Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

NHeLP
NATIONAL HEALTH LAW PROGRAM

Medicaid/CHIP Managed Care Regulations: Ensuring Accountability and Transparency

by Sarah Somers and Kelly Whitener

Georgetown University Center for Children and Families (CCF) and the National Health Law Program (NHeLP) have teamed up to bring advocates for children and low-income families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the final brief in the series, and it describes how the new rules strengthen the contracting requirements and ensure accountability and transparency. Other briefs in this series include:

- Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens, *which gives an overview of the rules with an appendix detailing which Medicaid provisions also apply to the Children's Health Insurance Program (CHIP).*
- Medicaid/CHIP Managed Care Regulations: Improving Consumer Information, *which covers new provisions for accurate, timely, accessible, and complete consumer information.*
- Medicaid/CHIP Managed Care Regulations: Enhancing the Beneficiary Experience, *which describes how the new rules improve enrollment processes and establishes a new beneficiary support system.*
- Medicaid/CHIP Managed Care Regulations: Network Adequacy and Access to Services, *which describes how the new rules assure network adequacy and access to services.*
- Medicaid/CHIP Managed Care Regulations: Assuring Quality, *which describes how the new rules advance quality measurement and improvement.*

It is important to note at the outset that these new managed care rules lay out the minimum standards states must meet in Medicaid and CHIP, but they also provide health and legal advocates a tremendous opportunity to improve care delivery for low-income families through strategic engagement with states and health plans as the rules are implemented over the next few years. States can and should do more than adopt the minimum standards for children and families. This issue brief series will identify those opportunities for action.

Background

In May 2016, the Centers for Medicare & Medicaid Services (CMS) completed its modernization of the regulations governing managed care in Medicaid and the Children's Health Insurance Program (CHIP).[1] One of CMS' primary goals in this regulatory overhaul is to promote transparency, enabling policy makers, beneficiaries, providers, and other stakeholders to better understand and monitor Medicaid and CHIP managed care programs. The revised regulations are also intended to strengthen program integrity standards to ensure that public funds are being used appropriately. In this issue brief, we discuss the major provisions designed to promote transparency and accountability: general contracting requirements, actuarial soundness and rate setting, Medical Loss Ratios (MLR), and website posting requirements.

Medicaid Managed Care Contracts

When states rely on plans to deliver Medicaid and CHIP services, the contract between the state and the plan is the fundamental legal document that defines the responsibilities of the plan. Poorly written contracts can lead to gaps or delays in benefits, or even worse, violations of Medicaid law and beneficiary rights. Historically, Medicaid contracts have been difficult to obtain, leaving advocates with little information about whether the contract complies with Medicaid rules and whether care is being delivered consistent with the contract provisions.

In recent years, some states have started making plan contracts available to the public, while others post or provide the requests for proposals for contracts. The final regulation will advance transparency even more by requiring states to post the actual contracts with managed care plans and Primary Care Case Management (PCCM) entities on the state website.[2]

Review your state's managed care request for proposals and resulting contracts to make sure they comply with Medicaid statute, regulations, and case law as well as any relevant state law. Contracts should also have provisions that enable states to hold plans accountable for meeting the standards, such as sanctions. For further guidance on this issue, see NHeLP, Guide to Accountability and Transparency in Medicaid Managed Care (2015).

Standard Contract Requirements § 438.3

Longstanding Medicaid regulations have described certain contracting requirements for managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP), including the types of entities eligible for comprehensive risk contracts and the payments made and services covered under the contract. The final rule maintains many of these provisions, but also increases CMS oversight, extends some requirements to other types of entities, and specifies certain performance standards that states must include in their managed care contracts. Because many of the provisions are similar to existing Medicaid rules, the effective date for most of § 438.3 is 60 days after publication of the rule in the Federal Register, or July 5, 2016. New or more heavily revised provisions have later effective dates, as noted below.

Applies to MCOs, PIHPs, and PAHPs.

Timeline: Effective as of July 5, 2016.

CMS Review § 438.3(a)

CMS retains its authority to review and approve Medicaid MCO, PIHP, and PAHP contracts. However, states must now submit the contract in a form or manner as specified by CMS at least 90 days prior to the desired effective date to assure adequate time for federal review.

Applies to MCOs, PIHPs, PAHPs, and PCCM entities.

Timeline:
Effective as of July 5, 2016.

Enrollment Discrimination Prohibited § 438.3(d)

Plans are required to accept eligible individuals in the order in which they apply and cannot discriminate on the basis of health status or need for health care services. This provision is largely unchanged from current law, but notably CMS added sex, sexual orientation, gender identity, and disability to the protected categories along with race, color, and national origin.

Applies to MCOs, PIHPs, and PAHPs.

