



Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

Program Integrity

*Center for Medicaid and CHIP Services
Center for Program Integrity*



Background

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Today, the predominant form of service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children's Health Insurance Program Reauthorization Act of 2009 adopted key Medicaid managed care provisions for CHIP
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs

Goals of the Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

Key Dates

- Publication of Final Rule
 - On display at the **Federal Register** on April 25th
 - Published in the **Federal Register** on May 6th (81 FR 27498)
- Important Dates
 - Effective Date was July 5th
 - Provisions with implementation date as of July 5th
 - Phased implementation of new provisions primarily over 3 years, starting with rating period for contracts starting on or after July 1, 2017
 - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
 - Applicability dates/Relevance of some 2002 provisions

Rating Period Examples

Provisions with implementation date of the rating period for contracts starting on or after July 1, 2017

Calendar Year contract and rating period cycle	Implementation of provisions for the rating period for contracts starting January 1, 2018
State Fiscal Year contract and rating period cycle (assuming July-June cycle)	Implementation of provisions for the rating period for contracts starting July 1, 2017
Federal Fiscal Year contract and rating period cycle (or State Fiscal Year that runs on FFY cycle)	Implementation of provisions for the rating period for contracts starting October 1, 2017
Any other contract and rating period cycle	The contract and rating period that starts after July 1, 2017

Resources

- Medicaid.gov – Home and Managed Care Pages
 - Link to the Final Rule
 - 8 fact sheets
 - Implementation timeframe table
 - Slides from past webinars
 - Link to the CMS Administrator’s “Medicaid Moving Forward” blog
- ManagedCareRule@cms.hhs.gov
- Medicaid_Integrity_Program@cms.hhs.gov

Topics for Today's Presentation

- Screening and Enrollment of Network Providers
- Other State Responsibilities for Program Integrity
- Managed Care Plan Responsibilities for Program Integrity
- Treatment of a Plan's Recovery of Overpayments
- Fraud Prevention Activities in the MLR

Definitions – 438.2

Network Provider: Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, **or a subcontractor**, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Subcontractor: An individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

Screening and Enrollment: General Rule

438.602(b)(1): The State must *screen and enroll*, and periodically revalidate, **all network providers** of MCOs, PIHPs, and PAHPs, *in accordance with the requirements of part 455, subparts B and E of this chapter*. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. ***This provision does not require the network provider to render services to FFS beneficiaries.***

WHO: Network providers who order, refer or render covered services (*see* 42 CFR 455.410(b)); State may rely on the results of screening conducted by Medicare contractors or other State Medicaid agencies (*see* 42 CFR 455.410(c))

Rating period for contracts starting on or after July 1, 2018

Screening of Network Providers

What are the screening requirements for network providers?

The provisions in 42 CFR part 455, subparts B & E, including:

- *Provider assignment to risk level to determine scope of screening activity (42 CFR 455.450)*
- *Verification of provider licensure (42 CFR 455.412)*
- *Criminal background checks (42 CFR 455.434)*
- *Site visits (42 CFR 455.432)*
- *Federal database checks (42 CFR 455.436)*
- *Review of disclosures (42 CFR part 455, subpart B)*

Screening v. Credentialing

- **Screening (42 CFR part 455, subparts B &E)** is a required element of the provider enrollment process effectuated via execution of provider agreement between the state and the provider
- **Credentialing (438.214)** is the process conducted by the plan to verify that the provider is qualified to perform/deliver services
 - Verification of licensure (455.412) overlaps with plan credentialing requirements in 438.214
 - Credentialing is primarily conducted as part of process to execute the network provider agreement
 - Plan may decline to enter into a network provider agreement with a provider that was otherwise screened and enrolled but did not meet the plan's credentialing criteria
 - Plans may not employ or contract with providers excluded from participation in Federal health care programs under section 1128 or section 1128A of the Act

Enrollment of Network Providers

Network providers that order, refer, or render covered services must enroll with the State Medicaid Agency

- Executed provider agreement with state per sections 1902(a)(27) (rendering providers) and 1902(kk)(7) (ordering and referring providers) of the Act
- ***DOES NOT OBLIGATE NETWORK PROVIDER TO PARTICIPATE IN FFS DELIVERY SYSTEM***
- To streamline the execution of the provider agreements required for enrollment of network providers, states may establish a separate category of provider agreement
- Managed care plans may make the state's provider agreement form available to their network providers to expedite the process

