A few weeks ago, the Centers for Medicare and Medicaid Services (CMS) released a proposed regulation entitled ***Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*** available here. The proposed rule is intended to do the following:

- Modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems
- Align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans
- Strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates
- Promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries
- Ensure appropriate beneficiary protections and enhance policies related to program integrity
- Require states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries
- Implement provisions of the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA)
- Address third party liability for trauma codes

The best initial analysis we have seen to date is by Sara Rosenbaum on the *Health Affairs* Blog available here, and we understand the National Academy for State Health Policy will begin publishing analysis on their blog here this week.

Since its release, the AMCHP policy team has been reviewing the regulation and connecting with key partners including the National Association of Medicaid Directors to get a sense of how people are responding to the proposal. The general sense from our Medicaid colleagues is that they have a number of key areas of concern – particularly with a new section [§ 438.54 on page p. 31134] where CMS proposes to apply a consistent standard for all managed care enrollment processes - applicable to both voluntary and mandatory managed care programs - that all states must provide a period of time of at least 14 calendar days of FFS coverage for potential enrollees to make an active choice of their managed care plan. Overall however the initial read of our Medicaid colleagues is that they generally see this proposal as a workable framework, with the addition of some flexibilities for states

Of particular note to children and youth with special health care needs (CYSHCN) leaders is a proposed expansion of Section 438.208(c)(2) and (3) that currently requires that managed care organizations complete an assessment and treatment plan for all enrollees that have special health care needs. CMS proposes to add "enrollees who require Long Term Services and Supports [LTSS] to this section. These

assessments and treatment plans should be performed by providers or MCO, PIHP or PAHP staff that meet the qualifications required by the state." (pg. 31183).

To help inform AMCHP next steps, we would love to know what you think and are hearing about the proposed regulation. Are there additional sections that you think AMCHP should support as particularly helpful in improving care for MCH populations? Are there areas of concern or provisions in your view that would hinder your work collaborating with Medicaid programs to improve MCH? Are there any major components missing? Please share your questions, comments and concerns with us directed to Brent Ewig at bewig@amchp.org. We will continue to use the AMCHP Legislative and Health Care Finance Committee to guide our response on this and appreciate your input and feedback to inform those efforts.