Medicaid Managed Care Final Rule: Examining The Alignment With Qualified Health Plan Requirements

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Editor’s note: This post focuses on provisions in the Medicaid and CHIP managed care final rule regarding alignment, and sometimes lack of alignment, between Medicaid managed care requirements and those governing other insurance coverage programs, specifically Qualified Health Plans in the ACA Marketplaces. Watch Health Affairs Blog for more coverage of this final rule.

On April 25, 2016, the Centers for Medicare and Medicaid Services released its massive (1425 pages with preface) Medicaid and Children’s Health Insurance Program (CHIP) managed care final rule. CMS also released nine fact sheets highlighting various aspects of the final rule, including a timeline for the implementation of its provisions.

Thirty-nine states and the District of Columbia rely on managed care to provide health care to their Medicaid population, including two-thirds of the 72 million Americans enrolled in Medicaid nationwide. The rule is the first major update of the Medicaid managed care (MMC) rules since 2002 and comprehensively overhauls MMC requirements and oversight.

The CMS press release accompanying the rule release states that the MMC rule had four key goals:
I found of interest the stated intent of CMS to align MMC requirements with other insurance coverage programs, specifically regulations applying to Qualified Health Plans (QHPs) in the federal and state health insurance marketplaces and to Medicare Advantage Programs. It certainly makes sense to align federal rules governing MMC, QHPs, and Medicare Advantage plans. Large insurers offer plans in all three markets and must conform to the rules of all three programs. Many consumers transition over the course of a year between QHP and Medicaid as their incomes rise and fall or family circumstances change. Others have household members enrolled in both programs—adults covered by a QHP and children covered by CHIP or Medicaid, or a male adult enrolled in a QHP and pregnant female enrolled in Medicaid.

The fact sheet issued with the final rule on “Improved Alignment with Medicare Advantage and Private Coverage Plans” identifies three areas in which the MMC rules will align more closely with private insurance coverage: medical loss ratio requirements, grievance and appeal procedures, and consumer information requirements. Separate fact sheets deal with MMC network adequacy and provider directory and quality improvement requirements, both of which are comparable to requirements imposed on QHPs.

This post will compare MMC and QHP requirements in these five areas. Although as stated the Medicaid managed care rule also attempts to align MMC and Medicare Advantage requirements, this post will not compare Medicare Advantage and MMC requirements comprehensively. Since Medicare and Medicaid are both public programs, the rules through which they govern managed care are often quite similar.

The term Medicaid Managed Care, or MMC, is used in this post comprehensively to include managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), prepaid inpatient health plans (PIHPs), and in some circumstances primary care case management entities (PCCM entities). Although I do not discuss CHIP specifically, most of the MMC provisions also apply to CHIP plans. Finally, a number of

(1) supporting states’ efforts to advance delivery system reform and improvements in quality of care for Medicaid and CHIP beneficiaries; (2) strengthening the consumer experience of care and key consumer projections; (3) strengthening program integrity by improving accountability and transparency; and (4) aligning rules across health insurance coverage programs to improve efficiency and help consumers who are transitioning between sources of coverage.
special rules apply when managed care is provided in long-term care settings. These are not discussed here as QHP plans do not cover long term care.

Medical Loss Ratio Requirements

Since 2012, all insurers in the individual, small group, and large group markets have been required to spend a minimum percentage (80 percent for individual and small group, 85 percent for large group) of their adjusted premium revenue on health care claims or on quality improvement expenses. Insurers that spent less than this amount have been required to rebate the difference between the amount they actually spent in a given year and their minimum medical loss ratio (MLR) target to their enrollees. This has had the practical effect of limiting the amount that insurers can spend on administrative costs (including broker and agent commissions) and make in profits.

The MMC rule requires MMC plans to calculate and report their MLR using a formula that resembles that applied to private insurers for plan years beginning on or after July 1, 2017. It sets the MLR target for MMC plans at 85 percent, equivalent to that required for large group private coverage, although states are allowed to set higher MLR target ratios. The rule does not obligate MMC insurers, as a matter of contract compliance, to meet this target. Rather, if an MMC insurer does not meet the MLR target, the state Medicaid program must take that into account in setting capitation rates for subsequent periods.

However, states are also permitted, but not required, to require MMC plans that fail to meet the MLR target to pay remittances to the state. (The remittances must be shared with the federal government to the extent that payments were originally attributable to federal financial participation.) The rule does not provide for rebates to enrollees, as do the private plan rules, and the method of calculating the remittances is left to the state.

