Integrated Care Resource Center

Spotlight: Key CMS Medicaid Managed Care Proposed Rule - Implications for States Serving Medicare-Medicaid Enrollees in Integrated Programs and Opportunities for State Comments

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on May 26, 2015 that would make extensive changes in how states design, implement, and oversee Medicaid managed care programs. ***States and others have until 5 PM on July 27, 2015 to submit comments to CMS on this proposed rule.***

The Integrated Care Resource Center (ICRC) has identified several provisions in the proposed rule that have implications for states that are either operating or planning to operate programs that integrate Medicare and Medicaid services for dually eligible enrollees; these provisions are summarized below. (The page numbers noted below refer to the June 1, 2015 *Federal Register* that describes the proposal and its rationale in the "Supplementary Information" section and the text of the proposed regulations beginning on p. 31252.) ICRC would be pleased to provide additional information and assistance to states wishing to comment on these aspects of the proposed rule.

Better Alignment of Medicaid and Medicare Appeals and Grievances Processes. Substantial changes are proposed to the Medicaid appeals and grievances requirements that would better align them with Medicare and private market appeals and grievances processes and timelines. The proposed rule would: (1) streamline the levels of internal health plan appeals to one level; (2) change the standard and expedited timeframes for resolution of appeals to align with Medicare timeframes; and (3) require enrollees to exhaust internal health plan appeals process before appealing to a state fair hearing. *(pp. 31102-31107 and 31137-31139)*

Minimum Medical Loss Ratio of 85 Percent. CMS is proposing a minimum medical loss ratio (MLR) of 85 percent for Medicaid health plans to provide greater consistency with the MLR requirements for Medicare Advantage, Marketplace, and other private market health plans. States would not be required to recoup funds from Medicaid health plans if they fall below this threshold, but health plan performance on this measure would be taken into account in setting future capitated rates. Because care coordination and management activities may be more extensive and complex in Medicaid health plans that cover long-term supports and services, states would have flexibility in determining the types of activities that could be classified as "medical" when calculating the MLR. *(pp. 31107-31113)*

Payment of "Crossover Claims" by Health Plans that Cover Medicare-Medicaid Enrollees. CMS is proposing that if a state contracts with a Medicaid health plan to cover Medicare-Medicaid enrollees and delegates the state's responsibility for coordination of benefits to the health plan, *and* if the state uses the Medicare automated crossover process for fee-for-service (FFS) claims, then the state must require the contracted health plans to use the same process. ("Coordination of benefits" refers to the process through which Medicaid agencies pay providers for Medicare beneficiary cost sharing on behalf of Medicare-Medicaid enrollees when providers submit Medicare "crossover claims" to the agency.) The aim of the proposal is to minimize the burden on providers who might otherwise have to submit crossover claims to different entities in different ways, and to make it easier for these providers to serve Medicare-Medicaid enrollees. *(p. 31116)*

Capitation Payments for IMD Services. CMS is proposing to allow Medicaid health plans to receive capitated payments from the state for services in an institution for mental disease (IMD) for enrollees ages 21 to 64 if the IMD stay is less than 15 days in a month, as long as the IMD is a hospital providing psychiatric or substance use disorder (SUD) inpatient care, or a sub-acute facility providing psychiatric or SUD crisis residential services. Currently, Medicaid is not allowed to pay for IMD services in FFS for those between ages 21 and 64. While capitated managed care plans currently can provide these services as "in lieu of" services if they substitute for more costly alternative care, these services cannot be included when the state is determining capitated payment rates. The proposed change would give states and health plans additional flexibility in funding these behavioral health services, which can be especially important for dually eligible beneficiaries under age 65, who often have serious and extensive behavioral health needs. *(pp. 31116-31118)*

Active Enrollment Choice Period with FFS Coverage. CMS is proposing a minimum 14-day period of FFS coverage to allow for active enrollment choices by potential Medicaid managed care enrollees. The 14-day period would apply to both voluntary and mandatory programs with some exceptions, including when there is only one managed care plan in a rural area, or when there is specific authority in an 1115(a) demonstration program for a different approach. This proposed 14-day choice period could have an impact on states that do not maintain FFS coverage for beneficiaries prior to enrollment in an integrated program, and it could also affect coordination of enrollment into integrated programs where states may have developed integrated enrollment processes into aligned Medicaid and Medicare plans that do not include such a choice period. CMS requests comment on whether a 14-day period is necessary, provides sufficient time for beneficiaries to make an election, or whether a longer minimum period, such as 30 days or 45 days, should be adopted. (pp. 31133-31135)

Medicaid Encounter Data Requirements. CMS is proposing that state contracts with Medicaid health plans must specify that enrollee encounter data must include rendering provider information, comply with CMS specifications and standards, and be submitted to the state in a format consistent with industry standards. CMS will issue clarifying guidance in the future on the level of detail that will be required of plans. At a minimum, CMS expects the initial guidance to include standards for: (1) enrollee and provider identifying information; (2) service, procedure, and diagnosis codes; (3) allowed/paid, enrollee responsibility, and third part liability amounts; and (4) service, claim submission, adjudication, and payment dates. This additional Medicaid encounter data guidance will give CMS the opportunity to make the requirements as similar as possible to the encounter data requirements for Medicare Advantage health plans. This could ease the encounter data administrative burden for health plans, providers, and states that serve Medicare-Medicaid enrollees in capitated arrangements. *(pp. 31166-31167)*