NAVIGANT
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HEALTHCARE

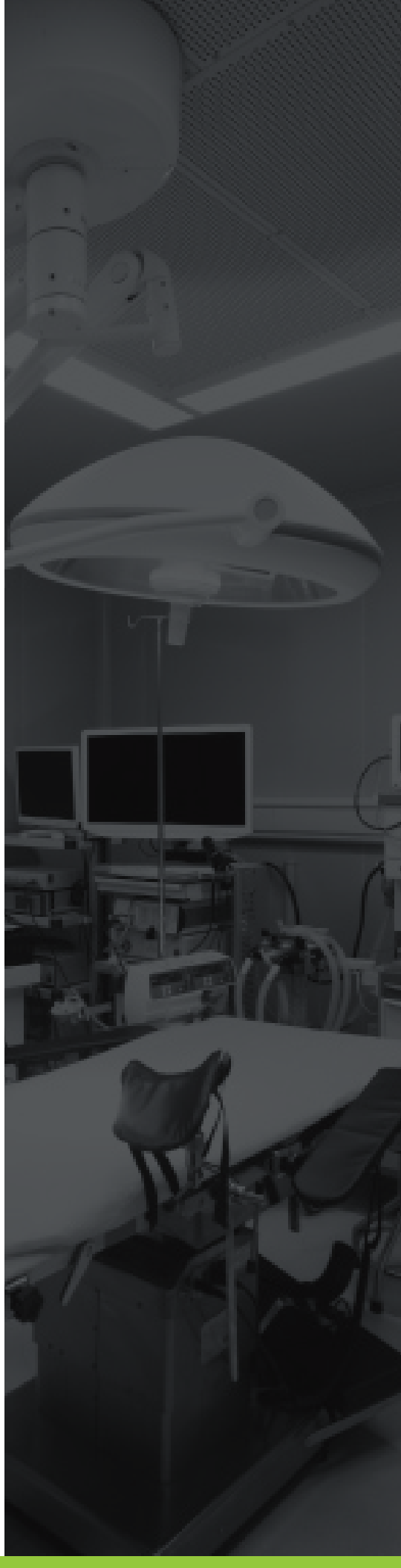
EVOLVING MEDICAID MANAGED CARE REGULATIONS: WHAT DO THESE CHANGES MEAN FOR YOU?

It has been more than two years since the Centers for Medicare & Medicaid Services (CMS) released its Medicaid and CHIP Managed Care Final Rule in 2016. Under the Trump administration, CMS promised to review these regulations and recently issued proposed updates in November 2018. The proposed rules clarify CMS' expectations and provide states some additional administrative flexibility to meet access, quality, and efficiency objectives.

The proposed rule will have limited overall impact on current Medicaid managed care operations for states and health plans. Many of the provisions are technical clarifications and tweaks to correct inadvertent references in the 2016 final Medicaid managed care regulations, align requirements with other government programs, or make clear CMS' expectations.

TOP TAKEAWAYS FROM THE PROPOSED RULE

1. **Greater operational flexibility for requirements already in effect:** While the proposed rule provides some additional administrative flexibility, states have already implemented most of the 2016 final Medicaid managed care regulations through contract amendments and/or policies. Moving forward, states may be able to take advantage of the relaxed provisions. For example, the rule:
   - *State network adequacy:* Allows states to use alternative quantitative network adequacy standards, rather than only time and distance. Examples of quantitative standards include provider-to-enrollee ratios, maximum wait times for appointments, and minimum percentage of network providers that are accepting new patients.
   - *Information:* Lets states include taglines only for materials that are critical to obtaining services, relaxes the definition of "large print," extends the timeframe for sending provider termination notices to the later of 30 calendar days prior to the effective date or 15 calendar days after the receipt or issuance of the notice, and permits less than monthly updates to paper directories if the managed care plan offers a mobile-enabled electronic directory.
   - *Capitation rate ranges:* Provides states the option to develop and certify a capitation rate range per rate cell, rather than certify a specific capitation rate per rate cell. To exercise this option, state actuaries must certify the upper and lower bounds of the proposed rate range as actuarially sound.
2. **Easier for states to justify the transition of populations and services into full-risk managed care:** CMS proposes an exception to its previous prohibition on new pass-through payments. The proposed rule allows states to make pass-through payments for a period of up to three years if expanding managed care programs to new populations or services, as long as certain conditions are met. This allowance may be most beneficial to states that currently make supplemental payments to provider types that serve populations or



provide services that states wish to transition to managed care. For example, states could make pass-through payments to nursing facilities as they transition those services and/or populations receiving long-term services and supports to managed care for the first time.

3. **Alignment of quality rating system (QRS) measures to enable meaningful comparison across states:** The proposed rule allows states to use an alternative state QRS and commits CMS to aligning performance measures within the QRS with other related CMS quality rating approaches. This includes the Medicare Advantage star rating system and summary indicators used by the QRS developed for qualified health plans in the federally-facilitated exchange.
4. **Remaining implementation timelines for 2016 final Medicaid managed care regulations still in effect:** We previously developed a cheat sheet to help states stay on track with requirements and timelines. Based on our review of the proposed rule, there are no changes to these previously set implementation timelines.

The deadline for the public to submit comments on the proposed rule is January 14, 2019. Subsequently, CMS will have to respond to public comments and issue a final rule before states will have to comply.

HOW WE CAN HELP

Navigant is supporting many states in these efforts and can help your state comply with CMS' Medicaid managed care regulations. Services we offer include the following:

- Assessment of current managed care policies, procedures, and contracts to identify opportunities to ease administrative burden while supporting compliance with federal regulations.
- Strategic planning and procurement assistance to expand managed care programs to new populations and services.
- Design and implementation of value-based purchasing programs and other state-directed payment programs, as states transition away from pass-through payments.
- Quality and access performance improvement, such as:
  - Development of provider network requirements, including non-physical health providers (e.g., home- and community-based services providers) where traditional network adequacy measures may not apply.
  - Development of an alternative QRS, including identification of performance measures and the methodology for plan ratings.
- Design, development, and submission of waivers and state plan amendments to request approval for additional program flexibility.

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