Timeline:
Effective as of July 5, 2016.

Services That May Be Covered § 438.3(e)

Longstanding Medicaid regulations have described the types of services plans may cover in addition to those that are required under the state's benefit plan. For example, plans may voluntarily agree to provide additional services as long as the cost of such services are not included in the payment rate. Plans may also provide any services necessary to comply with parity requirements for mental health and substance use disorders. Finally, plans may provide alternative services or deliver services in alternative settings under the new "in lieu of" services and settings rules. This is referred to as "in lieu of" services or settings because the plan is offering services or settings as an alternative to those required under the state plan. In order to offer in lieu of services or settings, four requirements must be met: 1) the state must determine that it is a medically appropriate and cost effective substitute, 2) the enrollee must not be required to use the alternative service or setting, 3) the services must be authorized and identified in the contract and offered to enrollees at the option of the plan, and 4) the utilization and actual cost of the in lieu of services must be taken into account in the capitation rates.[3]

Applies to MCOs, PIHPs, PAHPs, and PCCM entities.

Timeline:
Effective as of July 5, 2016.

Compliance with Applicable Laws and Conflict of Interest Safeguards § 438.3(f)

Plans must comply with federal laws outside of Medicaid, such as the Civil Rights Act and the Americans with Disabilities Act. The final rule maintains these requirements but also adds that plans must comply with section 1557 of the Affordable Care Act (ACA). "Section 1557" as it is commonly known, prohibits discrimination on the basis of race, color, national origin (including immigration status and English language proficiency), sex, age, or disability in any program or activity receiving federal funding or in any entity created under title I of the ACA, primarily the new insurance Marketplaces. This includes Medicaid and CHIP and has now been codified as part of the Medicaid and CHIP managed care contracting requirements.

TIP

Individuals who believe that plans have discriminated against them may file a complaint with the Office of Civil Rights at HHS. For more information about filing a complaint and link to the OCR complaint form, consult the HHS website.

Plans are also required to comply with conflict of interest safeguards that ensure state employees responsible for overseeing the plans are impartial.[4] State or local officers, employees, or independent contractors responsible for the expenditure of substantial amounts of Medicaid funding are also prevented from having a financial interest in plans while in those roles and some of their activities may be limited even after leaving office in order to avoid a conflict of interest.[5]

Applies to MCOs, PIHPs, PAHPs, and PCCM entities.

Timeline:

Effective for the rating period beginning on or after July 1, 2017.

Inspection and Audit of Records and Access to Facilities § 438.3(h)

Plans must provide the state and CMS with access to financial records of the entity or its subcontractors in order to inspect and audit them. The final rule expands on this longstanding requirement by including the Office of the Inspector General and the Comptroller General among those who must have access. It further specifies that inspections and audits can occur at any time and can include not just the related documents but also the physical premises, facilities, and equipment for up to 10 years from the completion of an audit or the contract expiration, whichever is later.

Applies to MCO, PIHP, PAHP, and PCCM entity subcontracts.

Timeline:

Effective for the rating period beginning on or after July 1, 2017.

Subcontracts §§ 438.3(k) and 438.230

All subcontracts must fulfill the Medicaid managed care requirements for the service or activity delegated to them under the subcontract. The final rule clarifies this requirement by adding a cross reference to § 438.230, which lays out the specific requirements governing subcontracting. First, the rules make very clear that the plan maintains the ultimate responsibility for complying with all the terms and conditions of its contract with the state. Second, if the plan delegates any of its obligations to a subcontractor, the delegated activities must be specified in the contract and the subcontractor must agree to comply with terms set forth by the state. Third, subcontractors are subject to the same inspection and audit standards as plans. Finally, all subcontracts must provide for termination of the subcontract, or specify other remedies, when the state or plan determines that the subcontractor has not performed satisfactorily.

Applies to states, MCOs, and any PIHP or PAHP contract providing services to MCO enrollees.

Timeline:

Effective as of July 5, 2016.

Parity in Mental Health and Substance Use Disorder Benefits § 438.3(n)

Earlier this year, CMS finalized the mental health and substance use disorder parity rule for Medicaid and CHIP.[6] The managed care rule was finalized a few months later and includes a provision requiring all MCO contracts to comply with all applicable mental health and substance use disorder parity rules.[7] In the event that MCO enrollees also receive services from PIHPs or PAHPs, all of the plan contracts must provide for services to be delivered in compliance with parity rules. Likewise, if the state provides services to MCO enrollees using a delivery system other than the MCO delivery system, like through a fee-for-service (FFS) carve-out, the state must provide documentation of compliance with parity when submitting the contract to CMS for review and approval.

