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CLIENT ALERT

CMS Issues Broad-Reaching Proposals to Better Align Medicaid Managed Care with the Commercial and Medicare Markets

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On May 26, 2015, the Centers for Medicare & Medicaid Services ("CMS") released a proposed rule ("Proposed Rule") containing the first proposed revisions to the Medicaid managed care ("MMC") program's regulations in more than 12 years.[1] When these proposed revisions are finalized, they will have broad-reaching effects on state Medicaid programs nationally as well as the plans, providers, and companies that serve Medicaid plans or Medicaid providers either directly or indirectly. Medicaid is the largest government payer, supplying health insurance coverage for approximately 70.5 million Americans and providing the core source of financing for safety-net hospitals and health centers that serve low-income communities, as well as nursing homes and community-based long-term care facilities.[2] Further, as of July 1, 2011, approximately 74 percent of Medicaid enrollees received services through managed care plans, and MMC enrollment is expected to grow as Medicaid expansion through the Affordable Care Act ("ACA") continues.[3]

Through its proposals, CMS seeks to modernize managed care in Medicaid and the Children's Health Insurance Program ("CHIP") to reflect changes in managed care delivery systems. Also, the Proposed Rule would better align the rules governing MMC and CHIP with the rules applying to Medicare Advantage ("MA") and the requirements for qualified health plans ("QHPs") sold through the "Exchange markets."[4]

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[1] The Proposed Rule was formally published at 80 Fed. Reg. 31098 (June 1, 2015) and is available at https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[2] The Henry J. Kaiser Family Foundation, Medicaid Moving Forward (Mar. 9, 2015), available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/. *See also* The Henry J. Kaiser Family Foundation, State Health Facts, Total Monthly Medicaid and CHIP Enrollment (Feb. 2015), available at http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/.

[3] The Henry J. Kaiser Family Foundation, State Health Facts, Total Medicaid Managed Care Enrollment (2011), available at http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/.

[4] Pursuant to Section 1311(b) of the ACA, Congress directed the states to establish Health Benefit Exchanges for the purchase of individual and small group market plans. The Exchanges established by

Comments on the Proposed Rule are due to CMS by 5:00 p.m. ET on July 27, 2015. We urge anyone that can be affected by the revisions recommended by the Proposed Rule to file comments. Indeed, there are several topics, highlighted below, where CMS is seeking industry input.

Organizations participating in the Medicare/Medicaid Financial Alignment Demonstrations should review the Proposed Rule along with the specific terms of their Memorandum of Understanding ("MOU") with their state and CMS, as MMC standards may apply to certain services and operations.[5]

Several of the more significant impacts of the Proposed Rule include updated network adequacy standards for all types of MMC entities, the application of medical loss ratio ("MLR") requirements to MMC entities, setting actuarially sound capitation rates, expanded quality-of-care requirements, appeals and grievances, beneficiary enrollment protections, Managed Long-Term Services and Supports ("MLTSS"), state monitoring and information standards, primary care case management, and third-party liability. Each is described in more detail below.

Network Adequacy

CMS seeks to update network adequacy requirements to modernize the regulatory framework and align MMC requirements, where feasible, with MA and QHP standards and to establish minimum standards while maintaining state flexibility. The Proposed Rule would ensure states' ongoing assessment and certification of the networks of MMC entities, including managed care organizations ("MCOs"), prepaid inpatient health plans ("PIHPs"), prepaid ambulatory health plans ("PAHPs"), and Managed Long-Term Services and Supports ("MLTSS") programs while moving states toward a time and distance-based approach like that employed under the MA program.

Time and Distance Standards Required

The Proposed Rule would require a state, at a minimum, to establish time and distance standards for the following: primary care (adult and pediatric), OB/GYN, behavioral health, specialists (adult and pediatric), hospital, pharmacy, pediatric dental, and any

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the states are called "State-Based Exchanges." Where a state failed to establish a Health Benefit Exchange, pursuant to Section 1321 of the ACA, Congress directed CMS to establish what has become known as a "Federally Facilitated Exchange" in the state at issue. References in this Client Alert to the "Exchange markets" include both the State-Based and Federally Facilitated Exchanges.

