering quality measurement:** The rule requires states to adopt a quality rating system (QRS) for all Medicaid and CHIP managed care plans and develop quality improvement strategies to reduce health disparities and support individuals who require long-term or special health services. Additionally, the scope of requirements for annual external quality review (EQR) of MCOs has been extended.

— **Aligning Medicaid, CHIP, and managed long-term services and supports (MLTSS):** The rule aligns CHIP managed care standards with many of those of the healthcare exchange marketplace and Medicaid to ensure consistency across programs. The new regulation also includes guidance on adequate planning for the MLTSS transition for FFS members. This includes stakeholder engagement procedures, expanding home and community-based services, the development of appropriate payment structures and program goals, and several components of benefit design and beneficiary support.

A deeper look at three impactful provisions

This rule serves as a broad modernization of Medicaid managed care and makes several updates to the existing regulatory framework. However, some of the key provisions mentioned previously are particularly impactful and warrant a more thorough examination from state Medicaid officers, particularly those engaged in transformation efforts.

Deep dive 1: MLR and rate setting requirements

In keeping with its broad theme of aligning Medicaid managed care standards with the standards of insurers operating on health benefit exchanges, the final rule includes a MLR standard for Medicaid MCEs. States may need to develop new monitoring and reporting processes in order to meet this requirement, but they will be given the opportunity to enforce MCE compliance with this standard through remittances (in the form of MCO recoveries). States will also be required to accommodate new requirements from CMS for rate setting transparency.

The MLR regulation requires states to incorporate a minimum MLR standard of 85 percent into their rate setting process for MCEs. In order to comply, each state will need to define a reporting process for collecting and auditing reported MLRs, build MLR targets into their premium development processes for MCEs, and build a process for collecting remittances or rebates where applicable. States will also need to ensure that their reporting on the rate setting processes complies with these new requirements. When this provision is phased in, states will be specifically required to share additional detail on the assumptions and methodology used in rate development and to report specific rate amounts per rate cell instead of rate ranges. This minimizes states' flexibility to adjust rates within a reported range. In order to accommodate this, CMS included a provision allowing states to adjust rates paid by as much as 1.5 percent up or down in certain cases.

Consideration for states

This CMS ruling is placing emphasis on transparency and accountability for MCE financial reporting. States that have both a strong data and analytics infrastructure and a robust program integrity framework will be well positioned to meet these new requirements. The accuracy and accessibility of both financial and encounter data will be key components of MCE oversight under this ruling.

Time line of implementation of key provisions

May 2016	July 2016	July 2017	July 2018	May 2019	July 2019
Federal financial participation for new activities related to EQR	**Access and delivery of member services must meet CMS's cultural competence standards** **Rate setting transparency standards (phase-in begins)**	**Program integrity requirements related to fraud, waste, abuse and recoveries*** **State may require plans to implement DSRIP or VBP initiatives*** **MLR reporting requirements begin***	**Network adequacy and enrollment screening requirements*** **Managed care state quality strategies developed** **EQR activities**	**Medicaid managed care QRS in place**	**Actuarially sound, capitated rates developed so that plan can achieve an MLR of 85 percent*** **QRS provisions**

* Implementation of this provision is no later than the rating period for contracts on or after the date shown on the time line.

Deep dive 2: Quality tracking and reporting provisions

The new regulatory standards for quality measurement and improvement put forth by the CMS rule will require more robust tracking and reporting on the part of states. Systems and processes will need to be adopted or developed to align Medicaid and CHIP quality indicators with those of marketplace standards. These provisions established by CMS include adoption of a QRS, expanded EQR requirements, and the development of state quality strategies. Another major development in the area of quality measurement from CMS is the passage of the Medicare Access and CHIP Reauthorization Act (MACRA). A provision of MACRA will involve publishing essential quality scores for all Medicare physicians. In designing QRS and quality improvement strategies, states may want to examine methods for alignment with MACRA so that information regarding the quality of MCEs and physicians is published in a consistent manner for healthcare consumers.

Adoption of Medicaid and CHIP managed care QRS

The implementation of a QRS will provide enrollees with information about quality of care similar to that which is available to privately insured individuals, increase transparency in Medicaid and CHIP managed care, and allow consumers to compare their plan choices. This will also align with the indicators that are currently used to frame the health exchange marketplace QRS regulatory standards (e.g., clinical quality management; member experience; and plan efficiency, affordability, and management). While some states do have quality ratings for managed care plans, there is currently no national standard. An approval process for states to maintain or develop an alternative QRS has also been put in place by the rule, provided that the alternative yields information regarding plan performance that is substantially comparable to that yielded by the forthcoming CMS-developed QRS.

