Insight

Micromanaged Care: The CMS Medicaid Rule

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INTRODUCTION

On Tuesday, May 26, the Centers for Medicare and Medicaid Services (CMS) proposed sweeping regulatory changes to Medicaid, particularly for managed care plans, and the Children's Health Insurance Program (CHIP). These regulations are the first major regulatory overhaul of the programs since 2002. The changes will impact the more than 46 million individuals now enrolled in Medicaid managed care plans, and the roughly 6 million children enrolled in CHIP. The proposed rules have an estimated regulatory cost of more than $112 million annually and impose more than 1.8 million burden hours.

The regulations pertaining to financial and actuarial soundness include the establishment of a federal minimum medical loss ratio (MLR) and modifying the definition and calculation of actuarially sound capitation rates. Provisions pertaining to quality improvement and beneficiary protection include the establishment of quality metrics and rating systems, requirements for network adequacy, adjustments to the appeals and grievances process, beneficiary rights including access to information, and adjustments loosening the restrictions on funding for mental health services.

Given the scope and impact these changes will have on millions of people and the entities who serve them, one might expect that they emanate from the legislative process. Instead, to the alarm of some, the changes are being made unilaterally through the administrative regulatory process. Critics point out that this administration has repeatedly taken it into their own hands to create health policy, and/or to implement legislation on their own schedule as opposed to the timelines set forth in law. This is another example of administrative policy-making and it is being used to extend controversial and ill-advised provisions of the Affordable Care Act (ACA)—such as the MLR,—into the one remaining sector of the health care industry that had so far escaped such mandates: Medicaid managed care. Further, the administration's efforts may undermine Congressional bipartisanship that has surfaced recently. Less than two months ago, major Medicare payment reform legislation was signed into law; this law provides for the transition of Medicare away from fee-for-service to pay-for-performance, and was a major bipartisan accomplishment achieved through years of cooperation by policymakers to finding common ground.

Summaries of some of the major Medicaid provisions follow.

FINANCIAL PROVISIONS

Medical Loss Ratio

The proposal garnering the most attention, and strongest opposition, is the imposition of a minimum MLR of 85 percent—a supposed cost-containment policy first imposed on health insurance plans by the ACA.[1] A

minimum MLR mandate requires that a minimum percentage of premium dollars collected (in this case, 85 percent), be spent on medical costs, activities to improve health care quality and efforts related to meeting mandatory standards, leaving only the remaining premium dollars (15 percent) available for administrative costs and profits. The MLR requirements are to take effect beginning in 2017, and should be calculated, reported, and used in the development of actuarially sound capitation rates.

While the MLR rule under this proposal mandates Medicaid managed care organizations (MCOs) achieve at least the same ratio as other plans were mandated to achieve, the enforcement mechanism is not the same, and does not have any teeth. Under the ACA, private plans that do not meet the minimum MLR requirement (such that medical costs are less than 85 percent of the premiums charged), must pay consumers a rebate at the end of the year for the excess premium costs. MCOs will not be required to pay rebates, because, for the most part, MCOs do not receive premiums from their enrollees; rather, they receive capitated payments from states for each beneficiary they insure. The MLR will thus be enforced, if at all, through the state's reduction of these capitated payments the following year, if the minimum requirement is not met; however, states are not mandated to make such reductions.

One thing that may be particularly challenging for MCOs in calculating the MLR is determining which expenses are "medical" and which are "administrative." While it seems it would make sense to simply use the same standards employed by plans already subject to a MLR mandate, there are expenses incurred by MCOs that would not typically be incurred by other insurers because of the characteristics of the population served by Medicaid, namely that they are all low-income (and/or have medical expenses so high that they have little funds remaining for non-health care related expenses). This means that sometimes an MCO will, for example, pay an enrollee's air conditioning bill because that is cheaper than having to pay for health problems which may result from heat exhaustion. While plan operators view such activities as a critical part of care management, some are concerned that this may not be allowed as a medical expense and therefore will be treated as administrative, making it more difficult to meet the MLR. It is worth noting that many Medicare Advantage (MA) plans serve a significant share of low-income individuals and have been required to meet an MLR of 85 percent since 2014; if they provide similar services, these decisions have presumably already been made for them, and it would make sense to use similar guidelines.

Some are also concerned about potential difficulty meeting minimum solvency requirements (which states impose on health plans to ensure they have adequate financial reserves to cover claims) because of the mandate, but the proposal specifically states that solvency funds should be counted towards medical costs, not profits. One strong argument against the federal mandate is that most states already impose MLRs, and a one-size-fits-all federal mandate is unnecessary and will not provide for the appropriate flexibility to meet the unique needs of different populations, as states can.

Actuarially Sound Capitation Rates

Many modifications are proposed pertaining to the definition and calculation of actuarially sound capitation rates. In addition to providing for "all reasonable, appropriate, and attainable costs", CMS clarifies that rates should be sufficient to provide appropriate compensation for reasonable non-benefit costs, and should promote program goals such as quality of care, improved health, community integration of enrollees, and cost containment. In recognizing that MCOs also provide long-term care services that are not strictly medical, CMS proposes modifying the definition of "capitation payment" to remove references to "medical" services. This could have major implications for MLR calculations, particularly addressing concerns related to determining which expenses must be treated as administrative, and which may not.

CMS also proposes implementing rate cells in which people with similar characteristics and expected health care costs would be grouped together in order to assist in setting more accurate capitation rates. Enrollees should be assigned to only one cell, and payments must not be expected to cross-subsidize. Each individual rate must be certified as actuarially sound and states must receive approval of rate certification, in addition to approval of each contract, from CMS.