[5] For example, CMS requires financial alignment programs to abide by Medicaid network adequacy standards for Long-Term Services and Supports ("LTSS") and Medicare network adequacy standards for medical services and prescription drugs. For services covered under both Medicaid and Medicare, the applicable network adequacy standard is determined through the MOU negotiation process and memorialized in a plan "so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area." CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (January 25, 2012), available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCMSCapitatedFinancialAlignmentModelPlanGuidance.pdf.

"additional provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to such time and distance standards."[6] Exceptions would be allowed as long as they are monitored by the state. Timeliness would be assessed as routine, urgent, or emergency care.

CMS asserts that time and distance standards provide a more accurate measure of the ability to gain timely access to covered services than provider-to-enrollee ratios. However, CMS goes on to ask for public comment on whether it should provide states with either more or less flexibility in this area—specifically, if the agency should allow a state to define the measures that the state would apply to the different provider types or if CMS itself should set time and distance standards or provider-to-enrollee ratios by provider type, county, or other geographic basis.

Ensuring access to pediatric providers is presented as a particular concern, with CMS holding that states and plans must use access standards for pediatric primary, specialty, and dental providers. CMS requests comment on whether it should include behavioral health providers in the list of those for which states must apply separate access standards for adult and pediatric providers. CMS also asks for comment on whether states should be required to apply time and distance standards to family planning providers. The agency does not propose requiring such standards for these providers, given Medicaid's guaranteed freedom of choice of family planning providers and the fact that providers of family planning services would include physicians and OB/GYNs who would already be subject to time and distance standards.

Other factors that states would need to consider, in addition to time and distance, are the following: expected Medicaid enrollment and utilization of services, the characteristics and health needs of the covered population, the number and types of health care professionals required to provide covered services, the number of network providers that are not accepting new Medicaid patients, and the geographic location and accessibility of both providers and enrollees. Also to be considered are the ability of providers to ensure accessibility of the location and the required equipment for enrollees with physical or mental disabilities, reasonable accommodations, and the ability to communicate in a "culturally competent" manner. Cultural competence would include ensuring access to covered services delivered in a manner so as to meet the unique needs of those with "limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of an enrollee's gender, sexual orientation, or gender identity." CMS proposes to add a corresponding regulatory standard to require the state to similarly ensure nondiscrimination in access to services under fee-for-service ("FFS").

In setting network adequacy standards, CMS advises states to look to standards for commercial insurance established by each state's insurance regulator and those established under the MA program, as well as historical patterns of Medicaid utilization since they may identify needs that are more relevant to Medicaid than to the commercial or Medicare markets. Moreover, states would be required to publish network adequacy standards to ensure transparency.

[6] 80 Fed. Reg. at 31145.

Network Adequacy Standards for MLTSS

CMS expects states to include distinct network adequacy standards for MLTSS. Such standards should look to the same factors as assessed for medical services but may vary, based on whether the enrollee or the provider must travel to provide the services. In setting MLTSS access standards, states should consider strategies "to ensure the health and welfare of enrollees using LTSS and to support community integration of individuals receiving LTSS . . . [as these] . . . enrollees may have different needs than those enrollees only using acute, primary, and behavioral health services."[7]

Monitoring Network Adequacy

States would be required to monitor plans to ensure that they are meeting those MLTSS standards on an ongoing basis. CMS requests comment on the approaches to be required; the agency has considered requiring enrollee surveys, encounter data, related HEDIS measures, secret shopper efforts, and consumer service calls. CMS further proposes to require that states collect plan documentation and certify the adequacy of MMC plan networks at least annually but requests comment on the appropriate timeframe for these efforts. MMC entities would also be required to demonstrate network adequacy "when there has been a significant change in the health plan's operations that would affect capacity and services," such as enrollment of a new population; changes in benefits, service area, or payment; or a significant change in the composition of a plan's provider network.

Application of MLR to MMC Entities

With the Proposed Rule, MMC plans join the ranks of MA and private health insurance plans in being subject to a minimum "medical loss ratio," which CMS defines as the sum of the plan's incurred claims, expenditures on quality improvement, and other required activities, divided by the adjusted premium revenue collected, calculated over a 12-month period. CMS proposes a minimum MLR of 85 percent, though states may choose higher minimums.

