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REACTIONS TO CMS' PROPOSED REGULATORY CHANGES TO MEDICAID AND CHIP MANAGED CARE

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OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) ended the year with proposed changes to Medicaid and the Children's Health Insurance Program (CHIP) managed care regulations finalized in 2016. Based on the Administrator's stated goals of reducing state administrative burden and increasing flexibility, CMS' proposals include changes to rate-setting and managed care operations; but do the proposals ultimately serve the stated goals?

RATE-SETTING PROPOSED CHANGES

CMS has proposed a few substantive changes to documentation and permissible payment arrangements from the 2016 final rule, along with several clarifications and technical corrections. Most of these proposed changes increase the flexibility for states and remove previous burdens or barriers that will likely be appreciated in most cases. Highlights include:

- **Creating Optional Narrow Rate Ranges** – Reportedly to accommodate competitive managed care plan procurements, CMS proposes to allow states to certify to a maximum range of 5% from the lower bound to upper bound capitation rate. However, once capitation rates are certified within the range, they cannot be changed without a revised certification subject to CMS approval. That also would mean states looking to gain additional flexibility provided by a rate range would forgo the ability to move rates ±1.5% without a recertification as permitted under current regulations.

- **Streamlined Directed Payments** – Created as an alternative to the elimination of pass-through payments in the 2016 final rule, directed payments require states to submit administrative "preprints" detailing the terms of provider payments directed by the states via managed care plans. CMS has frequently observed preprints requiring managed care plans to adopt minimum rates based on already approved State Plan fees. Seeing an opportunity to simplify the administrative approval process, CMS proposes to exempt these State Plan-approved minimum fee schedule directed payments from the preprint process. CMS also proposes to codify existing guidance to permit multi-year preprints for strategies that will advance over time, such as value-based, quality, and multi-payer directed payments.

- **Introducing New Pass-Through Payments** – CMS proposes allowing new pass-through payments when transitioning services and populations from fee-for-service (FFS) to managed care for the first time. This proposal allows states to continue historical supplemental payments to hospitals, nursing facilities, and physicians proportionately in managed care for up to three years. This continuation is intended to support the implementation of managed care and remove the unintended barrier that was created in the 2016 final rule.

- **Prohibiting Variation in Rating Assumptions by Federal Financial Participation (FFP)** – CMS proposes to further clarify in regulation that states cannot use different rating assumptions to cost shift for populations with higher FFP and identifies specific examples. Regulation would specify that profit margins, required provider fees, and minimum medical loss ratio (MLR) thresholds cannot be higher in other populations than for the population with the lowest average rate of FFP (or lower in the case of MLR). This provision is presumably targeting the newly eligible expansion population, which will be funded 90% by the federal government for calendar year 2020 and beyond, but could potentially affect other populations as well.

- **Prohibiting New or Modified Risk-Sharing Arrangements After the Start of the Rating Period** – To eliminate the practice of changing risk-sharing arrangements retrospectively, CMS would require states to submit contracts and rate certifications with such arrangements prior to the beginning of the rating period. While there may be retrospective changes to rates in certain cases, the risk-sharing provisions may not be modified and new risk-sharing arrangements could not be added after the rating period begins. This restriction does not mean CMS must approve the submissions prior to the start of the contract period but does present a more rigid timing requirement than has been enforced in the past.

Other proposed changes are less significant or are more clarifying in nature. These include a technical correction to MLR reporting requirements, a clarification on encounter data submission requirements, a commitment by CMS to provide annual rate certification documentation guidance, flexibility in approaches to sharing cross-over claims with managed care organizations, and a clarification for the application of the ± 1.5% provision.

STATE AND MANAGED CARE OPERATIONS PROPOSED CHANGES

Proposed changes to Medicaid and CHIP operations and requests for comments involve requirements in the following areas: information for enrollees and potential enrollees, network adequacy standards, enrollee appeals, quality rating systems, external quality review, quality strategy, and Institutions for Mental Diseases (IMDs) as an in lieu of setting. The substantive proposals and requests for comments are as follows:

- **Loosening Information Requirements** – To provide flexibility in format of enrollee communications, CMS proposes to limit the use of taglines to enrollee and potential enrollee materials that are critical to obtaining services and adopting the "conspicuously visible standard" for taglines used in the private market. In addition, hard copies of provider directories would be subject to quarterly, rather than monthly, updates as long as the managed care plan has a mobile-enabled app to access the current provider directory. CMS also proposes to modify the timeframe for managed care plans to notify enrollees of a provider that has been terminated from the network.