QUALITY IMPROVEMENT AND BENEFICIARY PROTECTION PROVISIONS

Quality Improvement

In the past several years, all payers, including CMS, have been working to find ways to ensure patients are receiving high quality health care. As such, federal quality standards have been imposed on MA and Medicare Part D plans as well as plans sold through the exchanges. CMS is now proposing to impose such quality standards on MCOs, and to make information regarding plan quality more transparent and easily accessible to the public. New standards for incentive arrangements would require that they be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. One way CMS suggests plans may be held accountable is through "withhold arrangements," which is a payment mechanism whereby a portion of the capitation rate is paid after the MCO meets targets specified in their contract. Further details on quality standards for MCOs will be forthcoming as this regulation makes its way through the approval process.

Network Adequacy

One of the main problems facing Medicaid beneficiaries is a lack of adequate access to health care providers, largely the result of low provider reimbursement rates causing providers to limit the number of Medicaid patients they will accept. CMS is attempting to address this issue by requiring states to set and publish network adequacy standards, which, among other things, should include time and distance standards for key medical services. Further, enrollees must have access to behavioral health services and long-term support services (LTSS), and access to services must be promoted in a culturally competent manner, which means eliminating barriers which may result from being disabled, communication challenges, gender differences, etc.

Mental Health Support

Medicaid patients often lack access to mental health services, despite disproportionately high rates of mental health disorders, largely due to current restrictions on funding for such services for Medicaid beneficiaries.[2] Under the Medicaid Institutions for Mental Disease (IMD) Exclusion, federal dollars are prohibited from being used to pay for services provided to Medicaid beneficiaries between the ages of 21 to 64 while they are patients in an IMD facility, regardless of whether or not those services are provided in or out of the IMD. Through this regulation, CMS clarifies that MCOs are permitted to receive a capitation payment from the state for such enrollees who spend 15 days or less in a given month in a mental health institute providing psychiatric or substance use disorder inpatient care. CMS recognizes the flexibility that MCOs have historically been permitted to provide care in alternative settings, and aims to propose rules on substitute providers under CMS's "in lieu of" policy. MCOs will not, however, be allowed to require patients to use an "in lieu of" facility rather than a state covered service or setting. CMS states that the 15 day limit is due to concerns over limited capacity; expanded Medicaid coverage and a continuous decline in the number of inpatient beds at IMD facilities is further limiting an already scarce resource.

Beneficiary Protections

New standards will be imposed to help protect and inform beneficiaries regarding their coverage and enrollment/disenrollment options. States will be required to implement enrollment standards that promote high quality managed care plans by providing information, encouraging active enrollment choices, and assuring intelligent default enrollment processes. CMS clarifies that all beneficiaries are entitled to assistance (by phone, internet, in person, etc) in understanding how managed care works, and assistance should be provided for enrollees who receive LTSS. Further, states are to provide choice counseling to any potential enrollee (before enrollment in managed care) or current enrollees when they have an opportunity to change plans.

Marketing and Communication

MCOs are currently prohibited from marketing to beneficiaries any plans which would be purchased "in conjunction with" enrollment in a Medicaid plan. This proposed rule would amend the regulation to exclude from the prohibition communications from an issuer of a qualified health plan (QHP) offered through the exchange, even if the issuer of the QHP is also the entity providing Medicaid managed care to the enrollee. This exemption is to allow for increased continuity of care as a beneficiary may transition between Medicaid and the health insurance exchanges as their income changes throughout the year. CMS would permit states to build upon these minimum marketing standards.

Plan providers expressed disappointment, that updates to marketing materials and communication regulations will extend the prohibition on unsolicited communications to communication through social media and electronic means (such as email and texts). CMS admits that these regulations on MCOs are generally more restrictive than those imposed on QHPs. Insurers point out that this could make it more difficult to communicate with members and inhibit access to assistance services. Further, because the states handle the application process, the plans don't have the ability to allow members upon enrollment to provide authority to be contacted in this way. As a result, plans must contact each member individually through a personal phone call and request such permission; this is obviously extremely time consuming and not the best use of resources.

Other Provisions

Assorted other provisions include requirements that states begin collecting claims data, monitoring the data for quality control, and submitting it to CMS. Enhanced audit and disclosure requirements are also intended to help

combat fraud and increase program integrity. Timelines for the appeals and grievance process are adjusted to provide greater protection and transparency of the process for beneficiaries. Sex was added as a protected class, and MCOs must ensure those with limited English proficiency have necessary resources. MCOs covering dual-eligibles must participate in the automated crossover process administered by Medicare so that providers do not have to submit multiple claims for payment if the provider is not in the MCO's network; this is intended to encourage providers to accept duals as patients.

CONCLUSION

The running theme throughout the agency's comments on the proposals was that these changes are needed to align these programs with the objectives of and requirements imposed on Medicare and private health insurance plans. While that rationale may make some sense, the process matters. Such significant reforms should only occur after the potential impacts of such changes have been analyzed and their merits debated in an open and transparent process. This is best done through Congressional hearings, held by Members of Congress who have constituents to provide insight and by whom they can be held accountable. Changes of this nature deserve more consideration than is provided through the administrative regulatory process. CMS's rationale seems to be that what Congress enacted legislatively for some programs, can and should be extended to other programs through regulation. However, Congress was and is more than capable of making changes to the Medicaid program as it sees fit. CMS should curtail its pattern of acting without congressional approval.

[1] The ACA imposed a minimum MLR of 85 percent on Medicare Advantage (MA), Part D, and large-group plans; a minimum MLR of 80 percent was imposed on individual and small-group plans.