While MLR requirements for the MA and commercial health plans were imposed by the ACA, CMS claims that its authority to impose a MLR on MMC entities derives from statutory requirements that "actuarially sound capitation rates must be utilized for Medicaid managed care plans."

CMS argues that this statutory requirement, found in Sections 1903(m)(2) and 1902(a)(4) of the Social Security Act, requires that capitation payments cover "reasonable, appropriate and attainable costs in providing covered services," and that MLRs can help assess this requirement by illustrating how funds are spent on "claims and quality improvement activities as compared to administrative expenses."

In the interest of administrative efficiency for states, CMS, and insurers with multiple product lines, the MLR regulatory standards to be imposed beginning in 2017 would

[7] 80 Fed. Reg. at 31147.

align with those already in place for MA and private health plans. CMS admits that its rules are most closely aligned with those for private commercial plans in the interest of the need for consistency between Medicaid and QHPs sold through the Exchange markets.

CMS proposes that states take into account past MLR experiences during the rate-setting process. States would be required to report annually to CMS a summary of the outcomes of the MLR calculations. Also, while the Proposed Rule does not require plans to pay a remittance for exceeding the MLR, CMS proposes that, if a state chooses to collect any remittances from plans not meeting the MLR standard, then the state would need to return to CMS the federal share of that remittance.

Stakeholders may comment on whether they believe the statute appropriately grants CMS this authority, but it is worth noting that some consider the 85 percent minimum MLR to be very close to the level at which plans are already operating. According to research by the Kaiser Family Foundation, 28 of the 38 states utilizing MMC entities already impose MLRs of at least 85 percent. CMS's analysis found that the average MLR of Medicaid plans was already between 85.5 and 87.9 percent, although one-fourth of plans had MLRs below 83.6 percent.

As with MLRs for plans in other market segments, stakeholders will want to review and comment on which activities and expenses may be attributed to the MLR numerator or denominator, such as fraud prevention activities, mandated solvency funds, utilization management, and others. CMS seeks comment on its proposal to consider "health quality improvement activities" to include service coordination, case management, state-led community integration activities, and other activities particular to the more complex populations served by MMC plans.

Commenters may also consider whether the national standard provides states flexibility to design MLRs that are appropriate for the states' unique Medicaid populations.

Setting Actuarially Sound Capitation Rates for MMC Programs

CMS proposes to revise the MMC rate-setting framework to ensure that Medicaid rates are developed in a transparent and consistent manner across MMC programs. In general, CMS establishes steps by which a state would identify and adjust the data that form the basis for the MMC capitation rates, without restricting appropriate flexibility for states to drive program improvements and innovation through managed care contracting.

In revising the rate-setting standards, CMS incorporates the principles of actuarial soundness, including that: (1) capitation rates should be sufficient and appropriate for the anticipated service utilization of the populations and services covered and compensate the health plans for reasonable non-benefit costs; (2) capitation rates should promote program goals, such as quality of care, improved health, community integration of enrollees, and cost containment; (3) the actuarial rate certification underlying the capitation rates should provide sufficient detail, documentation, and

transparency of the rate-setting components; and (4) a transparent and uniformly applied rate review and approval process based on actuarial practices should ensure that both the state and CMS act effectively as fiscal stewards and in the interests of beneficiary access to care.

Capitation Rate Ranges

Historically, CMS has permitted the use of rate ranges by states and has determined any rate paid to any managed care plan within the certified range to be actuarially sound, regardless of where it fell in the range. The agency now proposes to require that each individual rate paid to each MMC entity be certified as actuarially sound with enough detail for CMS to understand the specific data, assumptions, and methodologies behind that rate. States may still use rate ranges to gauge an appropriate range of payments on which to base negotiations, but states ultimately will have to provide certification to CMS of a specific rate for each rate cell.

