With enrollment reaching 74 percent of all beneficiaries, it is clear that managed care has become the standard organizing mechanism for a Medicaid program whose welfare roots are behind it and that now functions as a principal source of public insurance. Given this broad national policy direction, a strong yet flexible regulatory framework for Medicaid managed care becomes a fundamental policy goal, particularly as state programs continue to evolve toward structures capable of managing care for the highest need populations.

The modern contours of a 21st century regulatory framework finally came into full view on April 25 with the release of a 1,425-page final rule that will guide the delivery of health care for tens of millions of children and adults. All insurance regulation is important given the population health and welfare considerations at stake in modern health care financing structures. But nothing quite rivals Medicaid managed care in terms of the complexity involved in delivering and paying for health care for the poorest populations, who face particularly high health risks. As such, the importance of the Medicaid managed care rule for coverage, access, quality, efficiency, and value hardly can be overstated.

As reports already have noted, the rule is a behemoth, covering 1,425 pages in its prepublication form; states, the managed care industry, beneficiary advocates, and policy experts will be poring over its provisions for the foreseeable future. In this Health Affairs Blog post, a follow-up to a June 2015 post about the proposed rule, I offer an overview of what
the rule seeks to accomplish and how it tries to position health care delivery under a regulatory system covering over 70 million people.

The modern version of Medicaid managed care is the result of nearly 50 years of policy evolution, with its most important statutory underpinnings found in amendments to the program made by the 1997 Balanced Budget Act. The final rule, which closely hews to the choices made when the proposal was first unveiled, attempts to thread an extremely narrow needle; it balances, on the one hand, the need for minimum financial integrity, operational, and patient protection standards against, on the other hand, the need for flexibility on the part of states as the primary regulators of the Medicaid managed care industry, and the need of industry for deference in design and operation. The rule readies states to move steadily toward greater managed care growth but within parameters designed to protect consumer interests, while ensuring that such growth proceeds on a sound financial basis.

At the same time, the final rule reflects a fundamental underlying tension that has characterized Medicaid managed care from the beginning: how to reconcile the idea of closed-network, tightly managed service delivery systems (Medicaid managed care offers no out-of-network coverage for services covered by contracts other than emergency care, family planning, and care expressly approved by plans themselves) with the underlying challenge of ensuring access to health care for the poor, particularly in the case of specialized services.

Tim Jost’s excellent post compares the federal regulatory approaches found across Medicaid and qualified health plans and discusses the issue of market alignment, a key goal of the Centers for Medicare and Medicaid Services (CMS) in response to the fluidity of the population across different forms of insurance. Here I highlight the major directions taken in the final rule with respect to Medicaid managed care. (The rule also makes important changes to the Children’s Health Insurance Plan [CHIP], extending managed care protections, and standards to separate CHIP populations as well).

**Applicability**

As the proposed rule did, the final rule unifies requirements across all forms of managed care, from managed care organizations (MCOs) operating under comprehensive risk contracts to prepaid inpatient and ambulatory plans (PIHPS and PAHPS) and primary care case management (PCCM). (To be sure, some regulatory variation remains given the difference in size and scope among these models, including non-emergency medical transportation PAHPs.)

As in its proposed form, the rule also squarely recognizes that managed care is now an important tool in the provision of long term services and supports, a recognition that implicitly tips the hat in the direction of future growth in this area. Across this expanding managed care landscape, the rule juxtaposes minimum federal standards against a flexible approach when it comes to the choices states have in operating within these standards.

**Standard Contract Requirements**

**Contracts**

As in the proposed version, the final rule establishes minimum expectations for contracts between states and plans. Contracts remain subject to CMS review and approval, and contracts must identify capitation payment amounts based “only upon services covered under the State plan,” as well as services “deemed by the State to be necessary to comply
with federal mental health parity requirements set forth under federal regulations issued on March 30, 2016. Payments must adequately support support the “efficient delivery” of care.

