DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)
Strengthening Program and Fiscal Integrity and Accountability

April 25, 2016

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP). The rule, which is the first overhaul of Medicaid and CHIP managed care regulations in more than a decade, advances the Administration's efforts to modernize the health care system to deliver better care, smarter spending, and healthier people. It supports state delivery system reform efforts, strengthens the consumer experience and key consumer protections, strengthens program integrity by improving accountability and transparency, and aligns key rules with those of other health coverage programs.

Strengthening Program and Fiscal Integrity and Accountability

The final rule strengthens the fiscal transparency and integrity in Medicaid and CHIP managed care by requiring more transparency in the managed care rate setting process, adding a standard for the calculation and reporting of medical loss ratios, identifying minimum standards for provider screening and enrollment, expanding managed care plan responsibilities in program integrity efforts, and adding requirements related to encounter data submissions.

Promoting Transparency in Rate Setting

The federal government promotes the integrity of states' Medicaid managed care capitation rates by requiring that the rates be actuarially sound. The existing regulatory framework for actuarial soundness requires that capitation rates be developed in accordance with generally accepted actuarial principles and be certified by a qualified actuary. The final revisions to the Medicaid managed care rate setting framework add to this standard by setting forth the types of data to be used for rate setting purposes and the level of documentation and detail about the development of the capitation rates in the rate certification—such as trend factors, adjustments and the development of non-benefit costs—so that CMS can more effectively review and approve capitation rates. The final rule provides states flexibility to increase or decrease the certified capitation rate by one and a half percent without the need to submit a revised rate certification for CMS' review and approval.

Most final provisions related to rate setting do not apply to CHIP managed care because the same actuarial soundness requirement for rates does not apply.

Establishing a Medical Loss Ratio (MLR) for Medicaid and CHIP

A medical loss ratio (MLR) measures generally 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. Medicaid and CHIP managed care plans are currently the only major health care programs to which a MLR standard does not apply – although some states have adopted their own MLR standard or a similar measure of managed care plans' administrative expenditures and profits. The final rule requires that both Medicaid and CHIP managed care plans calculate and report their MLR according to standards that

are similar to Medicare Advantage and the private market, while accounting for unique characteristics of the Medicaid or CHIP programs. The final rule modifies the provision of the proposed rule by incorporating the private market standard, should one be adopted, for the treatment of fraud prevention expenses in the MLR calculation.

A common national standard for calculating MLR will allow comparability across states, facilitate more accurate rate setting, and reduce the administrative burden on managed care plans that operate in multiple states or have multiple product lines.

Minimum standards for provider screening and enrollment

The final rule requires state Medicaid and CHIP programs to screen and enroll all network providers who are not otherwise enrolled with the state to provide services to fee-for-service Medicaid beneficiaries. As done in Medicare fee-for-service and Medicaid fee-for-service, this standard requires that all providers in Medicaid, who order, refer, or furnish services under the managed care program are appropriately screened and enrolled. The rule does not, however, require providers who participate in a Medicaid managed care plan's network to also provide services to individuals enrolled in a state's Medicaid fee-for-service program. Managed care plans will be able to execute temporary network provider agreements, subject to requirements, pending the outcome of the screening and enrollment process to support network development.

This approach will result in administrative and cost efficiencies by eliminating the need for each managed care plan to conduct duplicative screening activities as part of the credentialing process for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers.

Expanding managed care plans' responsibilities in program integrity efforts

The final rule adds several components to strengthen Medicaid and CHIP managed care plans' program integrity through administrative and managerial procedures that prevent, monitor, identify, and respond to suspected provider fraud. This includes implementing procedures for internal monitoring, auditing, and prompt referral of potential compliance issues within the managed care plan; mandatory reporting of potential fraud, waste or abuse to the state; mandatory reporting of any potential changes in an enrollee's circumstances that may impact Medicaid eligibility as well as changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network; and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists. The rule provides flexibility as to how the state addresses treatment of recoveries by plans through the contract, however, states will need to specify how managed care plan recoveries due to fraud, waste and abuse are addressed in the contract and take recoveries into account in the rate setting process.

Strengthening Encounter Data Submission

The final rule includes changes that implement provisions of the Affordable Care Act and strengthen encounter data submissions from managed care plans to states and from states to CMS. The rule requires that all managed care plan contracts require complete, timely, and accurate encounter data submissions to the state in the level of detail and format required by CMS. Additionally, the final rule clarifies that federal financial participation is not available for Medicaid managed care expenditures if a

state's encounter data submission to CMS does not meet our criteria for accuracy, completeness, and timeliness.

The final rule is available at https://www.federalregister.gov/.

For more information, visit https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html