Expanded EQR processes

The EQR requirements now apply to all MCEs, including state-contracted prepaid ambulatory health plans and primary care case management entities, whose contracts include payment incentives for improved quality. In accordance with enhanced transparency standards, the results of EQRs must be made publicly available.[2]

Consideration for states

In accordance with the Balanced Budget Act of 1997, there is 75 percent enhanced Federal Medical Assistance Percentage (FMAP) funding when states contract with a certified external quality review organization (EQRO) for these functions. FMAP remains at 50 percent for noncertified EQROs.

2. Medicaid.gov, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQROFactSheet.pdf.

Development of managed care quality improvement strategies

States are expected to develop quality improvement strategies within three years of the publication of the final rule in the Federal Register. This explicitly includes:

- A plan to identify, evaluate, and reduce health disparities
- State-implemented mechanisms used to identify individuals who need long-term services and support or those who have special healthcare needs

Deep dive 3: Alignment with DSRIP and VBP transformations

In recent years, CMS has increasingly supported states' innovative efforts to transform care delivery and payment through approval of delivery system reform incentive payment (DSRIP) programs and encouragement of VBP reforms. Reinforcing this support, the ruling provides states with flexibility to use their MMC program to implement initiatives to improve and integrate care, enhance quality, and reduce costs.

Clarity for delivery system and care transformation efforts

In particular, the rule clarifies that states can require MCEs to develop and participate in broad-ranging delivery system reform or performance improvement initiatives (e.g., patient-centered medical homes, provider health information exchange, and access initiatives). This increases the tools and authority that states have to approach delivery system reform efforts through initiatives directed at both providers and health plans. However, it should be noted that while MCOs may now be required to participate in transformation efforts, CMS has reiterated that states cannot direct specific amounts of funding to specific providers through MCEs in the form of pass-through payments, except under limited circumstances.

Authority to transition to VBP

States also now have the authority to require and incentivize the transition to VBP. While not required by CMS, the rule's provisions give broad parameters for states to require and incentivize MCEs to transition to VBP. States may require that MCEs adopt VBP models to reimburse providers and design incentives using capitation rates and other payments to MCEs to encourage participation in specific models. In addition, states may mandate a minimum dollar or percentage increase across all providers or payers.

Impact on state managed care programs

This new rule is a momentous shift in how managed care programs are contracted, overseen, and administered. There is a broad spectrum nationally on how this will impact states. States should perform a comprehensive review of their existing and emerging managed care programs to gain a better understanding of their compliance with all new requirements and their position to take advantage of the new opportunities presented by the rule. Among others, key considerations include:

- Do MCE rate setting and financial reporting processes meet these new standards?
- Should states develop an in-house QRS or await additional guidance from CMS?
- How can I leverage the provisions of this rule to help compliment Medicaid transformation efforts occurring in my state?

Final thoughts

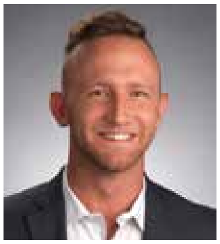
It is clear states are increasingly turning to MCEs for help in coordinating care and providing coverage for their Medicaid programs. This CMS ruling provides a regulatory framework that recognizes managed care as a principal and critical mechanism for state Medicaid programs and brings the requirements that govern managed care into the twenty-first century.

The key provisions stemming from the rule will have a considerable impact on states with a range of new or expanded requirements. However, this gives states the opportunity to strengthen key consumer protections, improve quality of care, and enhance program integrity. This ruling will also open the door for potential administrative efficiencies for health plans as they align Medicaid and CHIP standards with those of the healthcare exchanges and provide continued support for innovative delivery system and payment reform efforts.

Additional resources

- Improved Alignment with Medicare Advantage and Private Coverage Plans
- Strengthening Managed Care in CHIP
- Strengthening the Consumer Experience
- Strengthening States' Delivery System Reform Efforts
- Strengthening Program and Fiscal Integrity and Accountability
- Strengthening the Delivery of Managed Long Term Services and Support
- Modernizing Medicaid and CHIP Managed Care
- Improving the Quality of Care for Medicaid Beneficiaries
- Implementation Dates

About the authors



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