Non-Discrimination

Contracts must contain a standard non-discrimination standard that bars discrimination based on health status or need for health services or on race, color, national origin, sex, sexual orientation, gender identity, or disability. In keeping with a broad interpretation of the civil rights obligations applicable to federally assisted entities, the rule prohibits not only intentional but de facto discrimination, meaning “any policy or practice that has the effect of discriminating on the basis of” the prohibited characteristics. (Final regulations implementing Section 1557 of the Affordable Care Act, which applies civil rights laws on a system-wide basis, have not yet been issued.)

Services Offered; ’In Lieu Of’

Contracts may specify the voluntary provision of substitute services “in lieu of” state plan services, meaning “services or settings that are in lieu of services or settings covered under the State plan.” The ability to include “in lieu of” services whose costs are calculated into the capitation rate and thus qualify for federal financing turns not only on specific inclusion in the contract but on a determination by the state that an alternative service or setting is a medically appropriate and cost effective substitute for the covered service.

Services “in lieu of” covered services must be voluntary for members. This “in lieu of” authority gives states and plans the ability to negotiate innovative, evidence-based delivery alternatives to covered services, such as home visiting for high-risk mothers, infants, and young children as a substitute for certain in-office visits. As CMS notes (Preamble p. 156), an “in lieu of service” is “a substitute service or setting for a service or setting covered under the State plan.” Thus the “in lieu of” option seemingly would not permit federal financial participation for services completely unrelated to covered state plan services, with the exception of the new authority to states under the final rule (discussed below) to cover short stays in institutions for mental diseases (IMD).

Standard Contract Terms

Following the proposed rule, the final rule enumerates standard contract terms and provisions, including compliance with applicable laws both generally and under Medicaid; a qualified guarantee of free choice among network providers (“to the extent possible and appropriate,” as auto-assignment to primary care network providers remains a common feature of Medicaid managed care in many states); compliance with mental health parity requirements; and compliance with home- and community-based care waiver requirements in the event that such services are included in the contract.

To the extent that covered outpatient drugs are part of the contract, plans must be in compliance with Medicaid’s federal drug coverage rules with respect to the amount, duration, and scope of drug coverage and management and reporting requirements. Contracts that cover the enrollment of dually eligible beneficiaries must contain standard coordination of benefits language.

Actuarial Soundness, Medical Loss Ratio, And Rate Development

As proposed (and as required by law) the final rule requires that payments to plans be actuarially sound for services included in the contract. As such, an 85 percent medical loss ratio (MLR), proposed in 2015, becomes a basic component of actuarial soundness,
ensuring that as rates are adjusted to accurately reflect the cost of efficient covered health services to the enrolled population, plans allocate an appropriate amount to health care and related costs. The final rule thus moves Medicaid managed care firmly onto a sound rate-setting base that will assure reasonable and adequate payment for covered care, with planned investment in patient care measured by the type of standard benchmark used to measure the appropriateness of investment in people enrolled in group health plans.

Under the rule, actuarial soundness principles must relate to the specific sub-populations to be enrolled; the rule bars cross-subsidization from one rate cell to another. Rates must be developed “in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard . . . of at least 85 percent for the rate year,” with the MLR acting as a floor to ensure that “capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.” The process of rate development (along with extensive rate certification submission requirements) specified in the rule is designed to ensure that rates are fair and that methods for developing rates are consistent across plans. The multi-factorial rate development methodology includes:

1. a base utilization and price,
2. trend data tied to “the actual experience of the Medicaid population or a similar population,” and
3. a non-benefit component that accounts for reasonable expenses related to plan administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with provision of covered services.

If a risk adjustment methodology is used, then rates must use “generally accepted models and apply it in a budget neutral manner across all MCOs, PHIPs, and PAHPs . . . .”

At the same time, the rule recognizes that as agents of the state, managed care organizations assume roles broader than those of private insurers working for sponsors; managed care companies also administer key aspects of the program that are related to managed care but exist outside the capitation rate.