The manner in which the MLR comes into play in MMC plans highlights an importance difference between MMC and private sector health plans. Whereas in the private sector, MLR requirements focus on ensuring that plan enrollees get value for their premium dollars, in MMC the MLR must be understood in the context of the overall requirement of actuarially sound MMC rates. While an MMC plan with too low an MLR may spend too little on health care, an MMC plan with too high an MLR may end up short changing its enrollees as well. In setting capitation rates, therefore, states must consider whether MLRs are too high or too low.
There are also differences in the way in which MLRs are computed for MMC plans as compared to private plans. MLRs are calculated on an annual basis, to correspond to the annual state capitation rate setting process, rather than on a three-year rolling basis that now applies to private plans. Credibility adjustments—which take into account the fact that MLRs reported for small plans for a single year may not accurately reflect the plan’s experience over time, given the variability of health claims—are calculated differently for MMC plans than they are in the private market.

When calculating the MLR numerator, MMC plans can take into account additional quality improvement costs that do not apply to private plans, including the cost of external quality review (see below). And regulatory fees and taxes specific to MMC plans that do not apply to private plans can be subtracted from the MMC MLR denominator. HHS had considered allowing MMC plans to include fraud prevention costs in the numerator in the proposed rule; however, HHS decided in the 2017 payment rule not to consider fraud prevention costs as part of the numerator for private plans (and has no statutory authority to do so), and so it will not allow MMC plans to count them either.

**Internal And External Review**

The ACA required non-grandfathered individual and group health plans (insured and self-insured) to provide enrollees an opportunity to obtain internal and independent external review of adverse benefit determinations. Medicare Advantage enrollees have appeal rights as well. The MMC final rule aligns appeal rights for MMC enrollees more closely with those available to private and Medicare Advantage plan enrollees.

MMC plans, like private plans, must make available to their enrollees an internal process to appeal adverse benefit determinations. “Adverse benefit determination” is defined for the MMC program much as it is for private insurance plans, but also includes specifically Medicaid issues, such as the rights of residents of rural areas with only one MMC to obtain out-of-network services.

MMC plans must also provide an internal process for reviewing grievances involving plan conduct other than benefit determinations (such as quality of care or rudeness issues), a requirement imposed on Medicare Advantage plans but not private insurance plans. Whereas appeals from an adverse internal review decision in private plans go to an external review entity, appeals from an adverse MMC internal review decision must
be made to the state appeals entity. States can offer an opportunity for independent external review to MMC enrollees, but it must be optional.

MMC plans must give enrollees notice of adverse benefit determinations, which must include information on the right to appeal the determination and the reasoning grounding it. Internal appeals of adverse benefit determinations must be filed within 60 days. (Enrollees in private plans have 180 days to appeal). Internal appeals must be decided by a person who has appropriate clinical expertise (where relevant) and who was not involved in, or subordinate to a person who was involved in, the initial decision. Enrollees must have a reasonable opportunity to present evidence and testimony and must have access to information considered by the reviewer.

There is no time limit on filing grievances. Grievances must be resolved within 90 calendar days and internal appeals within 30 calendar days (compared to 60 days for private plans). Expedited appeals involving urgently needed care must be decided within 72 hours. Under limited circumstances, time frames can be extended by 14 calendar days.

If an MMC plan decides against an enrollee in an internal review, the enrollee can request a state fair hearing within 120 days of the decision. As with private coverage, an enrollee must normally exhaust internal appeal remedies before proceeding with a further appeal. If a MMC plan fails to make a decision within the prescribed time frames, however, the internal appeal process will be deemed exhausted and the appellant can proceed directly to a fair hearing.

At an enrollee’s request, the MMC plan must continue or reinstate coverage during the pendency of an appeal, although the MCC can recover costs paid for the enrollee’s care during the interim in the plan’s decision is upheld. The new appeals processes apply for plan years beginning after July 1, 2017.

**Consumer Information Requirements**

Group health plans and insurers in the group and individual market (whether grandfathered or not), are required by the ACA to provide to applicants and enrollees a summary of benefits and coverage that provides essential information about health plans. Network plans must link to their provider directory. Plans and insurers must also provide a uniform glossary of health coverage and medical terms that includes terms used in the
SBC. Healthcare.gov and state-based marketplace websites include information about the coverage offered by SBCs, including provider directory and formulary links.

