

Spotlight: CMS Medicaid Managed Care Final Rule – Provisions Related to Integrated Programs for Medicare-Medicaid Enrollees

The Centers for Medicare & Medicaid Services (CMS) issued a final rule (published in the May 6, 2016 *Federal Register*) that makes extensive changes in how states design, implement, and oversee Medicaid managed care programs. The final rule contains provisions aimed at strengthening quality standards, aligning Medicaid requirements and processes with Medicare Advantage and private health insurance, and increasing transparency. It also incorporates many new provisions specifically addressing individuals with special health care needs or disabilities and those using long-term services and supports (LTSS)—populations that are generally over-represented among beneficiaries enrolled in both Medicare and Medicaid (Medicare-Medicaid enrollees).

Summary of Provisions Related to Integrated Programs

The Integrated Care Resource Center (ICRC) has identified a number of provisions in the final rule of particular importance to states that are either operating or planning to operate programs that integrate Medicare and Medicaid services for Medicare-Medicaid enrollees. ICRC has summarized these provisions below, and would be pleased to provide additional information and assistance to states that have questions on these aspects of the proposed rule.

The page numbers shown for each provision are the pages in the [May 6, 2016 Federal Register](#) where CMS summarizes the proposed rule, comments received, CMS responses, and changes made in the final rule. The actual text of the final rule begins on p. 27852.

- **Quality Assessment and Performance Improvement Programs (Section 438.330).** States must require their Medicaid managed care organizations (MCOs) and other managed care entities to establish and implement an ongoing comprehensive quality assessment and performance improvement program that includes, at a minimum, mechanisms to detect both underutilization and overutilization of services and the quality and appropriateness of care furnished to enrollees with special health care needs. Quality assessment and performance improvement programs for plans offering LTSS must include assessments of care between care settings and comparisons of services and supports received with those set forth in the enrollee's treatment/service plan. Assessment and improvement programs must also assess plans' efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements for home and community-based services waiver programs.

States must develop objective performance measures that assess the LTSS provided by plans including, at a minimum, quality of life, rebalancing, and community integration activities. States may identify additional LTSS-focused measures for plans providing LTSS services. Although states will be given flexibility to select performance measures and projects, section §438.330(a)(2) of the Final Rule gives CMS the option to identify a common set of national measures and/or topics for quality improvement projects for inclusion in state contracts. States may allow plans that exclusively serve dually eligible individuals to substitute a Medicare

Advantage quality improvement project for one or more of the required performance improvement projects (§438.330(d)(4)).

- **Implementation date:** No later than rating period for contracts starting on or after July 1, 2017.
 - **Significant changes from proposed rule:** None related to integrated programs.
 - **CMS responses to comments:** FR pp. 27676-27685
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- **Medicaid Managed Care Quality Rating System (Section 438.334).** States are required to adopt a Medicaid managed care quality rating system (QRS) developed by CMS, which will align with the QRS developed for the Qualified Health Plans on the Federal Health Insurance Marketplace, or an alternative state-developed system that is reviewed and approved by CMS. The alternative system could use different performance measures and methods than the ones developed by CMS, but it must provide information that is “substantially comparable” to that produced by the CMS system.
 - **Implementation date:** States will not be required to implement a Medicaid managed care QRS until three years after CMS issues formal guidance specifying measures and methodologies in the *Federal Register*, which CMS estimates will happen in 2018. States would then have until 2021 to implement their alternative systems.
 - **Significant changes from proposed rule:** CMS dropped from the final rule a proposal to give states the option of using the Medicare Advantage Five-Star Rating system for those plans that serve only Medicare-Medicaid enrollees, such as Dual Eligible Special Needs Plans (D-SNPs).
 - **CMS responses to comments:** FR pp. 27686-27691
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- **Managed Care Elements of State Comprehensive Quality Strategies (Section 438.340).** States must include new details in their quality strategies that explicitly address the needs of people using LTSS, including mechanisms to identify them and assess their care needs. Quality strategies must also describe the state’s plan to address, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status.
 - **Implementation date:** No later than July 1, 2018.
 - **Significant changes from proposed rule:** None related to integrated programs.
 - **CMS responses to comments:** FR pp. 27700-27702
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- **External Quality Review (Sections 438.360 and 438.362).** The Final Rule permits states to substitute Medicare Advantage quality review information when it duplicates Medicaid information (Non-duplication of Mandatory Activities, Section 438.360), and Exemption from External Quality Review, Section 438.362). The Medicaid network adequacy requirements in

Sections 438.206 and 438.207 continue to apply since Medicare requirements do not duplicate them.

