

# Health Advocate

E-Newsletter of the National Health Law Program

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## Medicaid Managed Care: Modernized Federal Regulations Have Finally Been Released

Prepared by: Sarah Somers, NHeLP Managing Attorney

### Key Resources

[The Medicaid Managed Care Provisions Series](#)

[Health Advocate: Medicaid Managed Care: Modernized Federal Regulations are Long Overdue](#)

[Letter to CMS: Modernization of Medicaid Managed Care Regulations](#)

[NHeLP Recommendations Modernization of the Medicaid Managed Care Regulations](#)

**Coming in July's Health Advocate:**

**The ACA and LGBT Health**

### Introduction

On June 1, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that overhauls the Medicaid managed care regulations for the first time since 2002. These changes, some of which are significant, will not only affect millions of Medicaid beneficiaries, but will also have a profound impact on providers, health plans, and state and local officials. Thus, advocates should closely review and comment on these requirements. The regulations are published as: *Medicaid Managed Care, CHIP Delivered in Medicaid Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*, 80 Fed. Reg. 31,098-31,297 (proposed June 1, 2015) (to be codified at pts. 431, 433, 438, 457).

The proposed regulations retain the same basic structure and many of the same requirements as the current rules. The proposal also, however, updates and refines the legal and technical requirements governing Medicaid managed care, including enrollee rights and protections, quality assessment and performance improvement, network adequacy, grievances and appeals, actuarial soundness, and rate setting. The proposed regulations also impose new requirements, notably, a requirement that plans calculate and report a Medical Loss Ratio. This issue of the *Health Advocate* provides an overview of the most significant changes that will directly affect beneficiaries.

### Overview

Since the managed care regulations were adopted in 2002, the Medicaid program—and health care delivery in general—have changed significantly. Millions more Medicaid beneficiaries receive their care through managed care. The Affordable Care Act (ACA) significantly reformed Medicaid, as well as other publicly funded insurance programs, private insurance, and group health plans. Accordingly, one of CMS' primary purposes in promulgating the new regulations is to align existing managed care requirements with those governing other types of insurance coverage. The proposed rule also recognizes that delivery of Managed Long Term Services and Supports (MLTSS) is now much more prevalent in Medicaid managed care than it was when the current regulation was written. Thus, CMS has proposed many changes to account for the special needs of the growing number of enrollees who need MLTSS. CMS has also stated that the rule is intended to improve the beneficiary experience, increase access to

information about states' Medicaid managed care programs, and strengthen actuarial soundness and other payment regulations. Strengthening provider networks and ensuring program accountability safeguards are other stated goals of the proposed rule.

Overall, there is much here for advocates to support. Notably, CMS proposes more specific requirements for provider network standards, enrollment and disenrollment processes, and plan accountability. Advocates should also welcome stricter standards for availability of information about managed care, access for people with Limited English Proficiency (LEP) and disabilities, and state monitoring of plan performance. Significant improvements in grievance and appeals regulations are also welcome. At the same time, CMS has left significant discretion to state Medicaid agencies to determine characteristics of their managed care programs, including specific standards for network adequacy, disenrollment, and accessibility. The remainder of this *Health Advocate* summarizes some of the major provisions in the proposed rule.

## **Definitions**

The proposed rule includes a number of new definitions. In addition to the existing definitions for managed care organizations (MCOs), Prepaid Inpatient and Ambulatory Health Plans (PIHPs, PAHPs), and primary care case managers (PCCMs), CMS defines a "PCCM entity." This is an organization that provides oversight and case management functions in addition to primary case management, including intensive case management, development of enrollee care plans, enrollee outreach and education, claim and utilization review, and quality improvement activities. A definition is also added for a "Non-Emergency Medical Transportation (NEMT) PAHP," which is a PAHP that exclusively provides nonemergency medical transportation services.