In this regard, the rule exempts certain pass-through payments (that is, payments required by the state to be added to the contracted payment rate and paid to hospitals, physicians, or other providers) from actuarial soundness principles, including specified services for specified enrollees, delivery system reform payments, graduate medical education payments, and supplemental payments to federally qualified health centers and rural health clinics as required under law. (A separate CMS transmittal issued simultaneously with the rule specifies that supplemental payments to health centers and rural health clinics can be included in plan contracts as an alternative payment methodology if voluntarily agreed to by the providers.)

**Special Contract Provisions Related To Payment**

The rule sets minimum standards governing contract payment and incentive arrangements. The final rule requires contracts to describe, where applicable, all applicable risk sharing mechanisms and incentive arrangements, with incentive payments still capped (as under prior law) at 105 percent of the approved capitation amount. Incentive arrangements, including those for network providers, must be specific with respect to time and performance, cannot be renewed automatically, and must be available to both public and private contractors.

As in its proposed form, the final rule conditions incentives on payments that are necessary for specified activities, targets, performance, measures, or quality-based outcomes that
support program initiatives under the rule’s state quality strategy. In other words, incentive payments cannot be something for nothing. Furthermore, the rule specifies that states cannot condition incentives on contractors entering into intergovernmental transfers from local governments that form an important part of overall state Medicaid spending and therefore which is a key consideration in the case of public plans. The rule specifies that withhold arrangements be actuarially sound and that they take a plan’s operating needs into account given the size and characteristics of the plan and its enrollment, as well as capital reserve requirements.

Payment And Delivery System Reform

One of the more important developments in recent years has been CMS’ use of Section 1115 to create broadly structured Medicaid delivery system reform efforts tied to far-reaching quality and efficiency goals. In some cases, these reform efforts may involve entities that both deliver health care and operate a Medicaid plan. In other cases, delivery system reforms involve entities such as hospital systems that in turn contract with one or more plans.

While stating generally that a state cannot direct provider payments under its contract (unless they fall into one of the excepted categories noted above), the rule permits states to require pass-through payments and targeted delivery system payments. The rule also permits states to require plans to participate in actuarially sound multi-payer or Medicaid delivery system reform efforts and to use certain fee schedules or payment rules for certain services as well as alternative payment structures in order to implement value-based purchasing models. Where pass-through payments involving delivery system reform are used, the final rule specifies the broad terms of appropriate payment parameters with respect to the duration of such payments and the methodology by which such supplemental funding levels will be developed.

Institutions For Mental Diseases (IMDs)

Although federal funding is generally not available for services furnished to people who reside in IMDs, the final rule, as it did in proposed form, draws a crucial exception, permitting states to make monthly capitation payments to plans for adults ages 21-64 who receive inpatient treatment in an IMD, so long as the IMD meets provider participation standards and the stay is no longer than 15 days during the capitation period. This provision, a marked departure from prior policy, represents a crucial recognition by CMS of the severe shortage of short-stay residential treatment services for beneficiaries, while at the same time guarding against lengthy stays that discourage treatment in the most integrated setting.

Medical Loss Ratio Requirements

Beginning with contracts starting on or after July 1, 2017, risk plans must calculate and report their MLRs, the quid pro quo for actuarial soundness. The minimum 85 percent MLR minimum standard—that is, the proportion of premium revenues spent on clinical services and quality improvement—is expressed as a numerator consisting of incurred claims, and claims for activities that improve health care quality) over a denominator equaling the plan’s adjusted premium revenue minus taxes and regulatory fees.

As Tim Jost notes, the Medicaid MLR differs from that used for private plans, in that the numerator can include the cost of external quality review, while the denominator includes fees and costs specific to Medicaid managed care. The MLR can be adjusted by a credibility factor designed to take into account year-to-year variances from the MLR standard that are
statistically unpredictable. States may require that plans make repayments if they vary from the MLR. Whereas, as Jost points out, the MLR in the private market is designed to ensure that policyholders get value for their dollar, in the Medicaid context, the MLR is essentially the justification for actuarially sound payment. Activities related to health care quality are broadly defined and include health information technology and meaningful use.