Private health plans must meet minimal language accessibility requirements for SBCs and appeal notices. **QHPs must meet** more extensive specific language requirements and disability accessibility requirements. Proposed non-discrimination rules once finalized will extend the accessibility obligations of private plans.

The MMC final rule contains extensive consumer information requirements. They do not rely on the SBC, however, but rather create parallel obligations. States must provide in a timely manner to potential MMC enrollees general information about the program, including information about their rights to enrollment and disenrollment, the basic features of managed care, and the benefits that are covered by the program and how they are covered. Potential enrollees must also be provided with information about the service areas of MMC plans; any cost-sharing obligations they impose; their provider directories and formularies; quality and enrollee satisfaction information on MCC plans; and information on how to obtain counselling or referral services for plans that do not cover certain services because of moral or religious objections.

Each MMC plan must provide to enrollees within a reasonable time after enrollment an enrollee handbook which, as stated in the rule, “serves a similar function as the summary of benefits and coverage.” The information provided in this document is similar to that provided in an SBC, although additional and more specific information is required concerning emergency services, family planning services, services the plan does not cover for moral and religious reasons and how to access these services, grievance and appeal rights, and advance directives. Unlike the SBC, the handbook only becomes available after, and not before, enrollment. States must also develop and MCC plans use definitions of a list of managed care terms that look a lot like the Uniform Glossary terms.

MCC’s must make available electronically (in machine readable form) and upon request in paper provider directories providing information about their network providers. The information is basically the same as that required for QHP provider directories but includes more data about provider’s cultural and linguistic capabilities and disability access. Provider directories must be updated at least monthly and no later than 30 days
after an MCC receives updated provider information. MCCs must also make their formularies available electronically and in paper form.

Language and accessibility requirements are both broader and less specific under the requirements imposed on private insurance plans. Language translation requirements only apply for “prevalent” non-English languages, spoken by “a significant number or percentage of potential enrollees and enrollees who are limited English proficient,” as determined by the state. By contrast, most QHP language requirements apply specifically to the top 15 non-English languages in a state.

MCC plans must make all critical documents available in all prevalent non-English languages and make oral interpretation available in all languages. The MCC regulations also require taglines and documents with large print, TTY/TDY and American Sign Language access, and auxiliary aids and services available without cost to persons with disabilities. These requirements are more specific than those that currently apply to private insurers, although that may change once currently pending nondiscrimination regulations are finalized. MCC consumer information requirements are effective for plan years beginning after July 1, 2017.

Network Adequacy And Provider Directories

The final MMC rule includes provisions respecting network adequacy both in its state responsibilities and MMC plan standards parts. Under the MCC rule, states are required to develop and make publicly available time and distance network adequacy standards for primary care (adult and pediatric), OB/GYN, behavioral health, adult and pediatric specialist, hospital, pharmacy, and pediatric dental providers, and for additional provider types as determined by CMS. CMS had proposed, but backed off of, requiring states to develop time and distance standards for QHP provider networks.

The regulation lists factors states are to consider in setting standards, including the ability of providers to communicate with limited English proficient enrollees, accommodation of disabilities, and “the availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.” If states create exceptions from network adequacy standards, they must monitor enrollee access on an ongoing basis.
More specific standards in a separate section of the rule require states to ensure that female enrollees have direct access to a women’s health specialists, enrollees can get second opinions from an in-network provider or out-of-network if necessary, enrollees can go out of network if necessary to get medically necessary services, out-of-network providers coordinate with MMCs to ensure that enrollees do not have to pay more for out-of-network services, and enrollees have timely access to family planning services. Network providers must offer hours of operation no less than those offered to commercial enrollees or comparable to Medicaid fee for service, and must offer services 24/7 when medically necessary.

Standards governing QHPs require 30 days' notice to enrollees if their primary care provider is terminated from a network and provision for up to 90 days of continued care when an enrollee is under active treatment from a provider terminated from a network without cause. The MMC regulations require 15 days' notice to patients of the termination of their primary care provider, but do not seem to have any continuity of care requirements for the termination of a physician (although they do have requirements when a managed care plan is terminated.) The new network adequacy standards apply for plan years beginning on or after July 1, 2018.