Incentive Arrangements

Existing standards require incentive arrangements to be time-limited and not subject to automatic renewal, available to both public and private contractors, not conditioned on intergovernmental transfer agreements, necessary for the specified activity, and limited to 5 percent of the certified capitation rate. CMS proposes to add a new standard requiring incentive arrangements to be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. Further, states may use withhold arrangements to drive health plan performance toward specified goals or outcomes by retaining an amount from the base capitation rate payable to the plan unless satisfactory performance is achieved, as long as actuarial soundness of the capitation rates after consideration of the withhold arrangement is confirmed.

State Direction of Expenditures

CMS proposes to codify its long-standing policy that states may not direct expenditures by health plans under a risk contract. However, CMS also proposes ways that a state may set parameters on how plans make expenditures under the contract to promote delivery system and payment reform, performance improvements, and beneficiary access to care. Accordingly, CMS proposes to allow states to specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement, or to require plan participation in delivery system reform or performance improvement initiatives (including multi-payer or community-wide initiatives).

CMS also supports two state practices used to ensure timely access to high-quality, integrated care, specifically: (1) setting minimum reimbursement standards or fee schedules for providers that deliver a particular covered service, and (2) raising provider rates in an effort to enhance the accessibility or quality of covered services. Any contract arrangement that directs expenditures made by the plan for delivery system or payment provider initiatives must use a common set of performance measures across

all payers and providers so that CMS can evaluate the degree to which multi-payer efforts achieve the stated goals of the collaboration.

Rate Certification

CMS proposes to require the submission of contracts and rate certifications to CMS for approval no later than 90 days before the anticipated effective date of such contracts and rates. CMS also proposes to reserve the discretion to set forth timeframes and more detailed processes for the submission of the rate certification review and the approval process in subregulatory guidance. A state would be required to meet specific documentation standards under the rate certification process to demonstrate that its rates were developed consistent with generally accepted actuarial principles and practices and regulatory standards—and to enable CMS to conduct more efficient reviews. For example, CMS proposes that the rate certification should include sufficient detail of the risk adjustment methodology (either prospective or retrospective), including certain specified information, since that methodology is an integral part of the rate development process.

Other Payment and Accountability Improvements

Downstream Contractors and Enrollment of MMC Providers. CMS proposes a number of changes to address areas of vulnerability and implement certain program integrity safeguards under the MMC program. CMS proposes to add expectations for health plans that subcontract and delegate responsibilities under the contract with the state, based on the standards for first tier, downstream, and related entities under the MA program. CMS also proposes to require that states enroll all network providers of health plans, Primary Care Case Managers ("PCCMs"), and PCCM entities[8] that are not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries. This aims to address the lack of consistency in states' application of FFS provider screening and enrollment provisions to providers in state MMC programs.

Expanded Compliance Requirements. The Proposed Rule would expand the required elements that must be included in an MCO's and PIHP's compliance program. Also, the Proposed Rule would extend those requirements to PAHPs and to subcontractors that have been delegated responsibilities by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract with the state. The required elements include the common elements of an effective compliance program, such as procedures for internal monitoring, auditing, and the prompt referral of potential compliance issues within the managed care plan, as well as additional elements, including, but not limited to, mandatory reporting to the state of potential fraud and improper payments identified or recovered by managed care plans; mandatory reporting to the state of information related to changes in an enrollee's or provider's circumstances; mandatory referral of any potential fraud, waste, or abuse identified by the plan to the state Medicaid program integrity unit or to the state Medicaid fraud control unit; and suspension of payments to a network provider for which the state determines there is a credible allegation of fraud.

[8] See page 15 below for a description of PCCM and PCCM entities.

Recovery of Overpayments. CMS proposes that health plan contracts specify that recoveries of overpayments that the plan makes to providers that were excluded from Medicaid participation or that were due to fraud, waste, or abuse are to be retained by the plan. States are then expected to take such recoveries into account in the development of future actuarially sound capitation rates. Further, the federal government or states may retain the appropriate share of recoveries of overpayments due to their own audits and investigation. This has been an area of confusion for both states and health plans, since federal statutes and regulations do not currently specify who may retain such recoveries. The proposed approach is similar to that taken by CMS in addressing provider recoveries in the MA program.

