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Some Significant Changes Come To Medicaid Managed Care


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Last week, the Centers for Medicare & Medicaid Services issued its long-awaited proposal to overhaul the Medicaid managed care regulations. See 80 Fed. Reg. 31098 (June 1, 2015).

This article describes and analyzes three of the most significant changes CMS has proposed: (1) the medical loss ratio requirements, (2) network adequacy standards and (3) authorization of capitation payments for enrollees who are patients in an institution for mental diseases.

Background

CMS' last major overhaul of the Medicaid managed care rules occurred in 2002. Since that time, Medicaid managed care has exploded in size and complexity. In the preamble, CMS notes the jump in managed care enrollment, from 2.4 million Medicaid enrollees in 1992, to 12.6 million in 1998 to 39 million in 2011. In addition, Medicaid managed care now serves a wider range of populations and more geographic areas than it did in 2002. Most notably, states have expanded the use of managed care to cover individuals receiving long-term services and supports. These changes have lead CMS to update and modernize the managed care regulations.

Medical Loss Ratio

Arguably the most controversial provision of the proposed regulations is the addition of medical loss ratio ("MLR") requirements for Medicaid managed care organizations ("MCO"), prepaid ambulatory health plans ("PAHP") and prepaid inpatient health plans ("PIHP").

In the preamble, CMS cites two primary reasons for adding the MLR requirements to Medicaid managed

care. First, CMS seeks to align Medicaid managed care rules with commercial and Medicare Advantage standards "to support administrative simplicity for states and health plans to manage health care delivery across different product lines, as well as to enhance beneficiary protections." Second, CMS claims that the MLR requirements will help states monitor and evaluate the actuarially sound capitation rates.

CMS proposes to require that states develop capitation rates for MCOs, PAHPs and PIHPs that "would reasonably achieve" an MLR of 85 percent. Proposed 42 C.F.R. § 438.4(b)(8). In setting the rates, states would also need to "take into account" the entity's past and projected MLR. Proposed 42 C.F.R. § 438.5(b)(5). A state need not set a minimum required MLR; but if it does that minimum MLR must be at least 85 percent. Proposed 42 C.F.R. § 438.8(c). CMS explains that it chose 85 percent for these proposed rules because it "is the industry standard for [Medicare Advantage] and large employers in the private health insurance market."

If the managed care entity does not meet the 85 percent MLR (or a higher MLR minimum set by the state), then the state may require the entity to provide a remittance. Id. § 438.8(j). A remittance is at the option of the state, however. The proposed rules would not require a remittance. Id.

Calculating the MLR

The proposed rules would add a new Section 438.8 to require managed care plans to calculate and report an MLR. Section 438.8 specifies that the MLR is the ratio of a "numerator" to a "denominator," adjusted by a "credibility adjustment."

Numerator

The numerator in the MLR would be the sum of three things:

- Incurred claims, as defined in proposed Section 438.8(e)(2).

- Expenditures for activities that improve health care quality, including expenditures for: activities listed in the commercial rules in 45 C.F.R. § 158.150(b), health informational technology and meaningful use of electronic health records and external quality of care activities. In the preamble, CMS recognizes that Medicaid managed care plans may cover more complex populations than commercial plans and therefore "the case management/care coordination standards are more intensive and costly for Medicaid health plans than in a typical private market group health plan." CMS believes that the definition of activities that improve health care quality in Section 158.150 "is broad enough to encompass ... activities related to services coordination, case management and activities supporting state goals for community integration of individuals with more complex needs such as individuals using [long-term services and supports]."

- Expenditures for fraud/abuse prevention activities, capped at 0.5 percent of premium revenue. These include expenditures for: a compliance program, reporting improper payments, reporting potential enrollee eligibility-related changes, reporting potential provider eligibility-related

changes, verifying the delivery of services, referring potential fraud/waste/abuse to state authorities, and screening and enrolling providers in compliance with federal Medicaid regulations. Proposed § 438.8(e)

Denominator

The denominator in the MLR would be the "adjusted premium revenue," (i.e., the premium revenue minus taxes and licensing and regulatory fees, aggregated unless the state requires separate reporting and a separate calculation for specific populations). Proposed § 438.8(f).

