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Insights

Managed Care Proposed Rule Summary

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On November 8, 2018, the Centers for Medicare and Medicaid Services ("CMS") published a proposed rule aimed at Medicaid managed care. CMS indicated its intentions to streamline the managed care framework and relieve regulatory burdens created in the existing managed care regulations, which were recently overhauled in 2016.

The proposed rule (which is available here) is broad in scope and concerns several complex regulatory matters that impact all aspects of managed care ranging from capitation rate setting to requirements for beneficiary information. The following table, based on the CMS fact sheet accompanying the proposed rules, summarizes the key revisions to the existing managed care regulations.

Topic	Summary of Proposed Changes
Capitation Rates	• Allows states to develop and certify a rate range of up to 5%, and allows adjustments of capitation rates within a 1.5% range. • Prohibits states from retroactively making changes to risk-sharing mechanisms. • Clarifies that differences in capitation rates must be based on differences in the cost of providing care to a specific population and may not vary solely due to the rate of federal financial participation associated with a specific population.
Pass-Through Payments	• Permits pass through payments to continue for a 3-year transition period for states transitioning new populations or services from fee-for-service (FFS) to managed care.
State Directed Payments	• Expands on the types of allowable directed payment arrangements (i.e. cost-based rate, Medicare equivalent rate, commercial rate, or other market-based rates). • Removes the prohibition on specifying the amount and frequency of payments.

Network Adequacy Standards	• Replaces time and distance network adequacy standards with quantitative network adequacy standards that can be developed by states (i.e. minimum provider/enrollee ratios, maximum time or distance to providers, minimum percentage of providers accepting new patients, maximum wait times for appointments, etc.).
Quality Rating System (QRS)	• Expands flexibility for states to develop alternative QRS.
Appeals and Grievances	• Eliminates the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted. • Changes the timeframe for enrollees to request a state fair hearing to no less than 90 calendar days and no greater than 120 days to allow states the flexibility to choose a timeframe that aligns with FFS Medicaid. • Eliminates 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	• Eliminates requirement for taglines to be in 18-point font and instead adopts the “conspicuously-visible” standard used by the HHS Office for Civil Rights. • Eliminates the requirement to print taglines on all written materials and instead only requires taglines on materials critical to obtaining services. • Permits paper provider directories to be updated quarterly rather than monthly if the managed care plan offers a mobile-enabled provider directory. • Provides more flexibility in the timing of provider termination notices sent to beneficiaries.
CHIP	• Adopts applicable Medicaid proposals for CHIP, including network adequacy standards, medical loss ratio standards, quality rating system and other quality standards, appeals and grievances, and requirements for beneficiary information.

Please contact Meghan M. Linvill McNab if you would like to discuss the provisions in the proposed rule in more detail or if you are interested in assistance with submitting a public comment, which are due to CMS by January 14, 2019.