Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

June 3, 2015

CMS Proposed Rule on Medicaid Managed Care

What Is the Proposed Rule?

On May 26, 2015, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule laying out the agency's plan to update the federal regulations pertaining to Medicaid managed care, under which states contract with private health insurers to provide health care to enrollees. In general, federal agencies develop regulations to implement the laws passed by the Congress. CMS has that responsibility for Medicaid and the State Children's Health Insurance Program (CHIP). This includes how states deliver services to Medicaid enrollees through risk-based managed care, the primary focus of the proposed rule. The proposed rule also addresses managed care in CHIP and third party liability (TPL) in Medicaid, but those topics are not the focus of this brief report.

What Is the Current Status of the Proposed Rule?

CMS is taking public comments on the proposed rule through July 27, 2015. Once the comment period closes, CMS will review the comments and make any changes before preparing a final rule for review by the Office of Management and Budget (OMB). OMB review, which typically lasts up to 90 days, is the last step before an agency releases a final rule.

Background on Medicaid Managed Care

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), for a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people age 65 and older. (See CRS Report R43357, *Medicaid: An Overview*.)

Risk-based managed care is a system for delivering care to Medicaid enrollees. It differs from the traditional fee-for-service (FFS) arrangement in how states pay providers for their services. Under FFS, states pay providers directly for the services they deliver to Medicaid enrollees. The state assumes the financial risk for health care spending under a FFS arrangement.

Under comprehensive risk-based managed care, states contract with managed care organizations (MCOs), which are private health insurers. The MCOs in turn contract with networks of providers to deliver a comprehensive set of services. The state pays the MCO a fixed amount for each enrollee, called a capitation payment, and the MCO pays the providers. The MCO assumes the financial risk for spending. Federal regulations provide guidance to states on delivering care through MCOs, including requirements and standards for contracts and for setting capitation rates. Risk-based managed care also includes state contracts with Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) to deliver a limited benefit, such as dental coverage, for a capitated payment.

Basic Medicaid Facts:

Total enrollment: 59 million in FY2012, as measured on an average monthly basis.

Total spending: $494 billion in FY2014 ($299 billion in federal spending).

Comprehensive risk-based managed care accounts for about 50% of total enrollment (as of FY2011) and about 37% of total spending in FY2014.

Background on the Proposed Rule

The proposed rule is the first major federal regulation impacting Medicaid managed care since 2002. Because roughly half of all Medicaid enrollees are enrolled in comprehensive risk-based managed care, the proposed rule is likely to impact millions of Medicaid enrollees. As of September 2014, 39 states had contracted with MCOs to deliver care to their Medicaid enrollees. Some states require enrollment in managed care. Enrollment has increased over time as states have sought out managed care because it can make costs more predictable through capitation and may improve care for beneficiaries—through better care coordination, for example.

The proposed rule is also important for the Medicaid expansions under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Many states are relying on MCOs to deliver services to individuals newly eligible under the ACA. The proposed rule will influence how states structure their managed care programs going forward. With so many people getting Medicaid services through managed care and with recent changes to Medicare Advantage and the private health insurance market (including the introduction of health insurance exchanges) as a result of the ACA, CMS is updating the regulations to make sure they are aligned with today's health care landscape.

What Is Included in the Proposed Rule?

The proposed rule has generated substantial interest among stakeholders, including state Medicaid programs and insurers, because it makes significant changes to the existing managed care regulations. Below is a summary of the major changes to the regulations grouped by Medicaid managed care and CHIP requirements.

Medicaid Managed Care

Alignment with Other Health Coverage Programs

CMS has proposed changes to the Medicaid managed care regulations to better align them with the regulations established under the ACA that are applicable to private insurers. For example, the proposed rule applies a minimum medical loss ratio (MLR) of 85% to Medicaid to ensure that capitation rates are actuarially sound and "based on reasonable expenditures on covered services" for enrollees. The minimum MLR refers to the amount of premium revenue that a health plan spends on the delivery of care or on improving the quality of care as opposed to administrative costs or profits. CMS chose 85% as the threshold because it is the standard for Medicare Advantage and for large employers in the private market.

Setting Actuarially Sound Capitation Rates

The proposed rule establishes standards that states must meet in setting their capitation rates and that CMS will apply during the federal review and approval process. These standards would ensure that the rates are actuarially sound. The *Code of Federal Regulations*, at 438.6(c)(i), defines actuarially sound capitation rates as rates that (1) have been developed in accordance with generally accepted actuarial principles and practices, (2) are appropriate for the populations covered and the services to be provided, and (3) have been certified by qualified actuaries. As part of setting actuarially sound rates, the proposed rule also requires that states consider the historical and projected MLR of the MCO when setting its capitation rate.

Beneficiary Protections

The proposed rule establishes new beneficiary protections, including a beneficiary support system that is required to provide managed care enrollees with assistance in understanding the health plan materials and options available when enrolling in managed care. This new system includes standards providing for "choice counseling" so that enrollees can get assistance in choosing health plans.

Managed Long-Term Services and Supports

Existing federal law does not generally permit states to enroll individuals needing LTSS (such as nursing home care and home health care) into managed care. However, states can do so through waivers of federal law. Many states have obtained approval from CMS to implement Section 1915(b) and Section 1115 demonstration projects to begin using managed LTSS (MLTSS) to deliver services to individuals with complex health care needs.

The proposed rule establishes regulations for enrolling the LTSS population in managed care. It codifies principles that CMS published in May 2013 based on lessons learned from the state demonstrations. The principles include "stakeholder engagement" to ensure that stakeholders such as beneficiaries and providers are involved in the "monitoring and oversight" of the program. The proposed rule is likely to be heavily scrutinized as more and more states are considering MLTSS to manage costs and quality of care for this population.

Network Adequacy

Network adequacy refers to whether or not an MCO, PIHP, or PAHP "adequately makes services accessible and available to enrollees." The proposed rule establishes minimum standards for network adequacy for medical services and MLTSS. For example, the standards should ensure "ongoing state assessment and certification of MCO, PIHP and PAHP networks," and the state must establish network adequacy standards for specific provider types.

Quality

The proposed rule requires that states establish a comprehensive quality strategy to measure performance and improve quality of care for their Medicaid programs. It also requires that states establish a "Medicaid managed care quality rating system" to include information on performance for each MCO, PIHP, and PAHP. The system is designed to be consistent with Medicare Advantage and the qualified health plans established under the ACA.

Data

Encounter data is a key component of CMS's oversight of state Medicaid programs. The proposed rule defines enrollee encounter data as "information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and an MCO, PIHP, or PAHP" subject to certain standards. It establishes contract standards that define encounter data "submission and maintenance standards" for MCOs, PIHPs, and PAHPs. The rule proposes that federal Medicaid matching payments not be available to states that do not meet the established benchmarks for "accuracy, completeness, and timeliness" of data submitted to CMS.

CHIP

CHIP is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have income above Medicaid levels but have no health insurance. (See CRS Report R43627, *State Children's Health Insurance Program: An Overview*.) The proposed rule seeks to align CHIP managed care with Medicaid and the health insurance exchanges where appropriate. For example, it establishes an MLR standard of 85% and codifies managed care provisions established for CHIP in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

Kirstin B. Blom, kblom@crs.loc.gov, 7-2397

IF10234