Centers for Medicare and Medicaid Services

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability

Final Rule (Issued May 06, 2016)

"This final rule modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes."
*(*https://**www.medicaid.gov**/.../**managed**-**care**/**managed**-**care**-**final**-**rule**.html)

TA Network Summary

The regulations strengthen and "modernize" Medicaid managed care requirements in a number of areas and are explicitly applied to long term services and supports (LTSS) - i.e. for populations, including children, with complex health and behavioral health conditions. The information below summarizes areas and relevance to children's behavioral health.

Network Adequacy

- Language stipulates that states set quantitative time and distance standards and includes specifically that standards must be set for child health and for pediatric specialty care. Stakeholders can ensure standards include children's behavioral health care.
- Regulations require network monitoring. Stakeholders can ensure that monitoring occurs for children's behavioral health network standards.
- Regulations require close coordination with community and social supports. Stakeholders can ensure requirements pertain to coordination with relevant child community and social supports, such as the schools.

Service and Supports

- The regulations stress the importance of least restrictive setting and home and community services for populations needing long term services and supports, including children with special health care needs; the definition of children with special health care needs is left to the states. Stakeholders can ensure that the definition includes children with serious behavioral health challenges and complex trauma.
- The regulations require assessment processes to identify persons needing LTSS.
- The regulations require plans to create beneficiary support systems, with particular standards for persons who need long term services and supports and that take into account cultural/linguistic accessibility; the regulations also require outreach.

Stakeholders can explore the appropriate role for family and youth peer partners in beneficiary support systems and in outreach activities.
- Care coordination requirements are strengthened, including coordination with behavioral health, which could provide an opportunity for stakeholders to argue for more customized care coordination approaches for children with serious behavioral health challenges.
- The regulations allow capitation payment to include up to 15 days in an Institute for Mental Disease (IMD) if it is providing psychiatric and/or substance use disorder services (for 21-64 year olds).

Program Design and Quality

- The regulations require states to create stakeholder groups to provide input on design, implementation and monitoring of programs for populations needing LTSS. Stakeholders can make sure these groups include individuals representing children, youth and young adults with serious behavioral health challenges and complex trauma.
- Requirements are strengthened for quality monitoring, including that states must develop quality ratings systems; there is nothing specific to children's behavioral health. Stakeholders can ensure attention to quality ratings for children's behavioral health; CMS will set national standards at some point. Stakeholders can also provide input into the CMS process.
- Standards for grievance and appeals processes are strengthened.
- Beneficiary access to records is strengthened.
- The regulations strengthen/clarify reporting of encounter data.

Financial Standards

- The regulations set medical loss ratio, i.e., how much a managed care organization (MCO) has to spend on member care, at 85%.
- New standards for capitation rate-setting are established, and CMS will review states' rate-setting to ensure adequacy.

EPSDT

- The *proposed* regulations made it clear that MCO medical necessity criteria must meet the Early Periodic Screening, Diagnosis and Treatment (EPSDT) standard, but this language is not as clear in the final regulations. The intent is still there (and the EPSDT statute would prevail in any event).

Standards Application

- Standards are applied to pre-paid ambulatory health plans (PAHPs), pre-paid inpatient health plans (PIHPs), MCOs, and primary care case management (PCCM) entities that get an administrative payment to coordinate care. (It is conceivable that, depending how it is structured, a Care Management Entity -CME -might have to meet standards.)
- Deferrals and disallowances of federal match for failure to comply can be applied to just those areas not in compliance and not to the entire managed care program