The rules define "premium revenue" to mean: all payments from the state under the managed care contract, including any "state-developed one-time payments, for specific life events of enrollees"; unpaid cost sharing amounts that the managed care plan could have collected under the contract, unless the plan can show it made a "reasonable" effort to collect; and "[a]ll changes to unearned premium reserves."

Credibility Adjustment

Once the ratio of the numerator to the denominator is established, a "credibility adjustment" may be made to the MLR. In the preamble, CMS explains that "[a] credibility adjustment is a method to address the impact of claims variability on the experience of smaller plans due to random statistical variation."

The National Association of Insurance Commissioners adopted a "credibility adjustment table" designed to result in plans targeting an 80 percent MLR owing a rebate for not meeting that MLR less than 25 percent of the time. Similarly, CMS proposes to calculate a credibility factor each year in such a way "that a MCO, PIHP or PAHP receiving a capitation payment that is estimated to have a medical loss ratio of 85 percent would be expected to experience a loss ratio less than 85 percent one out of every four years, or 25 percent of the time." Proposed § 438.8(h)(4)(iv).

Reporting

The proposed rules would require MCOs, PAHPs and PIHPs to submit detailed data reports to the state each year regarding their MLR calculations. Proposed § 438.8(k). States would annually submit to CMS an actuarial certification and summary description of the reports they receive from the managed care entities, which must include the following MLR-related information: "the amount of the numerator, denominator, MLR experienced, the number of member months, and any remittances owed by each MCO, PIHP or PAHP for that MLR reporting year." Proposed 42 C.F.R. § 438.74.

Effective Date

CMS proposes to require that MLR standards be incorporated into managed contracts starting on or after Jan. 1, 2017. For multiyear contracts that start before 2017, the state would be required to ensure that the managed care entity comply beginning in 2017.

Network Adequacy and Access

CMS also proposes significant changes to the network adequacy and access rules.

The Medicaid statute requires that MCOs comply with "[s]tandards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity." Social Security Act § 1932(c)(1)(A)(i); see also id. § 1932(b)(5). Current CMS regulations include access standards for MCOs, PAHPs and PIHPs. 42 C.F.R. §§ 438.206, 438.207.

In the preamble, CMS asserts that it and the Office of Inspector General have found significant variation in state network adequacy requirements and it proposes new rules "to establish minimum standards in this area."

Proposed Section 438.68 would require states to develop "time and distance standards" for specific types of providers. CMS asserts that time and distance standards are "common in the commercial market and many state Medicaid managed care programs" and that they are the most accurate measure of an enrollee's access to services. However, CMS expressly requests comment on whether it should require a different standard, "or whether [it] should permit states the flexibility to select and define the type of measure for the network's adequacy of the specified provider types."

These time and distance standards would be required for each of the following types of providers: primary care, OB-GYN, behavioral health, specialists, hospital, pharmacy, pediatric dental and long-term services and supports. In addition, CMS would be given the flexibility to require time and distance standards for any other provider type, if the agency believed doing so would "promote[] the objectives of the Medicaid program." Proposed 42 C.F.R. § 438.68(b). Time and distance standards could vary by provider type and geographic area, which would allow states to vary their standards to account for the number of providers practicing in a particular geographic area.

Section 438.6 also specifies "elements" that states must consider in developing network adequacy standards, some of which are currently listed in Section 438.206(b) (factors plans must consider in establishing and maintaining a network). These "elements" include, for example, anticipated Medicaid enrollment, the number of professionals required to furnish the contracted services, the number of network providers who are not accepting new Medicaid patients, and the geographic location of the network professionals and the Medicaid enrollees. Proposed § 438.68(c)(1).

One "element" states must consider in developing network adequacy standards is "[t]he ability of health care professionals to communicate with limited English proficient enrollees in their preferred language." Id. § 438.68(c)(1)(vii). In contrast, current access rules simply require managed care entities to "participate[] in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds." § 438.206(c)(2). It is not clear what CMS intends with the new proposed provision. For example, does CMS expect MCOs to provide limited-English-proficient enrollees with an adequate network of providers consisting exclusively of providers that can communicate in the preferred language? Does CMS consider a health care professional willing to use a translator as having "the ability ... to communicate with limited English proficient enrollees in their preferred language" and, if so, who is responsible for arranging and paying for the translator?