## **Access to Information**

The proposed regulations require that information be available to potential and current enrollees in electronic format and that it be disseminated in a manner that complies with federal antidiscrimination and accessibility standards. States, enrollment brokers, and managed care plans must provide all required information in easy-to-understand, readily accessible formats. This includes operating a website, either directly or by linking to individual plan websites. Plans are required to use state-developed, standard definitions for a number of terms and model member handbooks and notices. States must also ensure that the format and website placement is prominent and readily accessible and the state and plan inform enrollees that information is available in paper format free of charge within five days.

The proposed regulations also strengthen existing requirements for accessibility for people with disabilities and LEP. They require states to identify the prevalent non-English languages spoken in the state and plan service areas. Information must be made available in each prevalent non-English language, and all written materials must contain taglines in those languages in 18 point print. Oral interpretation and auxiliary aids, such as TTY/TDY and ASL, must be available, and written materials must be available in alternative formats and through auxiliary aids and services. These accommodations must be offered at no cost.

## **Network Adequacy and Continuity of Care**

The current regulations require only that states ensure an adequate supply of providers, without much additional specificity. NHeLP, like many other advocacy and provider organizations, urged CMS to promulgate stronger and more specific standards for managed care network adequacy. At the same time, state Medicaid agencies and plans asked for maximum flexibility in designing networks. In the proposed rule, CMS seems to have taken the middle road. It proposes to require *states* to develop and enforce specific network adequacy standards. States would not be

required to set specific provider-beneficiary ratios, but must develop time and distance standards for (1) primary care, (2) OB/GYN, (3) behavioral health, (4) adult and pediatric specialist, (5) hospital, (6) pharmacy, (7) pediatric dental, and other provider types determined by CMS. States that cover MLTSS through capitated managed care plans must develop time and distance standards for MLTSS services where beneficiaries travel to providers and vice versa.

The proposed regulations require that, in assessing network adequacy, states must account for a number of factors, including (1) the number and types of health care professionals needed to provide covered services; (2) the number of network providers that are not accepting new Medicaid patients; (3) the geographic location and accessibility of the providers and enrollees; (4) the ability of providers to ensure physical access, accommodations, and accessible equipment available for Medicaid enrollees with physical or mental disabilities; and (5) the ability of providers to ensure culturally competent communication considering the ability of network providers to communicate with limited English proficient enrollees in their preferred language.

The current version of the continuity of care requirement is brief and lacks specific requirements. The proposed rule adds a new requirement that individuals transitioning from FFS to managed care or between plans be able to maintain a comparable level of services during transition. In addition, enrollees must be able to continue care with an out-of-network provider when lack of continuity could cause serious detriment to an enrollee's health or put him or her at risk of hospitalization or institutionalization.

### **Quality and Accountability**

The proposed rule significantly strengthens and expands upon the current regulatory quality of care provisions. CMS proposes to require states to implement comprehensive quality improvement standards that would encompass the entire Medicaid program, including FFS and PCCMs. The proposed rule also includes greater opportunities for stakeholder participation in quality assessment and performance improvement planning, including a new requirement that the state obtain input from the Medical Care Advisory Committee when engaging in strategy development. CMS also proposes additional specifications for quality assessment and performance improvement programs, managed care quality rating systems, and requirements governing External Quality Review (EQR) processes and organizations. Also, for the first time, the proposed rule applies EQR requirements to PAHPs.

### **Medical Loss Ratio and Actuarially Sound Rates**

The medical loss ratio (MLR) indicates the proportion of managed care plan expenditures for claims and quality improvement activities compared to spending on administrative expenses. The proposed rule sets, for the first time, MLR requirements for Medicaid managed care and requires that MCOs, PIHPs, and PAHPs calculate and report their MLR annually. The rule does not require states to mandate a minimum MLR but, if the state does so, it must be equal to or greater than 85 percent. This means that plans would be required to show that the amount of payments for incurred claims and quality improvement activities divided by adjusted premium revenue. Unlike in the private insurance market, plans are not required to issue rebates to enrollees if they fail to meet the MLR standard.