TIP

The specifics of mental health parity are complicated. Moreover, they are evolving, given how recently the parity rule was finalized. Advocates should watch for additional guidance from CMS and from support centers, including NHeLP.

Applies to MCOs, PIHPs, and PAHPs that include LTSS as a covered benefit.

LTSS Contract Requirements § 438.3(o)

Managed care plan contracts covering long term services and supports (LTSS) must provide that services that could be authorized through a home and community based waiver or state plan

Timeline:

Effective as of July 5, 2016.

amendment[8] are delivered consistently with certain standards.[9] These standards require that home and community based settings are integrated in the community, selected by the individual, and ensure individual rights of privacy, dignity, and respect, among other requirements.

Additional Rules for Contracts with PCCMs and PCCM Entities §§ 438.3(q) and 438.3(r)

438.3(q):
Applies to PCCMs and PCCM entities.

438.3(r):
Applies to PCCM entities.

Timelines:

438.3(q):
Effective for the rating period beginning on or after July 1, 2017.

438.3(r):
Effective as of July 5, 2016.

There are some special rules for PCCM and PCCM entity contracts. Section 438.3(q) requires PCCM and PCCM entity contracts to provide some of the same availability of services and beneficiary protections that apply to MCOs. PCCMs and PCCM entities must: 1) provide for reasonable hours of operation, including 24-hour treatment for emergency conditions; 2) restrict enrollment to beneficiaries who live near one of the delivery sites; 3) have sufficient numbers of providers to ensure prompt and high quality treatment; 4) prohibit discrimination based on health status or need for health care services; and 5) allow enrollees to disenroll in accordance with § 438.56(c). Further, § 438.3(r) requires PCCM entities to submit contracts to CMS for review and approval to ensure compliance with the contracting, consumer information, and applicable quality provisions.

Covered Outpatient Drugs § 438.3(s)

Applies to MCOs, PIHPs, and PAHPs that provide outpatient drugs.

Timeline:

Effective for the rating period beginning on or after July 1, 2017.

The final rule adds several new requirements for plans that provide outpatient drugs. First, the rule clarifies that while plans may be permitted to have a drug formulary, the plan must cover all outpatient drugs that are within the scope of the contract, even if they are not on the formulary. Drugs not on the formulary may be covered through a prior authorization process. If some outpatient drugs are outside the scope of the contract but within the definition of covered outpatient drugs in the statute, the state is required to provide them through FFS.[10,11]

Second, the rule requires plans to report drug utilization data to the state so that the state has all the necessary information to bill manufacturers for rebates as authorized under the statute.[12] The plans must exclude utilization data for drugs purchased through the 340B drug pricing program, because those drugs are not eligible for rebates, unless the state already has another mechanism in place to exclude them.[13]

Third, the rule requires plans to have a drug utilization review program. The Medicaid statute requires drug utilization review programs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.[14] Each plan must provide a detailed description of its drug utilization review program activities to the state on an annual basis.

Finally, the rule requires plans to have a prior authorization program. Each plan must provide a response to a request for prior authorization for a covered outpatient drug by telephone or other telecommunication device within 24 hours of the request and dispense a 72-hour supply of a covered outpatient drug in an emergency situation.[15]

Recordkeeping Requirements § 438.3(u)

Applies to MCOs, PIHPs, PAHPs, and their sub-contractors.

Timeline:

Effective for the rating period beginning on or after July 1, 2017.

The rule also adds a new requirement that plans and subcontractors retain certain records for at least 10 years. The records that must be retained include: enrollee grievances and appeals; base data; MLR reports; and the data, information, and documentation required for program integrity purposes.[16]

Actuarial Soundness and Rate Setting for Medicaid Managed Care §§ 438.4 and 438.5

Applies to MCOs, PIHPs, and PAHPs

Timeline:

These provisions are phased in from July 5, 2016 to the rating period beginning on or after July 1, 2019. See Appendix I for details.

Key Rate-Related Terms

Base Data: Historical data used by an actuary to develop capitated rates, consisting of encounter data, fee for service data, and audited financial reports.[17]

Rating Period: The time period for which managed care rates are being developed.

Risk Adjustment: A technical methodology that accounts for the health status of enrollees including the relative risk that costs for services will be incurred.[18] Risk adjustment is intended to provide for plans to receive higher rates for enrollees with greater health needs.

In capitated managed care, a plan receives a set payment to cover any costs required to provide services, known as the capitation rate.[19] The predictability of costs in a managed care system is one of the reasons states choose to use managed care to serve their Medicaid and CHIP beneficiaries. Setting appropriate rates requires a balance—if rates are too high, money is wasted and plans reap a windfall. If rates are too low, however, plans will not be able to cover all needed services without endangering their fiscal sustainability.