- **Broadening Network Adequacy Standards** – CMS proposes revising the network adequacy standards to allow states to adopt quantitative minimum access standards for specific provider types, including long-term services and supports (LTSS) providers, which would not be limited to time and distance standards. Such quantitative network adequacy standards could include provider-to-enrollee ratios, open panel status, average wait times, and provider hours of operation.

- **Modifying Enrollee Appeal Parameters** – CMS proposes to clarify that a managed care plan's denial of a non-clean claim is not an adverse benefit determination subject to an appeal. In addition, an enrollee's oral appeal would no longer require a subsequent written and signed appeal. CMS proposes to give states discretion to align the timeline for enrollees to file a state fair hearing request with FFS. This would permit states to elect a state fair hearing timeframe between 90–120 days from the managed care plan's notice of resolution.

- **Relaxing Alternative Quality Rating System (QRS) Standards** – If a state elected to implement an alternative QRS, it would not be subject to prior CMS approval; however, an alternative QRS would need to use the CMS mandated performance measures once established.

- **Seeking IMD Length of Stay Data** – While CMS did not propose changes to the requirements to make capitation payments for enrollees with short-term stays in an IMD for psychiatric or substance use disorder services, data is requested from states to counter the existing 15-day stay limitation.

- **Clarifying CHIP Requirements** – The proposed changes to the standalone CHIP regulations are primarily to clarify the scope of Medicaid regulations that apply to such managed care programs and that compliance for standalone CHIP programs is tied to the state fiscal year (beginning July 1, 2018) regardless of the actual contract period.

REACTIONS

Overall, the proposed rule is not drastic in its changes and states and managed care plans are likely to benefit from the possible regulatory relief. However, some of the proposed flexibilities may require more documentation from states and resulting scrutiny from CMS.

- The optional rate ranges offer little flexibility as the documentation requirements are stringent and states would forfeit the flexibility to modify capitation rates ±1.5% without a revised rate certification. Additionally, no support is provided for the proposed range of 5%, which is more narrow than typical rate ranges of the past.

- Regarding directed payments, states will find the preprint exemption for minimum fee schedules based on State Plan-approved rates and the multi-year approvals appealing. Preprints take work and both proposals will reduce administrative burden. However, these changes will only apply in certain cases and will not reduce the process for many other directed payments (such as those modeled after historical FFS supplemental payments). States may be interested in additional opportunities to further streamline this process, such as the evaluation requirement for directed payments subject to one-year approval.

- New pass-throughs will be useful for states that are thinking of expanding managed care to include hospital, physician, or nursing facility services currently provided in FFS. The 2016 final rule created a

barrier as these supplemental payments can be challenging to eliminate immediately or quickly transition to a directed payment. This proposal would maintain historical funding streams to providers that were prohibited under the existing regulations, which will likely garner greater stakeholder support for expanding managed care.

- The network adequacy proposed changes are likely among the most significant departures from the 2016 final rule. States and managed care plans have already invested significant resources to comply with the existing time and distance requirements. We anticipate the flexibility, if finalized, will be well-received. However, modification to network adequacy standards may be slow as states would need to determine which quantitative standards work best for each provider type subject to measure.

- A few of the proposals may have unintended consequences for some states. The restrictions on varying rating assumptions for populations with a higher FFP is intended to protect the federal Medicaid spend but creates valid actuarial concerns, especially for higher cost populations that are subject to standard FFP levels such as those requiring managed LTSS. States will need to consider their program structures and identify cases where these requirements may impact their current contracts and rate-setting approaches. Similarly, states will need to be aware of the proposed submission requirements for risk-sharing arrangements. It is not yet clear how CMS would enforce the submission timing, but it is possible states could find their FFP at risk or forfeit use of risk-sharing arrangements if contracts and rate certifications are not submitted prior to the rating period.

We appreciate the effort by CMS to revisit the regulatory framework based on experience and stakeholder input. Remember, the proposals do not become law until CMS issues a final rule and establishes effective dates for the changes. The comment period for the proposed rule closed January 14, 2019, and it is anticipated CMS will issue a final rule no earlier than the second calendar quarter of 2019. It will be interesting to see how CMS addresses public comments in the final rule and if additional proposals are considered in light of the comments received. Mercer will continue to partner with our clients to identify how the final changes will impact their unique Medicaid programs and how to use the changes for their benefit.