Federal CMS Medicaid Managed Care Final Rule

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Introduction

- On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations on Medicaid that revise and significantly strengthen existing Medicaid and Children's Health Insurance (CHIP) managed care rules.
- The final rule aligns many of the rules governing Medicaid managed care with those of other major sources of coverage such as the Affordable Care Act Marketplace and Medicare Advantage plans.
- This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade.

Goals

- Major goals of CMS in revising the regulations were to:
  - Align Medicaid and CHIP managed care requirements with other major health coverage programs where appropriate;
  - Support efforts to reform the delivery systems that serve Medicaid and CHIP beneficiaries;
  - Enhance the beneficiary experience of care and strengthen beneficiary protections;
  - Strengthen actuarial soundness payment provisions;
  - Strengthen program integrity; and
  - Promote quality of care

Top Issues for Florida

- Enhance the beneficiary experience of care and strengthen beneficiary protections
  - Beneficiary support and information
- Strengthen actuarial soundness payment provisions
- Strengthen program integrity
  - Appeals
- Promote quality of care
  - Network adequacy and access to care
  - Managed long-term services and supports (MLTSS)

Highlights of the Rule

- **Goal:** Enhance the beneficiary experience of care and strengthen beneficiary protections.
- **Beneficiary support and information.**
  - Enrollee information must be accessible to people with disabilities and available in locally prevalent non-English languages.
  - States must maintain a managed care website and states and plans can provide information to enrollees electronically.
- Implementation Timeframe: No later than rating periods for contracts starting on or after October 17, 2016.

(See the Final Rule on Non-Discrimination in Health Programs and Activities at Title 45 Code of Federal Regulations, Part 92.)

Highlights of the Rule

- **Goal:** Strengthen actuarial soundness payment provisions.
- **In Lieu of Services.**
- **Short-term Institutions for Mental Diseases (IMD) stays.**
  - For the first time, under the authority for plans to cover services "in lieu of" of those available under the Medicaid state plan, states can receive federal matching funds for capitation payments for adults who receive psychiatric or substance use disorder inpatient or crisis residential services in an IMD for no more than 15 days in a month.
- Implementation Timeframe: No later than rating periods for contracts starting on or after July 1, 2017.

Highlights of the Rule

- **Goal:** Strengthen program integrity.
- **Appeals**.
  - The final rule enables managed care enrollees to have services continue during appeals of denials.
  - Beneficiaries must exhaust the internal health plan appeal before proceeding to a state fair hearing. This creates a more streamline appeals process and more consistent protocols within health insurance markets.
- Implementation Timeframe: No later than rating periods for contracts starting on or after July 1, 2017.

Highlights of the Rule

Table 1: Changes to Timeframes for Appeals Process		
Process	**Existing Rule**	**New Rule for Plan Contracts Starting on or after July 1, 2017**
Beneficiary request for an internal plan appeal	State selects a period between 20 and 90 days from notice of adverse benefit determination	60 calendar days from date of the notice of adverse benefit determination
Standard timeframe for decision on an internal plan appeal	45 days* from plan's receipt of appeal	30 calendar days* from plan's receipt of appeal (state may set shorter timeframe)
Notice of expedited resolution of an appeal by health plan	3 working days from plan receipt of appeal	72 hours from plan receipt of appeal
Beneficiary request for a state fair hearing	State selects a period between 20 and 90 days from notice of adverse benefit determination; state option about whether beneficiaries can bypass internal plan appeal and go directly to fair hearing	120 calendar days from the date of the notice of internal plan appeal resolution; beneficiaries must exhaust internal plan appeal before accessing fair hearing
Health plan implementation of internal plan appeal decision or state fair hearing decision when an adverse benefit determination is overturned	Promptly and as expeditiously as the enrollee's health condition requires	72 hours from plan's receipt of notice reversing the determination

NOTE: *These timeframes may be extended by up to 14 calendar days at the enrollee's request or if the plan shows to the state's satisfaction the need for additional information and how the delay is in the enrollee's interest.

Highlights of the Rule

- **Goal:** Promote quality of care.
- **Network adequacy and access to care.**
  - States must establish time and distance standards for 11 specified types of providers and other network adequacy standards LTSS providers who travel to enrollees.
  - States must have a continuity of care policy for beneficiary transitions from FFS to managed care or from one managed care plan to another.
- Implementation Timeframe: No later than rating periods for contracts starting on or after July 1, 2017.

Highlights of the Rule

- **Goal:** Promote quality of care.
- **Managed long-term services and supports (MLTSS).**
  - For the first time, the federal rule includes provisions specific to MLTSS. States must identify enrollees with LTSS needs, and plans must comprehensively assess these enrollees.
  - Plans also must comply with CMS's person-centered planning and home and community-based setting regulations.
  - States and plans must create stakeholder advisory groups to oversee MLTSS programs.
- Implementation Timeframe: No later than rating periods for contracts starting on or after July 1, 2017.

Looking Ahead

- This Final Rule is a milestone in the ongoing modernization of the delivery systems in Medicaid.

- This rule seeks to establish a balance between the Federal minimum requirements and State flexibility to determine their own processes and standards.

Questions?