Deferring/Disallowing Federal Financial Participation ("FFP"). CMS proposes to defer and/or disallow FFP for expenditures under a MMC contract when a state's contract, as submitted for CMS approval or as administered, is non-compliant with applicable statutory and regulatory standards. Applicable standards would include, for example, whether final capitation rates, as specified in the contract and detailed in the rate certification, are consistent with the standards of actuarial soundness. Under this proposal, CMS would be able to defer and/or disallow partial FFP under the contract associated with only a particular service category if a violation involves only that category of services and not the delivery of services generally. Such determinations may be made prospectively, for example, when the contract or rate certification is submitted for CMS's review and approval, or retroactively based on how the contract is operationalized or if it is determined through audit that the rate development standards supporting the rate certification were not compliant with the applicable requirements.

Quality-of-Care Standards

The Proposed Rule introduces significant changes to the Quality Assessment and Performance Improvement and External Quality Review standards in current Medicaid regulations. Given the evolution of quality review and improvement and the increase in managed care in Medicaid, the proposed changes are intended to improve quality measurement and improvement efforts for managed care by concentrating on the principles of transparency, alignment with other systems of care, and consumer and stakeholder engagement.

CMS's proposed quality changes center on (1) standards for performance measures and topics for performance improvement projects, (2) the performance review and approval process, (3) the development of a quality rating system, (4) the expansion of the comprehensive quality strategy, and (5) revisions to the external quality review system.

Quality Assessment and Performance Improvement Program

CMS proposes to revise the quality assessment and performance improvement program requirements to provide itself with the authority to specify standardized performance measures and topics for performance improvement projects ("PIPs") in state contracts with MMC plans. After a public notice and comment process, CMS

would identify the standardized performance measures and topics for PIPs. The performance measures and PIP topics proposed by CMS would be in addition to the state-specific requirements that are already included in MMC contracts. CMS is, however, incorporating a process for states to individually request exemptions from the CMS-identified PIP topics.

CMS also recognizes in the Proposed Rule the need to assess quality in an appropriate manner when applied to specialized populations and services, such as LTSS. Thus, CMS is proposing that MMC plans have mechanisms to evaluate the quality and appropriateness of care furnished to enrollees using LTSS, including the assessment of an enrollee's care between care settings and a comparison of services received with those set forth in the enrollee's treatment plan. Additionally, the plans would include specific performance measures applicable to LTSS, and the state would incorporate the results of any LTSS balancing efforts at the plan level into program review.

Performance Review and Approval Process

CMS proposes to align performance reviews for MMC plans with the reviews of QHPs sold through Exchange markets and expects that this alignment will streamline quality and improvement approaches. Thus, as part of the state Medicaid contracting process, plans would be required to have a performance review that is at least as stringent as reviews by private accreditation entities as approved or already recognized in reviews of MA organizations or QHPs.

In balancing the review and approval requirement with the need for state flexibility, CMS proposes two options for states to meet the review and approval requirement. Under the first option, states could implement a review and approval process that is as stringent as a private accreditation entity's process, the standards for which, as CMS notes, would be purchased by the state. The process would be required every three years. Under the second option, states could rely on evidence that the MMC plan has been accredited by a private accrediting entity recognized by CMS; the state would receive a copy of the accreditation survey. For either option, this information would be publicly available on the state's website. The Proposed Rule would also permit states to apply both options at the same time, which could result in different standards being applied to current MMC plans. CMS requests comments on the review and approval process and stakeholders should consider the challenges and impact of implementing and complying with an individualized state review process or obtaining accreditation from a recognized entity.

Expanded Quality Rating System

CMS proposes to require states to deploy MMC quality ratings. Similar to the QHP rating system, states would establish a quality rating system based on three summary indicators: clinical quality management; member experience; and plan efficiency, affordability, and management. The parameters of the Medicaid quality rating system will be refined by a robust public process, including notice and comment, with an expected three to five years before implementation.

Additionally, the quality rating system would measure and report on the performance data collected from the plans based on standard measures required by CMS (also through a notice and comment process) along with the inclusion of stated specific measures. Then, the Proposed Rule would require that each state apply a methodology as developed by CMS to determine the quality ratings. CMS is considering whether states should have the flexibility to change the methodology to meet state-specific needs. CMS intends that the methodology development process would need to occur every two to three years to accommodate changes.