**Information Requirements**

Jost correctly points out that federal law does not utilize the explicit summary plan description terminology employed in the case of private plans. But the information requirements in the final rule are extensive, a reflection of a strong policy desire to increase the rate at which beneficiaries actually select a plan, as opposed to being default-enrolled into a plan, which is a common feature of Medicaid managed care.

The rule requires states and plans to provide a wide array of information available to both enrollees and prospective enrollees in a readily accessible and easily understood format (undefined). Furthermore, the rule requires a beneficiary support system that must make support available in multiple ways both before and after enrollment. This assistance includes choice counseling (but not actual selection of a specific plan), assistance in understanding managed care, assistance to beneficiaries who use or want long term services and supports, and expanded assistance on request to beneficiaries receiving long term services and supports with respect to grievances and appeals of adverse benefit determinations.

The information that must be made available to current and prospective enrollees is voluminous. Potential enrollees must be provided with extensive information accessible in terms of language and disability. Required information includes, among other matters, provider directories and formularies; cost sharing responsibilities; an explanation of network adequacy and access; and an explanation of all covered benefits, including benefits provided by the plan and those that remain directly provided by the state. (A crucial difference between Medicaid managed care and private insurance is that states have the option of excluding entire covered service categories, or portions of any covered service category, from their contracts, leaving certain services in the fee-for-service system or assigned to separate, specialized plans.) Written materials must be provided “in the prevalent non-English languages in the State” as well as in large print, and must explain how to receive both written translation and oral interpretation.

States must ensure the provision of provider directories (along with detailed contact information about providers following enrollment), enrollee handbooks (whose contents are described in detail in the rule), sample appeal and grievance notices, and sample denial and termination notices, as well as materials that “are critical to obtaining services.” Beneficiaries also must be informed of the special protection that applies to both traditional Medicaid as well as to managed care, namely, that should their plan seek to reduce or terminate benefits, assistance will continue at the current rate if they file a timely appeal or request for a fair hearing. (The final rule requires beneficiaries, like private plan enrollees, to exhaust their internal appeals rights before seeking external review via a fair hearing.)

For beneficiaries who pursue grievances and appeals, the final rule specifies the right to gain access, free of charge, to all “documents, records, and other information relevant” to an adverse determination, including “medical necessity criteria and any other processes, strategies, or evidentiary standards used in setting coverage limits.”

Finally states must actively engage beneficiaries during the development of managed care systems involving long term services and supports.
Managed Care Contracts Involving Indians

The rules contain special provisions for contracts covering Indians as defined under federal law, i.e., people who are members of federally recognized Indian tribes or who reside in an urban area and meet certain criteria. Chief among these provisions is a requirement that any plan enrolling Indians must include sufficient Indian health care providers to enable members to receive timely access to covered services.

Furthermore, the rules require that states ensure that Indian health care providers, whether participating or not in any particular network, be “paid for covered services provided to Indian enrollees who are eligible to receive services from such providers” in accordance with a federally defined rate. In other words, for Indians enrolled in Medicaid managed care, designated Indian health care providers are entitled to be paid at federally defined rates for covered services furnished to enrollees, regardless of their plan network status. This presumably becomes a key factor in setting actuarially sound rates for plans serving Indians, while maintaining the special trust status between the federal government and Indians and tribes, which also includes enhanced federal payments to states for care and services furnished to beneficiaries by an Indian Health Service or tribal facility.

General State Obligations In Managed Care: Enrollment And disenrollment

Federal law establishes a range of responsibilities for states that use managed care arrangements in addition to the special rules governing contracting and payment. The statute (and thus the rules) obligates states to retain managed care as an option for certain populations: dually eligible beneficiaries; most Indians; and children receiving SSI or in special placements related to disability, foster care, or adoption, or who receive special coordinated care services under the Title V Maternal and Child Health Services Block Grant.