Accordingly, Medicaid managed care plans have long been required by statute to set "actuarially sound" capitation rates, meaning that the rates must be projected to meet all reasonable and appropriate costs required to provide covered benefits to enrollees.[20] Before the regulatory overhaul, the regulations required only that rates be developed in accordance with actuarially sound principles and be certified by a qualified actuary.[21]

The final rule requires not only that rates be actuarially sound, but also that states follow a specific process when setting rates to ensure that they are actuarially sound, which is intended to enable CMS to more effectively review them.[22]

Steps for Setting Rates

- Identifying and considering base utilization and price data;
- Developing and applying trend factors, such as cost and utilization of services, to base data that are developed from the actual experience of the Medicaid population;
- Developing the non-benefit part of the rate to account for reasonable operational expenses (such as administrative costs, licensing and regulatory fees, risk margin, and cost of capital);
- Taking into account past medical loss ratios (discussed below);
- Selecting a risk adjustment methodology that uses generally accepted methodology and applying it in a budget neutral manner across all MCOs, PIHPs, and PAHPs; and

Making other adjustments necessary to establish actuarially sound rates.[23]

In general, rates must be appropriate for the covered populations and, while they can vary based on valid rate development standards, they cannot vary based on the rate of federal financial participation for different eligibility categories.[24] They must also be certified by an actuary and approved by CMS.[25] Rates must also be developed so that the managed care plan would achieve a medical loss ratio of at least 85 percent.[26]

States must provide and use base data consisting of all validated encounter data, FFS data, and audited financial reports reflecting coverage of the Medicaid population for at least the three most recent years before the rating period.[27] States that are unable to meet the standard that data be no older than three years may ask for an exception but must have a corrective action plan to come into compliance with the requirement.[28]

This is a highly technical area of the regulations. CMS has provided additional written guidance explaining these requirements. See *CMS 2016 Medicaid Managed Care Rate Development Guide* (Sept. 2015) and *CMCS Informational Bulletin, Addendum to 2016 Medicaid Managed Care Rate Development Guide* (July 1, 2016). Advocates wishing to dive deeper should consult these sources.

Applies to MCOs, PIHPs, and PAHPs

Timeline:

Effective for the rating period beginning on or after July 1, 2017.

Medical Loss Ratio § 438.8

CMS defines the medical loss ratio (MLR) as measuring, "how much a managed care plan spends on the provision of covered services compared to the total revenue it receives in capitation payments from the state."[29] For the first time, the final rule imposes a requirement for a national standard for determining the MLR for both Medicaid and CHIP—a standard that is similar to Medicare Advantage and the private market.[30]

The MLR and rate setting are closely linked. CMS explains that because MLR measures whether funds are spent on claims and quality improvement as opposed to administrative costs, it helps to show whether adequate portions of the capitation payments are being spent on services. When an MLR is too high, it means that the capitation rates were too low, raising concerns about access, quality of care, provider participation, and viability of plans.[31]

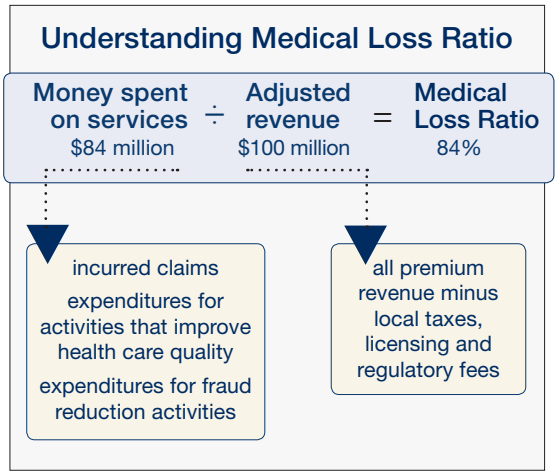
For rating periods starting on or after July 1, 2017, states must ensure that each MCO, PIHP, and PAHP report a MLR that complies with the new requirements.[32] If a state elects to mandate a minimum MLR, it must be equal to or higher than 85 percent, which is a common standard.[33] The MLR is the ratio of the numerator to the denominator, both of which have elements prescribed by the regulation.[34]

The numerator is the sum of the plan's incurred service claims, expenditure for activities that improve health care quality, and fraud reduction activities.[35] The regulation provides detailed specifications for the calculations for incurred claims. States must include not only direct claims but also unpaid claims liabilities, withholds from payments made to providers, and changes in claims related reserves.[36] Certain items must be deducted from incurred claims, such as overpayment recoveries and prescription drug rebates.[37] In addition, certain expenditures must be included in the incurred claims, such as the amount of incentive and bonus payments made to network providers.[38]