In the preamble, CMS encourages states to look to the time and distance standards established by the state insurance regulator and by the Medicare Advantage program "to inform the standards the state establishes for Medicaid managed care programs." CMS "intend[s] to assess the reasonableness of" states' Medicaid standards "within the context of other existing standards should the need for such evaluation arise."

Finally, the proposed rules would allow states to grant exceptions to their network adequacy rules, if the standards for granting an exception are specified in the contract with the managed care entity and based, at a minimum, on the number of health care professionals in the specialty practicing in the applicable service area. Proposed § 438.68(c)(1)(vii).

Payments for Individuals in an IMD

Since its original enactment in 1965, the Medicaid statute has excluded coverage of services for nonelderly adults who are patients in an "institution for mental diseases" ("IMD"). Specifically, the statute's definition of "medical assistance" excludes care delivered to an individual aged 21 to 64 years old "who is a patient in an institution for mental diseases." SSA § 1905(a)(29)(B).

CMS regulations define an IMD as "a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services." 42 C.F.R. § 435.1010

CMS proposes to add a new provision to the Medicaid managed care regulations expressly allowing capitation payments to MCOs and PIHPs for enrollees who are patients in an IMD for 15 days or less. Proposed Section 438.3(u) would allow monthly capitation payments for an enrollee receiving inpatient treatment in an IMD, "so long as the facility is an inpatient hospital facility or a subacute facility providing crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment."

CMS has long allowed Medicaid MCOs to cover services not covered under the state plan, if covering these services "in lieu of" state plan services would be cost-effective. Although not entirely clear, CMS appears to view proposed Section 438.3(u) as a clarification of a pre-existing policy with regard to MCO coverage of services for enrollees in IMDs as "in lieu of" services:

In light of the flexibility that managed care plans have had historically to furnish care in alternate settings that meet an enrollee's needs, we propose to clarify that managed care plans have had flexibility under risk contracts to provide alternative services or services in alternative settings in lieu of covered services or settings if cost-effective, on an optional basis, and to the extent the managed care plan and the enrollee agree that such setting or service would provide medically appropriate care.

We aim to propose rules on substitute providers under Medicaid managed care programs for CMS' ''in lieu of'' policy in particular. For reasons set forth later in this section, we believe that addressing managed care plan flexibility in the context of short inpatient or subacute IMD stays is necessary because of what we believe are access issues for short-term inpatient psychiatric and SUD treatment. 80 Fed. Reg. at 31116.

This would be a welcome clarification. It would clear up confusion about the extent to which, if at all, managed care plans are permitted to cover services for individuals who are in an IMD.

However, limiting the IMD stays to 15 days is problematic. CMS proposes this limit because it believes that concerns about access to inpatient psychiatric and substance use disorder services are focused on short-term stays, and because the longer an enrollee is a patient in an IMD, the less likely he or she will be incurring Medicaid-covered expenses (i.e., services delivered outside of an IMD). But it is not clear that a 15-day stay will actually cover the needs of Medicaid enrollees struggling with serious mental

health and substance use disorders. And if CMS believes that the Medicaid statute allows states to make a capitation payment for an enrollee who is a patient in an IMD for 15 days, we do not see why it would not similarly permit states to make a capitation payment for an enrollee who is a patient in an IMD for 45 days, for example, if the service is being provided in lieu of more expensive benefits that Medicaid would otherwise cover.

Other Topics in the Proposed Rules

The MLR, network adequacy and IMD provisions are not the only significant aspects of the proposed rules. Other important topics covered by the proposed rules include:

- capitation rates and actuarial soundness;
- long-term services and supports delivered through managed care;
- PAHPs for nonemergency transportation;
- standard contract provisions;
- program oversight and integrity, including with respect to sanctions, exclusions, quality of care, state monitoring standards and marketing requirements;
- beneficiary protections, including with respect to enrollment, disenrollment, grievances and appeals;
- encounter data and health information systems;
- managed care contracts involving Indians or Indian providers;
- Children's Health Insurance Program benefits delivered through managed care; and
- third-party liability.

Comments on the proposed rule are due July 27, 2015.

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