Beneficiaries by law also must have a choice of at least two plans, with a limited exception for rural residents, who must have the choice of at least two primary care providers as well as certain out-of-network rights.

Passive Enrollment And Default Enrollment

The importance of rapid enrollment and access to a network provider can hardly be overstated: In its final rule, CMS dropped its proposal to ensure that prior to the beginning date of enrollment, beneficiaries newly eligible for coverage must receive immediate fee-for-service coverage in order to ensure access to care while enrollment was pending. While such a requirement would appear to be a function of Medicaid’s promptness of access requirement, strong state resistance to the concept of coverage outside of managed care led to elimination of the proposal.

The final rule subjects the managed care enrollment process to regulation to ensure defined enrollment periods and choice. The rule allows states to use a passive enrollment approach in which beneficiaries are assigned to plans through a process that simultaneously provides a period of time “for the enrollee to make an active choice of delivery system” or select a different plan. At the time of enrollment, beneficiaries in passive enrollment arrangements must receive explanations regarding the significance of choice and the right to make an active choice.

Only plans with capacity and not subject to sanctions may receive passive enrollments, and the process “must seek to preserve existing provider beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries, i.e., that have ‘experience’ serving the Medicaid population. (The final rule does not define
preservation efforts.) But if such an emphasis is “not possible” then a state “must distribute beneficiaries equitably and may not “arbitrarily deny” a plan from receiving passive enrollment. The rule also enumerates permissible considerations for states in fashioning passive enrollment systems, including family preference, previous plan assignment, quality performance, procurement evaluation elements, accessibility for people with disabilities, and other reasonable criteria.

Default enrollment is also addressed under the final rule as a means of safeguarding the interests of beneficiaries who do not select a plan during the enrollment period and have not been passively enrolled into plans. Maintaining a default enrollment process is a requirement in light of the fact that in Medicaid managed care, coverage for services not exempted from plan contracts is conditioned on enrollment; in other words, without enrollment there is no coverage, for all practical purposes. Default enrollment is not subject to the list of factors governing passive enrollment other than capacity to enroll.

Disenrollment similarly is addressed under the rules. Federal policy historically has permitted plans to seek the disenrollment of plan members, and the final rule continues this tradition while at the same time barring states from permitting such requests when based on changes in health status, use of services, diminished mental capacity, or uncooperative or disruptive behavior related to special needs. An exception to this last prohibition occurs when a member’s “continued enrollment in the [plan] seriously impairs [the plan’s] ability to furnish services to either this particular enrollee or other enrollees.”

Disenrollment for cause by enrollees is defined as moving out of the service area, a need for services not available through a plan’s network (e.g., a caesarean section coupled with a tubal ligation), or exclusion of covered services by the plan on religious or moral grounds. (Under Medicaid managed care, enrollees remain entitled to family planning services from the provider of their choice, regardless of the provider’s network status.) Enrollees receiving long term services and supports also may request disenrollment if a change in status on the part of their provider would cause a change in their residential, institutional, or employment supports.

Discontinuation Of A Plan

In the event that a plan contract is terminated, the rule requires states to maintain a limited transition of care policy to assure continuity of care “when an enrollee, in the absence of continued services, would suffer serious detriment to their [sic] health or be at risk of hospitalization or institutionalization.” (Curiously perhaps, there is no specific transition of care policy for pregnant women through the pregnancy, delivery, and post-partum phase, and CMS explicitly rejected recommendations by commenters [p. 481] to make the beneficiary support system available to people facing a transition of care.)

Monitoring And Oversight

The rules set forth extensive monitoring and oversight responsibilities for state systems covering virtually all aspects of managed care, from enrollment and marketing to coverage, medical management, adherence to program integrity requirements, quality improvement, utilization management, financial management, grievance and appeals procedures, and more. Readiness reviews for contractual performance are a requirement, both for plans with no prior contracting experience and those beginning to enroll new eligibility groups.