"Activities that improve health care quality" are activities related to External Quality Review, Health Information Technology-related activities, or activities generally designed to increase the likelihood of desired health outcomes that are grounded in evidence-based medicine or clinical practices.[39] Certain activities are explicitly excluded, such as cost containment measures, quality improvement measures paid for by sources other than premium revenue, marketing expenses, and provider credentialing.[40]

The denominator is the adjusted premium revenue.[41] This is all the revenue collected through premiums, adjusted by deducting the local taxes and licensing and regulatory fees.[42]

States are not required to set a minimum MLR (although many states require it from their Medicaid MCOs).[43] If they do, they may (but are not required to) require plans to refund all or part of the excess payments if the minimum MLR is not met.[44] Regardless of whether the states require a minimum MLR, they must require each plan to report the calculated MLR and a number of related items, including the total incurred claims, expenditures on quality improvement activities, premium revenues, and non-claims cost, along with the methodology for allocation of expenditures.[45]



Advocates and other commenters urged CMS to mandate a minimum MLR and require managed care plans to pay remittance if they failed to meet the MLR. CMS agreed that this would be appropriate policy, however, it stated that the statute does not allow such a requirement.[46]

TIP Urge your state to require a minimum MLR of at least 85 percent if it does not do so already.

Summary of Website Posting Requirements

As noted, one of the key goals of the Medicaid and CHIP managed care regulations is to strengthen program integrity by improving accountability and transparency. Among the new and revised provisions are multiple requirements to post information to the state's website. Section 438.10(c) requires states to operate a website and many other provisions require posting of specified information. The chart in Appendix II summarizes the website posting requirements for Medicaid and CHIP, including the regulatory reference, effective date, and a short description of the item. Many of these topics were discussed in greater detail in prior briefs in this series, and they have been grouped accordingly.

TIP Encourage your state to provide opportunities for website testing and feedback, and to explore the advantages of having all related consumer materials posted on the state's website as a single source of consumer information, rather than linking to individual plan websites.

Conclusion

With this final rule, CMS has provided child health stakeholders with strengthened transparency requirements that will enable them to monitor a range of crucial Medicaid and CHIP managed care activities that were previously very difficult to track. Some of these requirements are effective immediately and advocates can and should begin researching and evaluating plans' compliance. Others, including the highly technical rate-related provisions, will be implemented over the next few years. This gives stakeholders some time to familiarize themselves with the provisions and, if necessary, consult with outside sources and experts to assist them in efforts to ensure that plans are complying with their responsibilities under the new regulations.

Appendix I:
Implementation Timelines for the Actuarial Soundness and Rate Setting Provisions

▶ As of July 5, 2016:

- § 438.4(a) Actuarially sound capitation rates defined
- § 438.4(b)(1) Requiring capitation rates to be set in accordance with specified standards and actuarial principles
- § 438.4(b)(2) Requiring capitation rates to be appropriate for populations covered
- § 438.4(b)(5) Prohibiting cross subsidization of rate cells
- § 438.4(b)(6) Requiring capitation rates be certified by an actuary
- § 438.5(a) Rate development standards definitions
- § 438.5(g) Requiring any risk adjustment methodologies to be budget neutral

▶ For rating periods beginning on or after July 1, 2017:

- § 438.4(b)(7) Requiring compliance with special contract provisions in § 438.6
- § 438.4(b)(8) Requiring capitation rates to be submitted to CMS in the proper format and on the required timeline
- § 438.5(b) Process and requirements for setting actuarially sound capitation rates
- § 438.5(c) Base data requirements
- § 438.5(d) Requiring reasonable trends developed in accordance with actuarially sound principles
- § 438.5(e) Defining the non-benefit component of the rate
- § 438.5(f) Adjustment requirements

▶ For rating periods beginning on or after July 1, 2018:

- § 438.4(b)(3) Requiring capitation rates to be adequate to comply with availability of services, assurances of adequate capacity of services, and coordination and continuity of care
- § 438.4(b)(4) Requiring capitation rates to be specific to payments for each rate cell

▶ For rating periods beginning on or after July 1, 2019:

- § 438.4(b)(9) Requiring rates to be developed such that they can reasonably achieve an MLR of 85 percent