For states that have an existing quality rating system, the Proposed Rule offers the option to retain or modify the existing system with CMS approval, even if the rating system would use different components, performance measures, or a different methodology than the Proposed Rule's quality system. Additionally, for plans serving only dual-eligible beneficiaries, states have the option to adopt the MA five-star rating system. Whichever quality rating system is applied to plans, states must post the ratings online so that beneficiaries can use the results to make informed decisions.

External Quality Review

The Proposed Rule identifies several changes and clarifications to the external quality review ("EQR") regulations. CMS proposes that results from Medicare or private accreditation reviews will be used in the EQR in addition to the already recognized sources of information. CMS further proposes to revise the independence standards for EQR organizations ("EQRO") because of the inclusion of accreditation reviews; an accrediting entity cannot also serve as an EQRO for a specific plan that it has accredited within the prior three years.

Significantly, the Proposed Rule incorporates an additional EQR activity—network adequacy. Changes under the Proposed Rule require that an EQRO validate MMC plans' network adequacy for the prior 12 months to determine whether the entity meets the established standards; this analysis would be included in the EQR technical report. The newly included network adequacy review activity differs from the assessment of availability of services and could include assessing how a plan meets access standards, testing the network information maintained by plans for accuracy, and communicating with providers to determine wait times or participation.

CMS proposes changes to the exemption for health plans from EQR activities that are duplicated under a Medicare review or accreditation process. The Proposed Rule permits states to rely on the results from a Medicare review or a private accreditation survey instead of performing three of the mandatory EQR requirements, as long as the standards are substantially comparable. EQROs would not have to validate PIPs or performance measures or conduct the compliance review because accrediting entities typically perform these reviews and validation as part of the accreditation process. This would not apply to the network adequacy review component.

Response to the Quality Provisions of the Proposed Rule

Through the Proposed Rule, CMS aims to improve the quality of care by expanding the quality review and performance of MMC plans and making the results publicly available. CMS proposes significant changes for the states' review and approval process or accreditation and the development of a plan quality rating system. These changes will impose substantial obligations for plans that do not currently exist in the MMC industry.

While CMS's focus in many of the revisions was on aligning MMC rules with QHP or MA requirements, stakeholders should identify where that alignment will not achieve the quality outcomes that CMS seeks. CMS acknowledges that stakeholders will have practical insight into the quality review process, and their comments should identify where proposed changes will not obtain the desired results.

Appeals and Grievances

CMS proposes to require PAHPs (other than non-emergency medical transportation ("NEMT") or NEMT PAHPs) to provide grievance systems as required of other MMC plan types. This is based on the fact that PAHPs have now evolved from small group practices to larger entities managing a subset of services, such as dental, behavioral health, and community-based services, which use authorization as a tool to manage utilization. As such, beneficiary protections are needed for these authorization determinations.

The Proposed Rule would limit plans to requiring one level of internal appeal before beneficiaries would be allowed to request a state fair hearing, similar to rules for individual QHP products and MA. Providers would be allowed to appeal on behalf of beneficiaries without the need for written consent from enrollees, similar to MA. Timing requirements for filing and determinations of grievances and appeals would be modified, reducing time for standard appeal determinations to 30 days from 45 and expedited appeal determinations to 72 hours from three working days. Procedural protections for appeals would be strengthened, including clarifying documentation that must be made available to beneficiaries.

Beneficiary Enrollment Protections

CMS proposes several new requirements related to Medicaid beneficiary enrollment in MMC plans to assure minimum consistency across state enrollment processes.

Under the Proposed Rule, states would still have flexibility to enroll Medicaid beneficiaries through either mandatory or voluntary processes; however, CMS proposes added enrollment measures to protect beneficiary choice. All states, regardless of enrollment mode, would be required to provide beneficiaries with informational notices, followed by a 14-day choice period accompanied by interim FFS coverage, if needed. This provision is separate from the 90-day statutory window during which beneficiaries must be allowed to change MMC plans.

