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ALERT

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Proposed CMS Rule Aims to Modernize Managed Care for Medicaid and CHIP Enrollees

On May 26, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (the "Proposed Rule") that would revise the Medicaid managed care regulations for the first time since 2002. Since the regulations were last updated, managed care plans have grown to cover a large percentage of the Medicaid population, including an increasing number of people with long-term services needs or disabilities. The Proposed Rule is intended to modernize the Medicaid managed care program, align Medicaid managed care rules with those applicable to other health insurance programs, and improve beneficiaries' experience of care, while still allowing states flexibility. In a press release, CMS Acting Administrator Andy Slavitt said that

> [a] lot has changed in terms of best practices and the delivery of important health services in the managed care field over the last decade. This proposal will better align regulations and best practices to other health insurance programs, including the private market and Medicare Advantage plans, to strengthen federal and state efforts at providing quality, coordinated care to millions of Americans with Medicaid or CHIP insurance coverage.

CMS stated that the proposed changes will help to "ease the administrative burden on issuers and regulators" while also providing "an appropriate level of protection for enrollees." The Proposed Rule includes significant changes in the following key areas:

- Medical Loss Ratio
- Actuarial Soundness
- Beneficiary Protections
- Quality Measurement Programs
- Payment Reform

> Managed Long-Term Supports and Services
> Children's Health Insurance Program

CMS is soliciting comments on the proposed rule. Comments will be accepted until 5 p.m., July 27, 2015.

Medical Loss Ratio (MLR)

The Medicaid managed care regulations do not currently include an MLR requirement, although many states have adopted some form of MLR. The Proposed Rule would impose an MLR requirement of at least 85 percent, meaning that at least 85 cents of every premium dollar would be required to be spent directly on health care. These MLR standards would go into effect for contract years beginning on or after Jan. 1, 2017. The Proposed Rule includes standards for what should be included in the MLR calculation but has invited stakeholders to identify non-direct care services that should nevertheless be considered "medical" for purposes of the MLR calculation. In doing so, CMS has acknowledged that certain activities, such as care management, should be evaluated for their overall contribution to improved health outcomes of beneficiaries.

Actuarial Soundness

The Proposed Rule includes requirements intended to make the rate setting process more transparent and to ensure actuarial soundness of rates. Current rules for actuarial soundness require that plans' rates be certified by a qualified actuary. The Proposed Rule includes a definition of "actuarially sound" that would require rates paid to Medicaid managed care plans to "provide for all reasonable, appropriate, and attainable costs" required under the managed care contract. CMS would review rates to ensure that they are appropriate and adequate and to determine whether the plan will reasonably be able to meet MLR requirements.

Beneficiary Protections

CMS aimed to create standards to ensure that beneficiaries have access to adequate provider networks and are well-informed about their Medicaid plans. The Proposed Rule would require States to develop and enforce network adequacy standards, including time and distance standards for primary care, OB/GYN, behavioral health, specialists, hospital, pharmacy, and pediatric dental. The Proposed Rule would also direct states to require plans to maintain accurate provider directories and formularies on their websites. States would be required to develop a system to educate beneficiaries about Medicaid Managed Care Plans, including the basic features of managed care, the service area of each managed care plan, covered benefits, provider directory information, cost sharing requirements available care coordination services, and quality measurements of each plan.

Quality Measurement Programs

The Proposed Rule seeks to strengthen the quality of care provided by strengthening transparency and quality measurement by establishing a quality rating system and broadening state quality strategies and consumer and stakeholder engagement. The Proposed Rule would require states to adopt a quality rating system similar to that used in the ACA exchanges. Each state would establish a rating system that would be based on three components: clinical quality management, member experience, and plan efficiency. The ratings would be published on a state website. The rule would also require that all states have quality strategies in place to ensure the delivery of quality health care. CMS would establish a national set of quality measures and states could develop additional measures to be used in combination with the

national quality measures. The Proposed Rule would also allow states to defer to the Medicare quality ratings for those plans that service only dual-eligibles.

Payment Reform

The Proposed Rule would require Medicaid plans to have mechanisms in place to promote care coordination and delivery system reform. Under the Proposed Rule, a state could require a plan to implement value-based purchasing models for provider reimbursement, including pay for performance arrangements, bundled payments, and other models that recognize and reward value and outcomes over volume of services. Additionally, under the Proposed Rule, a state could require Medicaid plans to participate in a multi-payer delivery system reform or performance improvement initiative, such as adopting a minimum fee schedule for providers furnishing a particular service under the Medicaid managed care contract, or providing a uniform dollar or percentage increase for all providers furnishing a particular service under the Medicaid managed care contract.

Medicaid Long-Term Services and Supports (MLTSS)

Many provisions of the proposed rule address MTLSS. Traditionally, long-term care providers have been paid on a fee-for-service basis, but the number of beneficiaries in managed long-term care has grown significantly in recent years. The proposed rule would set more detailed requirements for Medicaid managed care plans that cover long-term services and supports, including network adequacy standards, MLTSS-specific quality measures, establishment of enrollee-specific treatment plans, and stakeholder engagement in the design, implementation and oversight of a state's MLTSS program.

Children's Health Insurance Program (CHIP)

The proposed rule would align the CHIP managed care regulations with many of the proposed revisions to the Medicaid managed care rules to strengthen quality and access in CHIP care programs, such as a MLR threshold of 85 percent, CMS review of CHIP contracts, appeal rights, and quality measurement and improvement standards. If finalized, CHIP will more closely resemble Medicaid managed care.

This *GT Alert* was prepared by **Tricia A. Asaro** and **Amanda R. Ledford‡.** Questions about changes to the Medicaid and CHIP programs can be directed to:

- Tricia A. Asaro | +1 518.689.1416 | asaro@gtlaw.com
- Amanda R. Ledford‡ | +1 202.331.3140 | ledforda@gtlaw.com
- Or your Greenberg Traurig attorney

‡ Admitted in Virginia, and not admitted in the District of Columbia.

Albany
+1 518.689.1400

Amsterdam
+ 31 (0) 20 301 7300

Atlanta
+1 678.553.2100

Austin
+1 512.320.7200

Boca Raton
+1 561.955.7600

Boston
+1 617.310.6000

Chicago
+1 312.456.8400

Dallas
+1 214.665.3600

Delaware
+1 302.661.7000

Denver
+1 303.572.6500

Fort Lauderdale
+1 954.765.0500

Houston
+1 713.374.3500

Las Vegas
+1 702.792.3773

London*
+44 (0) 203 349 8700

Los Angeles
+1 310.586.7700

Mexico City+
+52 (1) 55 5029.0000

Miami
+1 305.579.0500

New Jersey
+1 973.360.7900

New York
+1 212.801.9200

Northern Virginia
+1 703.749.1300

Orange County
+1 949.732.6500

Orlando
+1 407.420.1000

Philadelphia
+1 215.988.7800

Phoenix
+1 602.445.8000

Sacramento
+1 916.442.1111

San Francisco
+1 415.655.1300

Seoul∞
+82 (0) 2 369 1000

Shanghai
+86 (0) 21 6391 6633

Silicon Valley
+1 650.328.8500

Tallahassee
+1 850.222.6891

Tampa
+1 813.318.5700

Tel Aviv^
+972 (0) 3 636 6000

Tokyo¤
+81 (0)3 3216 7211

Warsaw~
+48 22 690 6100

Washington, D.C.
+1 202.331.3100

Westchester County
+1 914.286.2900

West Palm Beach
+1 561.650.7900

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