Appendix II: Website Posting Requirements

	Medicaid	CHIP	Description
Improving Consumer Information			
Enrollee Handbook	§§ 438.10(c)(3) and 438.10(g)(3)(iii) Effective for the rating period beginning on or after 7/1/2017	§ 457.1207 Effective for the state fiscal year beginning on or after 7/1/2018	Plans must provide enrollees with an enrollee handbook within a reasonable time following enrollment. The handbook must include specified information that enables the enrollee to understand how to effectively use the managed care program.
Provider Directory	§§ 438.10(c)(3) and 438.10(h)(4) Effective for the rating period beginning on or after 7/1/2017	§ 457.1207 Effective for the state fiscal year beginning on or after 7/1/2018	Plans must post up-to-date provider directories including contact information, specialty, whether the provider is accepting new patients, and accommodations available for people with limited English proficiency and people with disabilities.
Drug Formulary	§§ 438.10(c)(3) and 438.10(i)(3) Effective for the rating period beginning on or after 7/1/2017	§ 457.1207 Effective for the state fiscal year beginning on or after 7/1/2018	Plans must provide a list of covered generic and name brand medications and each drug's tier.
Network Adequacy and Access to Services			
Annual Managed Care Program Report	§ 438.66(e)(3)(i) Effective for the rating period beginning on or after the date of publication of CMS guidance	Not applicable	States must post an annual program assessment report that includes, among other things, an assessment of the availability and accessibility of services within capitated plans and an evaluation of plan compliance with state network adequacy standards.
Network Adequacy Standards	§ 438.68(e) Effective for the rating period beginning on or after 7/1/2018	§ 457.1218 Effective for the state fiscal year beginning on or after 7/1/2018	States must post the time and distance standards for certain classes of providers, including pediatric primary care, specialty care, dental, and behavioral health.
Assuring Quality			
Accreditation Status	§ 438.332(c)(1) Effective for the rating period beginning on or after 7/1/2017	§ 457.1240(c) Effective for the state fiscal year beginning on or after 7/1/2018	States must post and annually update the accreditation status of each MCO, PIHP, or PAHP along with the name of the accrediting entity, the accreditation program, and the accreditation level.
Quality Rating	§ 438.334(e) Effective three years from the date of a final notice published in the Federal Register	§ 457.1240(d) Effective three years from the date of a final notice published in the Federal Register	States must post the annual quality ratings for each MCO, PIHP, and PAHP in accordance with the language and format requirements in § 438.10(d).
State Quality Strategy	§ 438.340(d) Effective beginning 7/1/2018	§ 457.1240(e) Effective for the state fiscal year beginning on or after 7/1/2018	States must post the final quality strategy, updates, and all reviews to the state's website.

Appendix II: Website Posting Requirements (cont'd)

	Medicaid	CHIP	Description
Quality Measures and Performance Outcomes	§ 438.340(b)(3)(i) Effective beginning 7/1/2018	§ 457.1240(e) Effective for the state fiscal year beginning on or after 7/1/2018	As part of the state quality strategy, states must identify certain quality measures and performance outcomes that will be posted annually to the state's website.
Quality Strategy Reviews	§ 438.340(c)(2)(ii) Effective beginning 7/1/2018	§ 457.1240(e) Effective for the state fiscal year beginning on or after 7/1/2018	States must post the results of the quality strategy review, conducted at least once every 3 years, and including an evaluation of the effectiveness of the quality strategy.
Annual External Quality Review Technical Report	§ 438.364(c)(2)(i) Effective beginning 7/1/2018	§ 457.1250(a) Effective for the state fiscal year beginning on or after 7/1/2018	States must post the most recent copy of the annual external quality review technical report summarizing findings on access and quality of care.
Accountability and Transparency			
Managed Care Plan Contract	§ 438.602(g)(1) Effective for the rating period beginning on or after 7/1/2017	§ 457.1285 Effective for the state fiscal year beginning on or after 7/1/2018	States must post the MCO, PIHP, PAHP, or PCCM entity contracts.
Documentation of Compliance with Availability and Accessibility of Services	§ 438.602(g)(2) Effective for the rating period beginning on or after 7/1/2017	§ 457.1285 Effective for the state fiscal year beginning on or after 7/1/2018	States must post the data and documentation showing that each plan offers an appropriate range and number of providers to meet the needs of enrollees in the service area. This is the data the state must use to base its certification that each plan complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.
Managed Care Ownership and Control Information	§ 438.602(g)(3) Effective for the rating period beginning on or after 7/1/2017	§ 457.1285 Effective for the state fiscal year beginning on or after 7/1/2018	States must post the name and title of individuals who own and control MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities, as well as some subcontractors.
Audit Results	§ 438.602(g)(4) Effective for the rating period beginning on or after 7/1/2017	§ 457.1285 Effective for the state fiscal year beginning on or after 7/1/2018	States must post the results of independent, periodic audits that verify the accuracy, truthfulness, and completeness of encounter and financial data submitted by each MCO, PIHP, and PAHP.

Appendix III: Applicability to Separate CHIP Program

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules outlined above. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules.