- **Implementation date:** No later than July 1, 2018.
 - **Significant changes from proposed rule:** None related to integrated programs.
 - **CMS responses to comments:** FR pp. 27709-27715
- **Network Adequacy (Section 438.68).** In addition to the time and distance standards that apply to all providers, the Final Rule includes specific standards for contracts that cover beneficiaries using LTSS. For example, for LTSS providers that travel to the enrollee to deliver services, states must consider elements that would support an enrollee's choice of provider and community integration of the enrollee.
 - **Implementation date:** No later than rating period for contracts starting on or after July 1, 2018.
 - **Significant changes from proposed rule:** None related to integrated programs.
 - **CMS responses to comments:** FR pp. 27658-27666 (MLTSS responses start on p. 27664)
 - **Better Alignment of Medicaid and Medicare Appeals and Grievances Processes (Sections 438.408, 431.244(f), and 438.410)** The Final Rule modifies the grievance and appeals system to better align Medicaid managed care requirements with Medicare Advantage requirements and those in private insurance to support beneficiaries navigating the appeals and grievance processes of various plans and programs.

Medicaid managed care plans are limited to one level of appeal before enrollees can access the state fair hearing (SFH) process, and the Final Rule requires that enrollees must exhaust the plan appeals process prior to accessing a SFH. The Final Rule also lengthens the timeframe for requesting a SFH to 120 days, and enrollees may also access the SFH if the plan fails to adhere to the notification and timeliness requirements of §438.408. In addition, the timeliness requirements for filing Medicaid managed care plan appeals is modified to 60 days to align with Medicare Advantage requirements. These changes have implications for states with integrated programs where there may be more than one level of plan appeal, where beneficiaries may access a SFH prior to exhausting the health plan appeals process, or where integrated health plan contracts provide less than 120 days to enrollees to request a SFH. Additionally, the alignment of Medicaid and Medicare Advantage timeliness requirements can help streamline the managed care plan appeals process for beneficiaries enrolled in integrated Medicaid managed care plans. The beneficiary support system required by Section 438.71 can be used to help beneficiaries navigate this process.

Timeframes are shortened from 45 to 30 days for resolution of standard appeals and 3 business days to 72 hours for expedited appeals, which generally aligns with Medicare Advantage requirements. Providers must obtain written consent from the enrollee prior to appealing on the enrollee's behalf, due to potential financial impact to the enrollee. Benefits should continue through the resolution of a timely appeal, with discretion given to the states regarding recoupment. The rule emphasizes a national approach to grievance and appeals systems to the

extent possible, but notes state flexibility to provide an external medical review process to be accessed at the enrollee's option.

- **Implementation date:** No later than rating period for contracts starting on or after July 1, 2017.
 - **Significant changes from proposed rule:** None.
 - **CMS responses to comments:** FR pp. 27515-27519
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- **Payment of “Crossover Claims” by Health Plans that Cover Medicare-Medicaid Enrollees (Section 438.3(t)).** Section 438.3(t) of the Final Rule provides that if a state: (1) 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 (2) uses the Medicare automated crossover process for fee-for-service 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 beneficiary cost sharing on behalf of Medicare-Medicaid enrollees when providers submit Medicare “crossover claims” to the agency.) The aim of this provision 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.
 - **Implementation date:** No later than rating period for contracts starting on or after July 1, 2017.
 - **Significant changes from proposed rule:** None.
 - **CMS responses to comments:** FR p. 27555
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- **Capitation Payments for IMD Services (Section 438.6(e)).** Section 438.6(e) of the Final Rule allows Medicaid health plans to receive capitated payments from the state for services in an institution for mental diseases (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. Under the long-standing “IMD exclusion,” Medicaid is not allowed to pay for IMD services in FFS for those between ages 21 and 64. While capitated managed care plans could provide these services as “in lieu of” services if they substituted for more costly alternative care, these services could not be included when the state was determining capitated payment rates. The Final Rule gives states and health plans additional flexibility in funding these behavioral health services in managed care settings, which can be especially important for dually eligible beneficiaries under age 65, who often have serious and extensive behavioral health needs.
 - **Implementation date:** July 5, 2016.
 - **Significant changes from proposed rule:** None.
 - **CMS responses to comments:** FR pp. 27555-27563
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- **Minimum Medical Loss Ratio of 85 Percent (Sections 438.4, 438.5, 438.8, and 438.74).** A medical loss ratio (MLR) measures generally how much a managed care plan spends on the provision of covered services compared to the total revenue it receives in capitation from the state. The Final Rule provides for an MLR of 85 percent for Medicaid MCOs in order to provide greater consistency with the MLR requirements for Medicare Advantage, Marketplace, and other private market health plans. (Medicare-Medicaid Plans in some states participating in the

