Highlights of the Medicaid Managed Care Final Regulations

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April 26, 2016

The final Medicaid Managed Care rule retains nearly all of the requirements of the proposed rule and does not make substantial changes to it. In particular, the regulations related to NHeLP's primary focus areas – grievance and appeal, network adequacy, transparency and accountability, and access for people with disabilities and limited English proficiency – remain largely unchanged. Thus, both the positive and problematic provisions originally proposed will govern the Medicaid and CHIP programs, and few of the changes that NHeLP suggested were accepted by HHS. Overall, however, we are pleased with the final rule and believe it can substantially improve care for Medicaid beneficiaries.

In this memo, we summarize selected regulations – primarily those related to NHeLP's main focus areas. While we will not discuss the requirements governing Medical Loss Ratio and actuarial soundness in this memo, we note that these requirements are largely unchanged from the proposed rule. Plans will still be required to calculate and report a Medical Loss Ratio.

Please note: This memo is based on our initial review of the final rule. We will be reviewing these regulations more thoroughly and will have additional, in-depth analysis in the coming days and weeks.

Grievance and Appeal

There were few changes to the grievance and appeal regulations. Notably, HHS retained the proposed requirement that plans must continue coverage of services pending an appeal decision. If an enrollee requests services within an authorization period, the plan may not end coverage at the end of that authorization period. 42 C.F.R. § 438.420.

Many plans in Medicaid programs around the country had a practice of terminating services at the end of an authorization period, even if the resolution of the appeal was

months away. This caused serious problems for individuals with disabilities or chronic needs, and advocates have urged HHS to fix this problem for years. Thus, this change is a welcome and long overdue improvement.

Network Adequacy

HHS changed very little from the proposed rules. Notably, HHS proposed to require states to develop time and distance standards for certain types of providers. This requirement is included in the final rules with only slight revision: behavioral health providers must include both providers who treat mental health conditions and those that treat substance use disorders. The state network adequacy standards must also account for both adult and pediatric providers. §438.68(b)(i)(3). HHS also added a requirement that states, when developing geographic access standards, account for the availability of triage lines and screening services, telemedicine, or other innovative technological access solutions. *Id.*, § 438.68(c)(1)(ix).

In a welcome change, HHS added a requirement that states must ensure that MCO and PHP networks "include sufficient family planning providers to ensure timely access to covered services." *Id.*, § 438.206(b)(7). According to the preamble, HHS agreed with commenters, including NHeLP, who recommended this addition. HHS also required plans to explain in their enrollee handbook that enrollees do not need a referral to see the provider of their choice – in-network or out-of-network – for family planning services and supplies. *Id.*, § 438.10.

MCOs and PHPs are required to produce treatment or services plans for all enrollees who require LTSS. They must do so for those with special health care needs only if required by the state. In the proposed rule, MCOs and PHPs were only required to produce these plans for enrollees with LTSS if the state required it. *Id.*, § 438.208(c)(3).

Advocates also recommended that HHS require designated care coordinators to coordinate plan services with services that an enrollee receives from other providers, such as Protection and Advocacy and legal services organizations, centers for independent living, agencies on aging, and state and local governments. Accepting this suggestion, the final regulation requires care coordinators to coordinate with "community and social support providers." *Id.*, § 438.208(b)(2)(iv).

States must permit enrollees to disenroll and switch to another managed care plan or FFS when the termination of a provider from their MLTSS network, but only when loss of the provider would result in a disruption in their residence or employment. § 438.56(d)(2)(iv).

Family planning services

The proposed regulation made clear that plans may place appropriate utilization controls on family planning services as long as the services "are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 441.20." Section 441.20 requires enrollees to be free from coercion or mental pressure and free to choose the method of family planning to be used. Advocates asked HHS to explicitly state that plans must cover all FDA-approved contraceptive drugs and devices, voluntary sterilization procedures, patient education and counseling on contraception, and follow-up services (including management of side effects, counseling for continued adherence, and device insertion and removal) without prior authorization, restriction, or delay. Although HHS did not make these changes in the text of the final regulation, the preamble does address when states and plans may adopt utilization controls for family planning services and supplies. For example, CMS made clear that states and MMC plans may not adopt step therapy requirements for family planning services and supplies. CMS made a strong statement that states and plans may not use utilization controls that "effectively deprive" enrollees of "free choice of equally appropriate treatments." Preamble, p. 508.

Language and disability accessibility

HHS added the definition of Limited English Proficiency (LEP) used by the Office for Civil Rights. The regulation does not define “prevalent language,” but leaves that decision up to the states. It adds denial and termination notices to the list of vital documents that must be translated into prevalent languages. Taglines need only be in “prevalent” languages. Large print taglines must be at least 18 point font. Oral interpreting must be provided in *all* languages not just prevalent languages. The final regulation also extends applicability to PCCMS. 42 C.F.R. § 438.10.

Quality

Overall, HHS made few changes to the proposed regulations, with a few notable exceptions.

States must require MCOs, PIHPs, and PAHPs to have an ongoing comprehensive quality strategy. *Id.*, § 438.340. HHS had proposed a requirement that states draft and implement a written quality strategy plan that includes Medicaid Fee-For-Service. *See* Proposed 42 C.F.R. § 431.502 (80 Fed. Reg. 31097, 31253). This requirement did not make the final regulation. HHS explained that, after considering the comments, “we are convinced that the time and resources required to develop and implement a

comprehensive quality strategy would e higher than we estimated in the proposed rule, and could hamper other state quality efforts." HHS does, however, "strongly encourage states to report on the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and to explore other ways to measure, improve, and report on the quality of care in FFS." Preamble, at 724.