**Quality: The Area Featuring The Biggest Difference Between MMC and QHP Requirements**

It is in the area of quality that MMC requirements differ most dramatically from private health plan (QHP) requirements. QHPs must meet accreditation standards. QHP insurers must verify that hospitals with more than 50 beds with which they contract have implemented a person-centered discharge program and use a patient safety evaluation system. QHP insurers must collect and submit validated clinical quality measure data. They must contract with HHS-approved QHP enrollee survey vendors to collect and submit enrollee satisfaction survey data on their behalf.

CMS will use the quality and satisfaction survey data to calculate ratings that will be displayed on the marketplace website for each QHP product type using a five-star scale beginning in the 2017 open enrollment period. Insurers with non-child-only QHP products covering more than 500 enrollees must implement a quality improvement strategy complying with recently released guidelines for 2017. The quality improvement
strategy must offer incentives to providers or enrollees to improve health care quality or outcomes.

MMC quality requirements are more comprehensive and complex. States that contract with managed care entities to provide Medicaid services must draft and implement quality improvement strategies for assessing and improving the quality of MMC services. The term “quality improvement strategy” means something different under the MCC rules than under the QHP rules, however. MMC quality improvement strategies are focused on plan, not provider, performance. MMC quality improvement strategies must address improving quality and performance outcomes, but also must include a plan to identify, evaluate, and reduce health disparities; and mechanisms to identify individuals who need long-term services and supports or who have special health care needs.

States must require that each MMC establish and implement an ongoing quality assessment and performance improvement program. These programs focus on the quality and appropriateness of care provided enrollees, particularly those with special needs or requiring long-term care services and supports. Performance improvement projects must be designed to achieve significant, sustained, and objectively measureable improvement in health outcomes and enrollee satisfaction.

States must require MMC plans to report their accreditation status, and must in turn report MMC plan accreditation information on the state’s website. The rule does not require states to mandate MMC plan accreditation, however, although accredited plans can be deemed to meet certain external review requirements. CMS is developing a quality rating system for MMC plans that will presumably resemble the system it has developed for QHPs. States must either adopt this system or develop their own quality rating systems, must rate MCC plans, and must publish quality rating information on MCC plans.

The biggest difference between QHP and MCC quality oversight requirements is that states must contract with external quality review organizations (EQROs) to perform annual external quality reviews of MCC plans. EQROs must be independent organizations that meet regulatory competence requirements and review MCC plans applying external review protocols. EQROs must validate MCC plan performance improvement projects, performance measures, and network adequacy and may validate
encounter data, consumer or provider quality of care surveys, and other quality studies or measures.

States may use information from Medicare or private accreditation reviews under some circumstances to fulfill external quality review requirements and may exempt Medicare managed care organizations from external quality review if specific requirements are met. States must compile and make publicly available an annual external quality review report. The MCC rule’s quality assessment and performance improvement and accreditation provisions are effective for contracts effective on or after July 1, 2017, and the remaining quality requirements for contracts effective on or after July 1, 2018.

**Different Programs That Sometimes Require Different Rules**

The MCC rule contains many other provisions intended to ensure the protection of MMC enrollees and of the integrity of the MMC program. What emerges from the regulatory provisions analyzed here, however, as well as the remaining provisions of the MMC rule, is a quite different program than that through which coverage is provided by QHPs in the marketplaces.

QHPs plans and MCC plans are, of course, both managed care plans; some of them are operated by the same insurers and they are identical in many respects. Moreover, Medicaid enrollees and QHP enrollees are in many instances members of the same families, or, over the course of a year, the same people whose incomes have slightly risen or fallen. But on the whole, Medicaid enrollees are more vulnerable and needy, with far fewer financial resources than most QHP enrollees. Tighter oversight is appropriate to ensure their protection.

Moreover, the Medicaid program is entirely government financed. Although private MMC plans provide Medicaid services, Medicaid is a public program. By contrast, although marketplace plans receive premium tax credit and cost-sharing reduction payments, they are in the end private health plans enrolling private individuals who pay for much of the cost of their own care. The MMC final regulation is, therefore, appropriately much more focused on ensuring comprehensive program oversight to ensure that public funds are handled properly. By contrast, QHP oversight resembles more closely traditional insurance plan regulation.
In the end, therefore, although the final MMC rule does align some aspects of MMC and QHP, the two programs are fundamentally different in important ways, and the rules reveal these significant differences.

TAGS: external review, internal review, medical loss ratios, network adequacy, provider directories, states, summary of benefits and coverage

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