Standard Contract Requirements § 457.1201

The Medicaid standard contracting requirements are generally applicable to CHIP without modification, except:

- § 457.1201(a) requires only CMS review of contracts for CHIP rather than prior approval;
- § 457.1201(b) excludes HIOS from CHIP;
- § 457.1201(c) requires submission of rates only upon request from the Secretary;
- § 457.1201(d) does not require voluntary enrollment in managed care;
- § 438.3(g) regarding provider preventable conditions does not apply to CHIP;
- § 438.3(j) regarding advance directives does not apply to CHIP;
- § 457.1201(i) uses CHIP rules regarding sub-contractual relationships at § 457.1233(b) rather than Medicaid rules at § 438.3(k);
- § 438.3(o) regarding LTSS does not apply to CHIP;
- § 438.3(p) regarding HIOS does not apply to CHIP; § 457.1201(m) requires PCCM compliance with CHIP disenrollment standards at § 457.1212 rather than Medicaid standards at § 438.56(c);
- § 457.1201(n) describes additional rules for PCCM entities in CHIP rather than following the Medicaid rules at § 438.3(r);
- § 438.3(s) regarding outpatient drugs does not apply to CHIP;
- § 438.3(t) regarding dual eligibles does not apply to CHIP;
- § 457.1201(o) describes CHIP attestation requirements; and
- § 457.1201(p) describes the CHIP requirement not to avoid costs.

Subcontracting Requirements § 457.1233(b)

The Medicaid subcontracting requirements described at § 438.230 are applicable to CHIP at § 457.1233(b).

Rate Development Standards § 457.1203(a)-(b)

The provisions governing CHIP rates are much less detailed. The regulations require states to use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles.[47] The regulation specifically allows states to establish higher rates if necessary to ensure sufficient provider participation.[48] States must provide, if requested, a description of the manner in which rates were developed.[49]

Medical Loss Ratio § 457.1203(c)

The Medicaid MLR requirement described at § 438.8 is applicable to CHIP at § 457.1203(c).

Appendix IV: Definitions Applicable to Managed Care Entities

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is –

- A federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
  - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
  - Meets the solvency standards of § 438.116.

Prepaid ambulatory health plan (PAHP) means an entity that –

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and,
- Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

Primary care case management (PCCM) is a system whereby the state contracts with a primary care case manager to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries. Primary care case manager means a physician, a physician group practice or, at state option, any of the following: a physician assistant; a nurse practitioner; a certified nurse-midwife.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the state –

- Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
- Development of enrollee care plans.
- Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
- Provision of payments to FFS providers on behalf of the state.
- Provision of enrollee outreach and education activities.
- Operation of a customer service call center.
- Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- Coordination with behavioral health systems/providers.
- Coordination with long-term services and supports systems/providers.

Endnotes

[1] 42 C.F.R. Part 438 and 42 C.F.R. Part 457 Subpart L, available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[2] 42 C.F.R. § 438.602(g)(1).

[3] This section is most commonly referenced in relation to services delivered while a Medicaid beneficiary is a patient at an Institute for Mental Disease (IMD). Generally speaking, the Medicaid statute does not allow payment for services provided to an individual ages 21 to 64 who is a patient of an IMD (see Social Security Act § 1905(a)(29)). However, the final rule allows plans to receive a capitation payment if the facility is a hospital providing psychiatric or substance use disorder inpatient care or a subacute facility providing psychiatric or substance use disorder crisis residential services and the stay in the IMD is for less than 15 days that month. In the case of IMDs, the actual cost of the IMD services is not taken into account in the capitation rates.

[4] 42 C.F.R. § 438.58.

[5] Social Security Act § 1902(a)(4)(C).

[6] Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Alternative Benefit Plans, 81 Fed. Reg. 61 (March 30, 2016).

[7] 42 C.F.R. 438 Subpart K.

[8] Social Security Act § 1915(c) waivers or state plan amendments under §§ 1915(i) or 1915(k).

[9] 42 C.F.R. § 441.301(c)(4)

[10] Social Security Act § 1927(k)(2) defines the scope of coverage of outpatient drugs.

[11] 81 Fed. Reg. 27545.

[12] 42 C.F.R. § 438.3(s)(2). Social Security Act § 1927(b)(1)(A) authorizes drug rebates.

[13] The 340B drug pricing program requires drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices. 42 U.S.C. § 256b.

[14] Social Security Act § 1927(g).

[15] Id. § 1927(d)(5).

[16] 42 C.F.R. § 438.416 (enrollee grievance and appeal records), § 438.5(c) (base encounter data, FFS data, and audited financial reports), § 438.8(k) (medical loss ratio reporting requirements), § 438.604 (data, information, and documentation that must be submitted), § 438.606 (source, content, and timing of certification), § 438.608 (program integrity requirements under the contract), and § 438.610 (prohibited affiliations).