State Delegation of Screening

- Permitted, see preamble at 81 FR 27602
- Considerations
 - quality control and consistency in conducting these activities;
 - duplicative efforts with respect to network providers that participate in several managed care plans;
 - ability of managed care plans or a fiscal intermediary to conduct all of the functions required in subpart E of 42 CFR part 455, including on-site visits and fingerprint-based criminal background checks for high-risk providers, and access all necessary databases
- State must maintain oversight of the activity
- A network provider agreement between the managed care plan and network provider does not satisfy the agreement that is needed between the state and the provider

Screening & Enrollment: Network Development

438.602(b)(2): MCOs, PIHPs, and PAHPs may:

- Execute network provider agreements pending the outcome of the enrollment process for up to 120 days
- But must terminate a network provider immediately upon
 - notification from the State that the network provider cannot be enrolled
 - or the expiration of one 120 day period without enrollment of the provider, and
 - notify affected enrollees

State Responsibilities (438.602(a))

- Monitor managed care plan compliance with the following provisions (link to monitoring and oversight requirements in 438.66)
 - **438.604:** Data, information, and documentation that must be submitted
 - **438.606:** Source, content, and timing of certification for data, documentation and information in 438.604
 - **438.608:** Managed care plan compliance with specified program integrity requirements
 - **438.610:** Prohibited affiliations
 - Clarified that prohibited affiliations apply to “individuals or entities” and subcontractors
 - **438.808:** Exclusion of entities
 - Clarified that exclusion applies to MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities operating under 1915(b)(1) authority as specified in statute

State Responsibilities

- **438.602(c):** Review of ownership and control disclosures (42 CFR part 455, subpart B)
 - Managed care plans and any subcontractors
- **438.602(d):** Federal database checks to confirm identity and exclusion status of plans and subcontractors consistent with 42 CFR 455.436
- **438.602(e):** Arrange for an independent audit, at least once every 3 years, of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the managed care plans

Rating period for contracts starting on or after July 1, 2017

State Responsibilities (438.602)

- **438.602(f):** Have a mechanism to receive and investigate information from whistleblowers
- **438.602(h):** Maintain conflict of interest safeguards consistent with 438.58

Rating period for contracts starting on or after July 1, 2017

- **438.602(i):** Ensure that the managed care plan is not located outside the U.S. and that no payments are made for services or items to any entity or financial institution outside the U.S.

Effective date of the final rule (July 5, 2016)

State Responsibilities - Transparency

- **438.602(g)(1):** Managed care plan or PCCM entity contract
 - Rating period for contracts starting on or after July 1, 2017
- **438.602(g)(2):** Documentation of plan's compliance with availability and accessibility requirements, including adequacy of provider network in 438.206
 - Rating period for contracts starting on or after July 1, 2018
- **438.602(g)(3):** Name and title of individuals disclosing plan or subcontractor ownership or control (438.604(a)(6))
 - Rating period for contracts starting on or after July 1, 2017
- **438.602(g)(4):** Results of periodic audits of encounter and financial data required under 438.602(e)
 - Rating period for contracts starting on or after July 1, 2017

Managed Care Plan Responsibilities

438.604 sets forth the data, information and documentation that managed care plans will submit to the State:

- Encounter data and other data generated by the managed care plan for purposes of rate setting (438.5(c) – base data)
- Data supporting the State’s determination of compliance with the MLR provisions (438.8(k))
- Data to ensure that solvency standards are met (438.116)
- Data supporting the availability and accessibility of services (438.206)
- Managed care plan and subcontractor disclosures on ownership and control required in 42 CFR 455.104 (438.602(c))
- Managed care plan reports on recovered overpayments (438.608(d)(3))

Rating period for contracts starting on or after July 1, 2017; 438.604 in 2002 rule remains applicable until relevant rating period

Managed Care Plan Responsibilities

438.606 addresses the certification requirements for the data, information and documentation in 438.604

- ***Who can certify?***
 - CEO; CFO; or Individual who reports directly to CEO or CFO with delegated authority to sign so that CEO or CFO is ultimately responsible
- ***What is the certification standard?***
 - Best knowledge, information and belief the data, documentation and information is accurate, complete and truthful
- ***What is the timing of the certification?***
 - Certification accompanies the submission

Rating period for contracts starting on or after July 1, 2017; 438.606 in 2002 rule remains applicable until relevant rating period

Managed Care Plan Responsibilities

438.608 contains managed care plan and subcontractor responsibilities for program integrity:

- **438.608(a)(1)(i)**: Establish written policies, procedures and standards of conduct with all applicable federal and state provisions
- **438.608(a)(1)(ii)**: Provide for direct reporting by designated Compliance Officer to the CEO and the board of directors
- **438.608(a)(1)(iii)**: Maintain a Regulatory Compliance Committee on the board of directors and at the senior management level
- **438.608(a)(1)(iv)**: Establish a system for training and education for senior management in addition to the Compliance Officer and employees
- **438.608(a)(1)(v) & 438.608(1)(vi)** – unchanged from 2002 rule
- **438.608(a)(1)(vii)**: Establish system with dedicated staff for routine internal monitoring and prompt response to compliance risks/issues and correction of such issues

Managed Care Plan Responsibilities (cont.)

- **438.608(a)(2):** Prompt reporting of all overpayments identified or recovered, specifying overpayments due to fraud, waste, or abuse
- **438.608(a)(3):** Prompt notification to State of information that may impact enrollee's eligibility
 - Changes in enrollee's residence
 - Death of the enrollee
- **438.608(a)(4):** Prompt notification to State of information that that may affect provider participation, e.g., termination of the network provider agreement

Managed Care Plan Responsibilities (cont.)

- **438.608(a)(5):** Method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered were received by enrollees
- **438.608(a)(6):** Establish written policies related to the False Claims Act, including protections for whistleblowers
- **438.608(a)(7):** Mandatory referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit or any potential fraud to the State Medicaid Fraud Control Unit (MFCU)
- **438.608(a)(8):** Provide for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23

Rating period for contracts starting on or after July 1, 2017

Managed Care Plan Responsibilities

Managed care plans and any subcontractors will also perform the following activities:

- **438.608(c)(1):** Disclose in writing any prohibited affiliations in 438.610
- **438.608(c)(2):** Provide written disclosures of information on control and ownership in 42 CFR 455.104
- **438.608(c)(3):** Report to the State within 60 calendar days of identification of payments in excess of the capitation rate or other payments established in the contract

Definitions – 438.2

Overpayment: Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act

Abuse: (incorporated from 42 CFR 455.2) Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program

Fraud: (incorporated from 42 CFR 455.2) An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law

Treatment of Managed Care Plan Recoveries

- **438.608(d)(1)** requires the contract to specify:
 - The retention policies for treatment of recoveries of all overpayments to providers by plans
 - Process, timeframes, and documentation required for reporting recovery of all overpayments
 - Process, timeframes, and documentation requirement for payment of recoveries of overpayment to State where plan is not permitted to retain the recovery
- Makes clear that this provision does not apply to any recoveries under False Claims Act or other investigations

Rating period for contracts starting on or after July 1, 2017

Reporting of Overpayments

- **438.608(d)(2)** requires managed care plans to have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification
- **438.608(d)(3)** requires managed care plans to report recovered overpayments annually to the state
- **438.608(d)(4)** requires the state to use the reports in (d)(1) and (d)(3) for purposes of rate setting

MLR: Fraud Prevention Activities

- The final rule does NOT include a calculation standard for fraud prevention activities in the MLR
- If the private market rules (45 CFR part 158) adopt a standard for consideration of fraud prevention activities, that will be incorporated into the Medicaid MLR calculation at 438.3(e)(4)
- Note that fraud reduction efforts are part of incurred claims at 438.8(e)(2)(iii)(B)

Additional Resources on Program Integrity Provisions

- Medicaid.gov provides a compendium of resources on program integrity, *available at:*

<https://www.medicaid.gov/affordablecareact/provisions/program-integrity.html>

Medicaid.gov>Affordable Care Act>Program Integrity

- In March, CMS issued sub-regulatory guidance on 42 CFR part 455 – Medicaid Provider Enrollment Compendium (MPEC)

Future Presentations

In the coming weeks, we will host in depth presentations on the following topics at 12:00-1:30 EST):

- **July 21 - Rate Setting, Delivery System Reform, and MLR**

1-844-396-8222 PIN: 998 282 470

<https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=ta0a5ddf69daaf6413cb7812e95a56b04>

- **July 28 – Covered Outpatient Drugs**

1-844-396-8222 PIN: 997 279 759

<https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=t69d04d2711a0a0ce391453c2a9aa3d98>

Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations

Medicaid_Integrity_Program@cms.hhs.gov

Questions