Under the proposed rule, the calculation of the MLR is a key component in determining actuarially sound rates. Such rates are those projected to provide for all reasonable, appropriate, and attainable costs and that are reviewed and approved by CMS. CMS requires that rates be set such that an MCO, PIHP, or PAHP has an MLR of at least 85 percent. CMS "believes that considering the MLR as part of the rate setting process would be an effective way to ensure that program dollars are being spent on health care services, covered benefits, and quality improvement efforts, rather than on potentially unnecessary administrative activities." 80 Fed. Reg. at 31, 107.

## Grievances and Appeals

Advocates will find a number of changes in the proposed regulations governing grievances and appeals. Most significant, the rule would address a long-standing issue about which advocates have complained for many years. Medicaid law and the U.S. Constitution prohibit termination of services for Medicaid beneficiaries without the opportunity for a hearing. In practice, this means that state Medicaid agencies generally may not interrupt or terminate services during an appeal until a final hearing decision is reached. But, since 2002, the federal regulations have allowed MCOs and PIHPs to terminate services at the end of an authorization period. (*e.g.*, 90 days of in home care) The proposed rule eliminates the link between continued services and an authorization period and requires that plans continue services until a final appeal decision. CMS offers this as “a critical enrollee protection, given the nature and frequency of many ongoing services, particularly for enrollees receiving” long term services and supports. *Id.* at 31, 339.

Other changes are also likely beneficial to Medicaid enrollees. The proposed rule expands and clarifies that “adverse benefit determinations” include not only actions to terminate or reduce services, but also decisions about medical necessity for, and appropriateness or effectiveness of services and the setting in which health care is provided and, as such, give rise to notice and hearing rights. The rule would also, for the first time, require PAHPs to have a grievance process. In changes that may be less welcome, the proposed rule would require exhaustion of internal plan appeals and impose a uniform 60 day deadline in which appeals must be filed. Plans would, however, have only 30 days to make a determination on the appeal, rather than the current timeframe of 45 days.

## Long Term Services and Supports

As noted above, CMS has proposed many changes to specific requirements governing Medicaid managed care to ensure that it appropriately serves enrollees who need LTSS. The proposed rule would codify existing CMS guidance setting forth key principles states should follow when implementing MLTSS programs through a Medicaid waiver. In addition to defining LTSS, the proposed regulation includes standards for enrollee materials, stakeholder engagement, compliance with the Americans with Disabilities Act, LTSS beneficiary support, person centered planning, provider qualifications, and more.

## Reproductive Health

Many of the changes described above will benefit enrollees who need reproductive health services, such as requiring that MCOs, PIHPs, and PAHPs establish time and distance standards for OB/GYNs. In addition, under the proposed rule, utilization controls for family planning services may only be allowed when they do not interfere with an enrollee’s freedom to choose a family planning method.

## Conclusion

In addition to the matters highlighted above, there is much more to the proposed rule that will interest advocates and on which they will want to comment. Comments are due to CMS by July 27. Accordingly, to assist advocates who want to weigh in on this proposed rule, NHeLP will be providing detailed analysis and model comments in the weeks to come.

## About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

## Author

The following NHeLP attorney contributed to this month's *Health Advocate*:

[Sarah Somers](#)  
Managing Attorney  
NC Office



## Offices

### Washington, DC

1444 I Street NW, Suite 1105  
Washington, DC 20005  
(202) 289-7661  
[nhelpdc@healthlaw.org](mailto:nhelpdc@healthlaw.org)

### Los Angeles

3701 Wilshire Blvd, Suite 750  
Los Angeles, CA 90010  
(310) 204-6010  
[nhelp@healthlaw.org](mailto:nhelp@healthlaw.org)

### North Carolina

101 East Weaver Street, Suite G-7  
Carrboro, NC 27510  
(919) 968-6308  
[nhelpnc@healthlaw.org](mailto:nhelpnc@healthlaw.org)

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