The final rule also adds new definitions for "health care services" and "outcomes" and changed the definition of "quality." These definitions now include services and measure concepts beyond medical services, such as satisfaction or goal achievement from supportive services. This is particularly helpful to populations with behavioral and LTSS needs. *Id.*, § 438.320.

The final rule did not include the proposed requirement that states must accredit MCOs, PIHPs and PAHPs, or have them obtain private accreditation. This requirement was dropped from the final regulations. If such an entity is accredited, however, CMS must have access to the accreditation report and must post it on the website.

Finally, in a welcome addition to the requirements of the proposed rule, states must require plans to address health disparities in their MMC quality strategies based on race, ethnicity, sex, primary language, age, and disability status. *Id.*, § 438.340.

Transparency, monitoring, and stakeholder involvement

The final Medicaid managed care rule largely retains the proposed requirements, which should significantly improve transparency, oversight, and opportunities for stakeholder engagement. However, HHS did not accept a number of our recommendations regarding data and program reporting requirements.

Oversight and monitoring. States are required to establish a managed care monitoring and reporting system under § 438.66. NHeLP and other health advocates welcomed HHS' proposal to expand and clarify monitoring activities and to use that data to improve managed care program performance. States are required to produce an annual report of its monitoring and oversight activities, including financial performance, accessibility of services, encounter data, grievances and appeals, and quality improvement.

However, in the final rule, HHS declined to establish additional monitoring requirements, such as direct testing of provider directories, network adequacy, timeliness standards, prescription drug formulary adequacy, and disenrollments. NHeLP also urged HHS to

require states to actively engage consumers and other stakeholders in monitoring activities by providing quarterly updates to the Medical Care Advisory Committees and LTSS stakeholder groups, as applicable, which it did not do. HHS extended the publication of the state's annual managed care report no later than 180 days after the end of the contract period. Thus, we are concerned that much of the data and other information provided in the report will be outdated and of little use for monitoring.

Transparency. Under § 438.602(g), states are required to publicly post MCO, PIHP, PAHP, or PCCM contracts, information on ownership and control, documentation showing access and availability of services including provider networks, and the results of periodic audits. The final rule makes posting of this information mandatory, and not just available upon request.

However, the final rule backtracks from the proposed rule, which required posting encounter data, information on the actuarial soundness of capitation rates, compliance with MLR requirements, solvency reviews, and annual reports of overpayment recoveries. The final rule does not include this requirement.

Stakeholder engagement. States and managed care companies are required to establish stakeholder groups for LTSS under § 438.70 and § 438.110. These new stakeholder groups are in addition to the Medical Care Advisory Committees.

NHeLP and other advocates urged HHS to provide detailed requirements for stakeholder groups, including composition, meaningful participation, and state support for stakeholder group activities. HHS. however, retained language from the proposed rule that prescribes only broad requirements for such groups.

The final rule does provide for an enhanced role for MCACs and the LTSS stakeholder groups, requiring their consultation in developing quality improvement strategies, performance improvement plans, the develop of quality star ratings, and reporting on state oversight activities.

Other notable provisions

Payments for services in Institutions for Mental Diseases (IMD). The proposed rule allowed states to make payments to MCOs and PIHPs for enrollees who stayed up to 15 days in an IMD. This is a reversal of previous policy and is an exception to the Medicaid rule prohibiting payment for services in an IMD. Some advocates objected to this provision, arguing that it would encourage institutionalization and remove an incentive for Medicaid agencies and plans to arrange for community based

services. Despite objections, HHS included this provision in the final rule. HHS did, however, include a requirement that provision of IMD services must meet the requirements for "in lieu of" services. *Id.,* § 438.6(e). The final regulations codify this longstanding policy allowing states to cover alternative services or settings "In lieu of services" those covered under the state plan. *Id.,* §438.3(e). HHS writes that this will provide the enrollee with meaningful choice between IMD and community based services. Moreover, HHS states that a managed care plan may not force the enrollee to receive services at an IMD. Preamble at 221-22. Despite this addition to the regulation and HHS assurances, this exception to the IMD exclusion continues to cause us concern. It is likely that it will encourage institutionalization of people with mental health and substance use disorders. Most individuals in crisis are either not in the position to demand in lieu of services or not given the option to choose. Families of these people may feel that they have no choice but to agree to placement in an IMD. Meanwhile, plans and state agencies have less incentive to develop and provide community-based options.

Beneficiary Support System (BSS). NHeLP and other advocates suggested that HHS expand the powers of the BSS. In particular, we advocated that the BSS functions required to be available to LTSS beneficiaries also be available to all beneficiaries, particularly assistance and education about grievance and appeals processes. HHS did not accept these suggestions. The summary of comments in the preamble indicates that plans and state agencies pushed back on this requirement, complaining that it would be too burdensome. Thus, advocates should view the retention of the BSS requirements as a victory for beneficiaries. *Id.*, §438.71.

Provider discrimination. While HHS did not add a specific provider non-discrimination requirement to the final regulations, it clarifies that plans cannot discriminate against health care providers based on race, color, national origin, language, disability, age, or sex under governing federal statutes. Preamble, p. 937.

Conclusion

NHeLP will be providing additional, in-depth analysis of the final rule. Watch for the next issues of the *Health Advocate*, upcoming issue briefs on our core issues, and announcements for advocate's calls and webinars.

You can find the full text of the rule here.

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