DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Fact Sheet: Notice of Proposed Rulemaking (NPRM); Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (CMS-2408-P)

November 8, 2018

In 2016, CMS issued a final rule that was a comprehensive rewrite of the Medicaid and CHIP managed care regulations to better align managed care rules with other health care coverage programs. Since publishing that final rule, CMS has received significant stakeholder feedback that the 2016 regulations were unnecessarily prescriptive and added costs and administrative burden to state Medicaid and CHIP programs. As this administration has promised in its March 14, 2017 letter to Governors, CMS has affirmed our commitment to partnership with states to improve Medicaid and the lives it serves. As part of that promise, CMS has conducted a thorough review of the managed care regulations to prioritize beneficiary outcomes and state priorities. In our commitment to partnership with states, CMS also formed a working group with Medicaid Directors to create a consensus framework for review and to prioritize areas of concern. This proposed rule is the result of that review and seeks to further streamline the Medicaid and CHIP managed care regulations by reducing unnecessary and duplicative administrative burden. This proposed rule also seeks to further reduce federal regulatory barriers to help ensure that state Medicaid and CHIP agencies are able to work efficiently and effectively to design, develop, and implement Medicaid and CHIP managed care programs that best meet each state's local needs and populations.

Nationally, over two thirds (68.1 percent) of all Medicaid beneficiaries were enrolled in comprehensive managed care in 2016, up from 65.5 percent in 2015. In 37 states, at least 50 percent of all Medicaid beneficiaries were enrolled in comprehensive managed care, up from 34 states in 2015. As states continue to expand their use of comprehensive managed care to deliver Medicaid services, enrollment in comprehensive managed care increased by 7.2 percent – from 50.9 million in 2015 to 54.6 million in 2016. With these increases, we continue to see more states moving new populations into managed care that have traditionally been in Medicaid fee-for-service.

This proposed rule is designed to achieve several key goals:

1. Promoting Flexibility
    a. Providing states with greater flexibility to use limited, actuarially sound rate ranges as means to facilitate competitive bidding among health plans;
    b. Removing barriers that made it difficult to transition new services and populations into managed care because of existing fee-for-service payment arrangements by proving states with a three year transition period to come into compliance with requirements related to state-directed and pass-through payments;
    c. Providing states more flexibility to set meaningful network adequacy standards using quantitative standards that can take into account new service delivery models like telehealth;
    d. Removing outdated and overly prescriptive administrative requirements that govern how plans communicated with beneficiaries to better align with standards used across federal programs and enable the use of modern means of electronic communication when appropriate.
2. Strengthening Accountability
    a. Requiring CMS to hold ourselves accountable to issue guidance to help states move more quickly through the federal rate review process and to allow for submission of less documentation in certain circumstances while providing appropriate oversight to ensure patient protections and fiscal integrity;

b. Maintaining the requirement for states to develop a Quality Rating System (QRS) for health plans to facilitate beneficiary choice and promote transparency, but with greater ability for states to tailor an alternative QRS to their unique program while requiring a minimum set of mandatory measures to align with the Medicaid and CHIP Scorecard.

3. Maintaining and Enhancing Program Integrity
    a. Maintaining the current regulatory framework for program and fiscal integrity, including provisions related to the actuarial soundness of rate setting, provider screening and enrollment standards, and medical loss ratio (MLR) standards;
    b. Strengthening federal requirements to protect federal taxpayers from cost shifting by prohibiting states from retroactively adding or modifying risk-sharing mechanisms and ensuring that differences in reimbursement rates are not linked to enhanced federal match.

The proposed rule includes significant regulatory revisions in the following areas of the managed care regulatory framework:

Topic	**NPRM Proposes to:**
Setting Actuarially Sound Capitation Rates	• Permit states to develop and certify a rate range of 5 percent within certain parameters. • Provide that states adjusting capitation rates within the permissible 1.5 percent range would not have to submit a revised rate certification or actuarial justification. • Codify requirements for CMS to issue annual sub-regulatory guidance to help streamline rate review processes and to address updates or developments in the rate review process to reduce state burden and facilitate prompt actuarial reviews. • Prohibit states from retroactively adding or modifying risk-sharing mechanisms to protect against cost-shifting. • Specify that differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations and that any differences in the assumptions, methodologies, or factors used must not vary with the rate of federal financial participation associated with the covered populations in a manner that increases federal costs.
Pass-Through Payments	• Allow states that are transitioning Medicaid populations or services from fee-for-service to managed care a 3-year transition period during which states would be permitted to require managed care plans to make pass-through payments for the same populations or services at an amount that is less than or equal to the amount of existing fee-for-service supplemental (upper payment limit) payments.
State Directed Payments	• Permit directed payments that utilize a State Plan approved fee schedule to be implemented without prior approval. • Allow multi-year approval (instead of annual approval) in certain circumstances. • Acknowledge more types of directed payment arrangements and remove the prohibition on specifying the amount and frequency of payments.
Network Adequacy Standards	• Replace the requirement for states to establish time and distance standards with a more flexible requirement that states establish quantitative network adequacy standards. • Clarify that states have the authority to define “specialists” in the most appropriate way for their programs.

Topic	NPRM Proposes to:
Quality Rating System (QRS)	• Require CMS to develop a minimum set of mandatory performance measures that will apply equally to the federal QRS and alternative QRS. • Eliminate the requirement that a state receive approval from CMS prior to implementation of an alternative QRS while maintaining CMS oversight authority. • Make more explicit that CMS will consult with states and other stakeholders in developing the QRS including the development of sub-regulatory guidance on the "substantially comparable" standard for an alternative QRS.
Appeals and Grievances	• Eliminate the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted. • Change the timeframe for enrollees to request a state fair hearing to no less than 90 calendar days and no greater than 120 calendar days to better align with Medicaid FFS requirements. • Eliminate the enrollee notice requirement for claims denied for not meeting the definition of a clean claim at 42 CFR 447.45(b).
Requirements for Beneficiary Information	• Replace the requirement for taglines to be in 18-point font with the adoption of the "conspicuously-visible" font size standard as used by the HHS Office for Civil Rights. • Eliminate the requirement to print taglines on all written materials and instead only require taglines on materials that are critical to obtaining services. • Permit paper provider directories to be updated quarterly rather than monthly if the managed care plan offers a mobile-enabled provider directory. • Provide managed care plans more flexibility by permitting notices of provider terminations to be sent by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of a termination notice.
CHIP	• Adopt applicable Medicaid proposals, including for network adequacy standards, medical loss ratio standards, quality rating system and other quality standards, appeals and grievances, and requirements for beneficiary information. • Address CHIP-specific technical and clarifying edits, including for appeals and grievances, sanctions, and program integrity safeguards.

For more information, the proposed rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24626.pdf

Additional Medicaid managed care resources are available at: https://www.medicaid.gov/medicaid/managed-care/index.html

Public comments are due: January 14, 2019

For questions regarding Medicaid managed care, email: ManagedCareRule@cms.hhs.gov