Network Adequacy And Access
With considerable attention paid to the issue of access to medical care for beneficiaries, especially those with a need for specialized services, the final network rule was eagerly anticipated. Whereas the proposed rule addressed not only time and distance but also provider-to-patient ratios, the final rule requires states to develop only time and distance standards for:

- primary care, both adult and pediatric;
- obstetrical and gynecology services;
- behavioral health (both adult and pediatric);
- adult and pediatric specialty care;
- hospital care;
- pharmacy services; and,
- dental care.

Time and distance standards are also required for long term services and supports (LTSS), as are “network standards other than time and distance for LTSS provider types that travel to the enrollee to deliver services.” In developing network adequacy standards, states must consider anticipated enrollment, expected utilization of services, and characteristics and health care needs of the Medicaid population to be enrolled, as well as the number and types of network providers required, the number of network providers not accepting new patients, and geographic location and transportation. States can also consider “innovative” access tools such as telemedicine and must consider the ability of providers to offer reasonable accommodation in terms of language, disability, and cultural competency.

Perhaps limiting the impact of the final rule’s modest movement toward a meaningful network adequacy standard is a provision that authorizes a state to exempt specific contractors from its access standards, subject to ongoing access monitoring by the contractor itself, with reports generated to the state and CMS.

States must assure that their plans have adequate network capacity to support the expected enrollment in their service area and must maintain supporting documentation to show that each plan maintains the necessary range of primary, specialty, and (where applicable) long term services and supports. Coordination and continuity of care capabilities are a requirement under the final rule for plans serving people with special health care needs. Expanded coordination of care requirements designed to ensure a regular source of primary care as well as access to specialized care and necessary discharge planning are also included.

Additionally, the rule establishes expanded service obligations for enrollees who need long term services and supports, including, as in the proposed rule, “mechanisms to identify persons who need LTSS or persons with special needs,” assessments, treatment, and service plans, and direct access to specialists. These specialized service requirements apply to the rating period for contracts with plans that begin after July 1, 2017.

Plans must maintain written agreements with their network providers and networks must be sufficient in scope to deliver all contracted services, with timely coverage of out-of-network care “if the provider network is unable to provide necessary services.” Plans must specifically demonstrate a sufficient family planning network (although enrollees have the right to seek family planning services from the provider of their choice, regardless of network status.) Under the access rules that apply to plans, all covered services must be available on a 24/7 basis if medically necessary and states must have regular access monitoring systems. The access standards take effect in rating periods for contracts beginning on or after July 1, 2018; before that time, prior access standards continue to apply.
Enrollee Rights

The final rule retains an enrollee bill of rights provision that delineates obligations related to provision of information, respectful treatment, patient engagement in treatment decision-making, access to medical records, and health information privacy. The final rule protects provider-enrollee communications, including those regarding treatment options and alternatives.

The rule maintains an EMTALA-level definition of emergency medical care, requiring coverage of both inpatient and outpatient care on an out-of-network basis. Additionally, the rule extends emergency-related out-of-network coverage to parallel the Medicare Advantage standard, requiring plans to pay for post-stabilization treatment out of network that is required to either maintain stabilization or resolve the health problem. Post-stabilization responsibilities under the final rule are triggered either when a plan’s own providers approve the service or when furnished within one hour of a request that either goes unanswered or over which there is a dispute between the treating provider and the plan.

Marketing

As with enrollment, marketing activities are regulated, as they were before. In a bow to the importance of beneficiary knowledge regarding plans that participate in both the Medicaid and qualified health plan markets—information of particular importance to beneficiaries in low wage working families, who may experience frequent shifts throughout the year in the source of subsidy owing to changes in family income—communications from QHPs are excluded from the definition of “marketing,” even if the QHP issuer is also the Medicaid managed care provider.