In states where managed care enrollment is voluntary, but the state does not use passive enrollment, beneficiaries would have the 14-day choice period to affirmatively choose a managed care plan or opt for FFS coverage. If a beneficiary fails to make a choice during that period, the state may then enroll the beneficiary into the state's default plan. In voluntary enrollment states that use passive enrollment, beneficiaries would be given the 14-day choice period to choose another plan after which the state may automatically enroll them, providing a beneficiary with a confirmation notice of plan selection and explanation of the right to disenroll within 90 days.

The Proposed Rule would require states to "preserve provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid." Where this is not possible, states must equitably distribute beneficiaries among available plans and may not arbitrarily exclude any plans. Additional assignment criteria are permitted, to reflect beneficiary location and preferences, previous plan assignment, access needs for disabled beneficiaries, as well as quality and procurement considerations. When plans reach enrollment capacity, priority must be given to already enrolled beneficiaries.

Due to inconsistent application of the above 90-day disenrollment provision, CMS proposes to clarify that the disenrollment period pertains only to initial enrollment and that states have the flexibility to accept written or oral disenrollment requests, so long as the state's method is clearly communicated to all enrollees. CMS also proposes to clarify that, in instances where a beneficiary requests disenrollment through a plan (plans are authorized to approve but not disapprove such requests), the state has the same amount of time to process the request as if it received it directly. CMS also proposes to allow MLTSS beneficiaries to disenroll and switch plans when provider termination causes disruption in their housing or employment.

CMS seeks comments as to the impact of these changes on managed care plans and, specifically, as to whether the 14-day choice period gives sufficient time for beneficiary selection.

Enhanced Beneficiary Support

CMS also proposes to add new beneficiary supports for both potential MMC enrollees and those changing plans. This concept is derived from existing support systems in the Exchange markets and State Health Insurance Programs ("SHIPs"), which aid in limiting default enrollment and assisting beneficiaries in evaluating choice of plans. States would be required to furnish support using multiple platforms—phone, Internet, in-person, and auxiliary aids, as needed.

CMS intends to subject all counseling providers chosen by states to "enrollment broker" standards of independence and conflict of interest, including prohibiting contracted or other financial relationships with MMC entities. Federal grantees providing counseling services without a MOU with the state, such as federally qualified health centers and Ryan White providers, would be exempted from conflict-of-interest requirements. CMS specifically requests comments regarding firewalling of entities providing non-Medicaid

federally financed beneficiary protections (e.g., representation at hearings) to allow the provision of counseling services.

Coverage and Authorization

CMS would limit utilization management controls on clinical services by requiring authorization periods be reasonable and take into account ongoing chronic conditions and the need for LTSS. States would be required to monitor plans' authorization activities. Utilization controls that interfere with freedom of choice regarding family planning would be prohibited. The definition of "medical necessity" would be revised to include criteria related to early and periodic screening for those under 21 and treatment of mental and physical defects and conditions found. Expedited authorizations would need to be determined within 72 hours instead of three working days.

Continuation of Benefits While Appeal Is Pending

CMS proposes that MMC plans would no longer be able to stop any services pending determination of appeals. States may decide to allow recoupment from an enrollee if an adverse benefit determination is upheld on appeal so long as the same standard is applied between Medicaid FFS and managed Medicaid.

Continued Services to Beneficiaries and Coordination and Continuity of Care

The Proposed Rule would require states to have a transition of care policy for individuals switching from one delivery system to another within Medicaid or from FFS to managed care. Such policy would need to include, among other things, receipt of services for a period of time and assurance that medical records are transitioned. References to "primary care" would be deleted and references to "health care" would be expanded in some places to reflect a broader range of appropriate services. Care coordination activities would be expanded to cover coordination between care settings as well as with outside entities, such as community and social support agencies. Health risk assessments for new enrollees would be required to be performed within 90 days and shared with other providers thereafter.

Managed Long-Term Services and Supports

CMS proposes several new requirements related to MLTSS. CMS encourages states to draw upon existing resources to implement four required elements of a support system specifically for MLTSS beneficiaries. These elements include an enrollment and benefits complaint mechanism; education; assistance with grievances, appeals, and fair hearings; and a review of program data to identify and resolve systemic issues.