[17] 42 C.F.R. § 438.5(c). See also Actuarial Standards Board, "Medicaid Managed-Care Capitation Rate Development and Certification," http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-certification/#22-base-data (last revised Dec. 2013).

[18] 42 C.F.R. § 438.5.

[19] See 42 C.F.R. § 483.3.

[20] Social Security Act, § 1903(m).

[21] 42 C.F.R. § 438.6(c)(1)(i).

[22] Id. § 438.4 (requiring actuarially sound rates); see also Centers for Medicare & Medicaid Services, Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Strengthening Program and Fiscal Integrity and Accountability 1 (Apr. 25, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-program-and-fiscal-integrity-and-accountability.pdf.

[23] 42 C.F.R. § 438.5(b). The details of trends, adjustments, and the non-benefit part of the rate must be reasonable and, when relevant, developed in a manner consistent with generally accepted actuarial principles and practices; Id. §§ 438.5(d), (e), (f), (g).

[24] 42 C.F.R. § 438.4(b)(1), (2).

[25] Id. § 438.4(b). Documentation for rate certification is detailed in § 438.7.

[26] Id. § 438.4(b)(9).

[27] Id. § 438.5(c)(1), (2).

[28] Id. § 438.5(c)(3).

[29] Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Strengthening Program and Fiscal Integrity and Accountability 1, (Apr. 25, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-program-and-fiscal-integrity-and-accountability.pdf.

[30] Id.; see also 42 C.F.R. § 438.8 (Medicaid MLR); 42 C.F.R. § 457.1203(c). The Medicaid managed care MLR is modeled on the private market rules in 45 C.F.R. part 158.

[31] 81 Fed. Reg. 27521.

[32] 42 C.F.R. § 438.8(a). The MLR for CHIP plans must be calculated following the same requirements as Medicaid plans as of the state fiscal year beginning on or after July 1, 2018. 42 C.F.R. § 457.1203.

[33] 42 C.F.R. § 438.8(c).

[34] Id. § 438.8(d).

[35] Id. § 438.8(e)(1). Fraud prevention activities are only included in the calculation to the extent that that they are used in the private market calculation, 42 C.F.R. § 438.8(e)(4). Currently, however, fraud prevention activities are excluded from incurred claims in the private market. 45 C.F.R. 158.150(c)(8).

[36] 42 C.F.R. § 438.8(e)(2)(i).

[37] Id. § 438.8(e)(2)(ii).

[38] Id. § 438.8(e)(2)(iii).

[39] Id. § 438.8(d)(3); 45 C.F.R. § 158.150(b). Activities must be designed to improve health quality; increase the likelihood of desired health outcomes in a way that can be objectively measured and verified; be directed toward enrollees; provide improvements to the population beyond those enrolled as long as they do not increase costs; and be grounded in evidence-based medicine, clinical best practices, or criteria issued by professional medical associations, 45 C.F.R. § 158.150(b)(1). In addition, the activity must be primarily designed to improve health outcomes and reduce health disparities, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health activities, or enhance the use of health care data. Id. § 158.150(b)(2).

[40] 45 C.F.R. § 158.150(c).

[41] 42 C.F.R. § 438.8(f)(1).

[42] Id. § 438.8(f)(2).

[43] The Henry J. Kaiser Family Foundation (KFF) has a listing of minimum MLR policies in effect for Medicaid MCOs in 2015. See Kaiser Family Foundation, State Health Facts, "Minimum Medical Loss Ratio (MLR) Policies for MCOs (July 1, 2015).

[44] 42 C.F.R. § 438.8(j).

[45] Id. § 438.7(k).

[46] 81 Fed. Reg. 27532.

[47] 42 C.F.R. § 457.1203(a). Actuarially sound principles are defined in § 457.10 as "generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered are certified by actuaries who meet the qualification standards established by the Actuarial Standards Board."

[48] Id. § 457.1203(b).

[49] Id. § 451.1203(d).

Support for this brief series was provided by a grant from the Robert Wood Johnson Foundation™. The authors would like to thank Tricia Brooks for her contributions. Design and layout provided by Nancy Magill.

Center for Children and Families
Health Policy Institute, Georgetown University
Box 571444, 3300 Whitehaven Street, NW, Suite 5000
Washington, D.C. 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu


ccf.georgetown.edu/blog/


facebook.com/georgetownccf


twitter.com/georgetownccf

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's McCourt School of Public Policy. Visit ccf.georgetown.edu.

NHeLP
NATIONAL HEALTH LAW PROGRAM

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals and families. NHeLP advocates, educates and litigates at the federal and state levels. Visit healthlaw.org.