Coverage And Authorization Of Services: Medical Necessity And Practice Guidelines

Because of the complexity of managed care contracts as they relate to the scope of coverage under a state’s Medicaid plan (i.e., either coextensive with the plan or narrower than the full state plan scope of coverage), each contract must identify each service and specify the amount, scope, and duration of contractual coverage.

The final rule builds on this long-standing requirement by expanding this specificity to formally codify a federal medical necessity standard, a key regulatory advance. Under the rule, a state’s contract must specify the extent to which the plan is responsible for covering services that address:

the prevention, diagnosis, and treatment of an enrollee’s disease, condition, and/or disorder that results in health impairments and disability; the ability for [sic] an individual to achieve age-appropriate growth and development; the ability for [sic] an enrollee to attain, maintain, and retain functional capacity; and the opportunity for an enrollee receiving long term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their [sic] choice.

As in the proposed rule, the final rule requires that coverage determinations adhere to time frames (14 days) including expedited time frames (72 hours), with notice given to both the provider and beneficiary. Plans must meet federal grievance and appeals requirements.
Medical necessity and authorization rules take effect beginning with the rating period for plan contracts beginning on or after July 1, 2017.

In keeping with plan custom, the final rule contemplates that plans will adopt practice guidelines. The rule specifies that to qualify for adoption, practice guidelines must be based on valid and reliable clinical evidence or consensus among specialty providers, be adopted in consultation with network providers, and reviewed and updated periodically.

**Information Systems**

In keeping with the sweeping transformation to information technology that has taken place since the previous managed care rule was published in 2002, the final rule addresses health information requirements extensively. Basically, plans’ information systems must be sufficient to collect the data elements necessary to enable states to meet the needs of their own claims processing and information retrieval systems. Plans must be able to collect enrollee and provider data as specified by the state, as well as information on all services furnished through encounter data meeting minimum federal specifications or other data systems specified by the state.

**Quality Measurement And Improvement And External Quality Review**

The final rule requires a quality assessment and performance improvement program that encompasses numerous elements, including external review, the development of a quality strategy, state review of the accreditation status of its plans (states are not required to establish accreditation as a plan requirement), and a managed care quality rating system for all risk based plans. States are expected to develop and implement a quality rating strategy that becomes effective three years following the date of publication of the final rule in the Federal Register (scheduled for May 6, 2016). The rule provides that the results of external quality reviews must be made publicly available.

**Program Integrity**

As was the case with the proposed rule, the final rule requires that any provider that is a member of a plan network must independently have a Medicaid provider participation agreement in effect with the state agency. As a result, states retain the ultimate responsibility for screening, enrolling, and periodically revalidating all plan network providers. The rule establishes a 120-day grace period during which time a provider can be a plan network member pending the outcome of the state review, while requiring immediate termination at the end of the 120-day period if the provider is not approved or is informed by the state that credentialing has been denied.

Beyond the new standard restricting provider network status to providers that independently have been certified as qualified to participate in Medicaid, the final rule specifies that states may (but are not required) to impose sanctions if an MCO:

1. fails substantially to provide medically necessary services required under its contract;
2. imposes excessive premiums and charges on beneficiaries not permitted under the program;
3. discriminates against beneficiaries based on health status, including wrongful disenrollment; misrepresents or falsifies information to the state or CMS;
4. misrepresents information to a current or potential enrollee or a health care provider;
5. fails to comply with incentive plan requirements; or,
6. distributes false or misleading marketing materials.
Although plans are entitled under the law to pre-termination hearings when they are notified that their contracts will be terminated, the final rule permits states to provide enrollees with written notice of the state’s intent to terminate the contract and permit enrollees to disenroll immediately.

ASSOCIATED TOPICS: COSTS AND SPENDING, HEALTH PROFESSIONALS, MEDICAID AND CHIP, MEDICARE, PAYMENT POLICY, QUALITY

TAGS: FEDERAL REGULATIONS, MACRA, MACRA FINAL RULE, MANAGED CARE ORGANIZATIONS, MEDICAL LOSS RATIO