CMS has espoused 10 key MLTSS principles in previous guidance for Section 1915(b) waiver and Section 1115(a) demonstration programs, including program planning, stakeholder engagement, enhanced home and community-based services, payment alignment, beneficiary support and protections, qualified providers, and quality. CMS proposes to codify these principles into a rule and apply them across all MLTSS

programs. Among these new requirements, states would be required to establish network adequacy standards for MLTSS programs, including time and distance standards and network provider accommodations for disabled beneficiaries. Additionally, plans would be required to submit documentation to states demonstrating compliance with required benefit offerings. States would also be required to establish credentialing and re-credentialing policies for all covered providers. Finally, states would be required to establish mechanisms for MLTSS stakeholder feedback.

State Monitoring Standards

CMS aims to modernize state monitoring standards over all of a state's managed care programs, including the agency's oversight responsibilities. The Proposed Rule would require that a state's monitoring system address specific aspects of the managed care program that include, at a minimum, the following: administration and management; appeal and grievance systems; claims management; enrollee materials and customer services; finance, including MLR reporting; information systems, including encounter data reporting; marketing; medical management, including utilization management; program integrity; provider network management; quality improvement; the delivery of LTSS; and other items of the contract, as appropriate.

The Proposed Rule would further require states to conduct readiness reviews at certain program points, including prior to the start of a new managed care program; when a new contractor enters an existing program; or when the state adds new benefits, populations, or geographic areas to the scope of its contracted managed care plans. The readiness review would be required to, at the baseline, assess the plan's operations and administration, service delivery, financial management, and systems management. The state would be required to submit its annual program assessment to CMS and post it publicly.

Information Standards

Due to its concern that existing regulations are not sufficiently clear and do not reflect current technology advances, CMS proposes to replace the entire existing regulatory section on information standards with a more structured and coherent set of state and managed care plan standards for beneficiary information. These provisions would align MMC beneficiary information dissemination practices with those of the MA program and the commercial insurance market and would apply consistently across MMC plans with respect to enrollee materials.

The Proposed Rule would add three new standards to strengthen dissemination requirements and recognize the cultural and linguistic diversity of Medicaid beneficiaries. The first two changes would require the state and MMC entities to make materials available in prevalent languages, including taglines explaining the availability of written materials in those languages as well as oral interpretation in understanding the materials. The third change would require each MMC entity to make available vital documents in each prevalent non-English language in its service area. CMS proposes

that provider directories, member handbooks, appeal and grievance notices, and other notices that are critical to obtaining services be considered vital documents.

Further, as has been required for QHPs, CMS proposes to enhance transparency by requiring MMC entities to post provider directories and formulary drug lists on their websites in a CMS-specified machine-readable file and format. Such actions would enable third parties to utilize the information and develop mechanisms to improve access for enrollees and potential enrollees.

Primary Care Case Management

CMS proposes to adopt the new term "PCCM Entities" to reflect the development of entities conducting more intensive case management and care coordination, measure of performance outcomes, and quality improvement activities, and who receive higher reimbursement. The activities of these entities have been referred to as an "enhanced" PCCM model, and the entities have been paid a more robust per member/per month fee, based on the activities covered under their contract. CMS proposes to recognize those PCCM programs that are truly managing care and to subject them to the same standards that apply to other MMC entities. Other health care delivery systems, such as integrated care models, patient-centered medical homes, and accountable care organizations, would remain unaffected by the changes in the Proposed Rule.

Third-Party Liability

State Medicaid programs are required to take all reasonable measures to identify and seek payment from liable third parties, such as commercial insurance companies, casualty coverage, and medical support provided under a court order, before billing Medicaid. Previously, CMS required states to review all claims paid under a range of International Classification of Diseases ("ICD") diagnosis codes indicative of trauma to help states identify possible sources of third-party liability. CMS did allow states to request waivers for review of certain codes deemed to be unproductive in identifying third-party liability. With the upcoming transition to ICD-10, CMS must eliminate references to ICD-9. CMS now proposes to eliminate all references to a specific coding system and replace these with a general description of the types of trauma-related diagnoses that states are expected to review. The revision would allow states to revise the trauma code editing process but would not change any current trauma code editing with regard to codes that a state has identified as unproductive in identifying third-party liability.

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