CMS Financial Alignment Initiative calculate and report a joint MLR under their existing three-way contracts, so are not covered by this provision.) States would not be required to recoup funds from Medicaid MCOs if they fall below this threshold, but health plan performance on this measure would be taken into account in setting future capitated rates. States have flexibility in defining what activities are classified as services as opposed to administrative costs in order to take into account specific features of the Medicaid program, especially the care coordination and management activities that may be needed in providing care for populations with complex service needs. The Final Rule deletes the term “medical” from the definition of services in Section 438.8(e)(2)(i)(A) to emphasize that all services, including behavioral health, acute care, pharmacy, non-emergency medical transportation, and LTSS are included in the definition.

- **Implementation date:** No later than rating period for contracts starting on or after July 1, 2017.
 - **Significant changes from proposed rule:** Deletion of “medical” from Section 438.8(e)(2)(i)(A).
 - **CMS responses to comments:** FR pp. 27521-27535
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- **Medicaid Encounter Data Requirements (Sections 438.2, 438.242, and 438.818).** Section 438.818 of the Final Rule provides that state contracts with Medicaid MCOs 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: enrollee and provider identifying information; service, procedure, and diagnosis codes; allowed/paid, enrollee responsibility, and third party liability amounts; and 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 plans, which could ease the encounter data administrative burden for health plans, providers, and states that serve Medicare-Medicaid enrollees in capitated arrangements.
 - **Implementation date:** No later than rating period for contracts starting on or after July 1, 2018.
 - **Significant changes from proposed rule:** States will not be required to post encounter data on their websites or make it available on request, as initially proposed in section 438.602(g)(2). States will also not be required to submit to CMS a detailed plan on how they propose to ensure submission of complete, accurate, and timely encounter data, as initially proposed in section 438.818(d).
 - **CMS responses to comments.** FR pp. 27737-27744
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- **Managed Care Enrollment 14-Day Choice Period (Proposed Sections 438.54(c)(2) and 438(d)(2).** In the Final Rule, CMS decided to not to include the proposed 14-day fee-for-service coverage period prior to managed care enrollment. Commenters noted that the proposal could cause disruptions in care or delays in care coordination for vulnerable populations. CMS noted

that “the 90 day without cause disenrollment window afforded to all enrollees in connection with their initial managed care enrollment serves as a choice period.” (FR p. 27617)

- **Implementation date:** Not applicable.
 - **Significant changes from proposed rule:** Proposed Sections 438.54(c)(2) and (d)(2) dropped.
 - **CMS responses to comments:** FR pp. 27613-27619
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- **Marketing Activities (438.104)** CMS’ comment on the Final Rule clarifies that “types of health care coverage, such as integrated D-SNPs [dual eligible special needs plans], are public health benefit programs that are not insurance” and therefore not subject to the prohibition of Medicaid managed care plans marketing private insurance products.
 - **Implementation date:** July 5, 2016.
 - **Significant changes from proposed rule:** No changes required to text of rule to achieve this clarification.
 - **CMS responses to comments:** FR p. 27504

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for individuals dually eligible for Medicare and Medicaid. The state technical assistance activities are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit <http://www.integratedcareresourcecenter.com>.

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