



---

**Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)  
*Improved Alignment with Medicare Advantage and Private  
Coverage Plans***

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.

***Alignment with Medicare Advantage and Private Coverage Plans***

As more individuals gain coverage as a result of the Affordable Care Act, coordination and alignment of Medicaid and CHIP standards with the private insurance market is increasingly important to improve operational efficiencies for states and health plans. Alignment of standards and requirements for health plans across insurance products can also improve the experience of care for individuals whose circumstances may change and who may transition between health care coverage options. Finally, this alignment can reduce administrative burden on regulators and issuers that offer products in several coverage programs and make it easier for managed care plans operating in other markets to also operate in Medicaid.

**Medical Loss Ratio (MLR)**

Medicaid and CHIP are currently the only health benefit coverage programs in which an MLR standard does not apply to managed care plans, although some states have adopted their own MLR standard or similar measure of health plans' administrative expenditures and profits. To promote alignment, and to ensure that capitation rates are actuarially sound, the final rule requires that Medicaid and CHIP managed care plans calculate and report an MLR. The standards for calculating the MLR are consistent with the standards applied by Medicare Advantage plans and the private market with some variation to account for the unique characteristics of the Medicaid and CHIP programs. Capitation rates must be developed in a manner so that managed care plans can be expected to reasonably achieve at least an 85 percent MLR and that MLR reports for prior years are taken into account.

**Appeals**

The final rule seeks to align many aspects of the Medicaid and CHIP managed care appeals process with that of Medicare Advantage and the private market. Specifically, the rule aligns definitions and timeframes for the resolution of appeals, streamlines levels of internal appeals, and requires that enrollees utilize the managed care plan's internal process before proceeding to a state fair hearing. Aligning appeal procedures across these areas provides consumers with a more streamlined appeals process and allows health insurers to adopt more consistent protocols across product lines and markets.

## **Consumer Information**

The final rule better aligns the scope of enrollee information and dissemination practices with the Medicare Advantage program and the private market. For example, the final rule permits states and Medicaid and CHIP managed care plans to use a range of communication methods, including mail, email, and website posting for the dissemination of required information while maintaining the ability of consumers to obtain these materials in paper form upon request and at no cost. Additionally, managed care plans must include provider directories and drug formularies on their websites.

## **Provider Screening and Enrollment**

The final rule contains an important program integrity provision to ensure that all providers participating in managed care networks are screened and enrolled by the state Medicaid program. As done in Medicare 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 final rule would not, however, require providers who participate in the Medicaid managed care plan 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.

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>