DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)
Strengthening States' Delivery System Reform Efforts

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 States' Efforts at Delivery System Reform and Quality Improvement

The final rule contains several provisions designed to strengthen states' delivery system reform efforts and support local priorities and initiatives while ensuring quality of care for Medicaid beneficiaries. The delivery system reform provisions encourage innovation and promote flexibility while aligning Medicaid managed care with the goal of high-value care that improves beneficiary outcomes while controlling costs.

The final rule builds on CMS' efforts to support states and Medicaid managed care plans that are working together on delivery system reform. Specifically, under the final rule, we clarify that states can:

- Encourage managed care plans, through their contractual agreements, to develop and participate in broad-ranging delivery system reform or performance improvement initiatives. This approach acknowledges the role of the managed care plan as an important partner in such initiatives and would provide the managed care plan the ability to participate as an equal collaborator with other payers and participants. Examples of these initiatives could include participation in:
    - patient-centered medical homes;
    - efforts to reduce the number of low birth weight babies;
    - broad-based provider health information exchange initiatives; and
    - initiatives to improve access to providers.
- Establish reimbursement standards or fee schedules for providers that deliver a particular covered service to support timely access to care.
- Partner with managed care plans to adopt value-based purchasing approaches that base provider reimbursement on their performance on quality measures.
- Use incentive arrangements for managed care plans that meet quality or performance targets established through the contract. Examples of quality or performance targets for the managed care plan may include, but are not limited to, those highlighted above.
- Use withhold arrangements to encourage managed care plans to meet quality or performance targets established through the contract. Examples of quality or performance targets for the managed care plan may include, but are not limited to, those highlighted above.

The final rule strengthens the delivery of services under managed care by setting standards for the State and managed care plans related to network adequacy, the rate setting process, and the intersection of both of these pieces to support robust Medicaid managed care programs.

Also, the final rule sets forth requirements for managed care plans to cover services or settings that are an alternative to those covered under the State plan, which are also known as "in lieu of services." The final rule also provides that states may make a capitation payment for enrollees with a short-term stay in an Institution for Mental Disease to address access concerns for inpatient psychiatric and substance use disorder services.

In addition, building upon the principles set forth in the HHS National Quality Strategy and the CMS Quality Strategy, the final rule strengthens the tools available to states and beneficiaries to measure and monitor the impact of delivery system reform efforts. In particular, the final rule:

- Sets parameters for the first Medicaid and CHIP quality rating system (QRS), modeled on the QRS that exists for the Marketplace, to enable states to better measure and manage the quality of care and to assist consumers in shopping for plans. States can develop and use, with CMS approval, an alternative to the CMS-developed QRS that is tailored to the particular populations served by the state.
- Improves transparency of Medicaid managed care quality information by requiring states to post on their websites accessible information on managed care plan accreditation status and annual external quality reviews.

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