mhpa Medicaid Health Plans of America

Medicaid Managed Care: Comprehensive Compliance & Continuous Accountability

The Medicaid program is a joint federal and state partnership that provides free or low-cost health coverage to approximately 78 million Americans, including many low-income individuals, families and children, pregnant women, the elderly, and people with disabilities. Federal law sets overarching requirements for Medicaid programs, such as the coverage of certain benefits, but provides states substantial flexibility related to operational aspects of program implementation.

Managed care is the predominant Medicaid program delivery system in 40 states, Washington, D.C., and Puerto Rico, with managed care organizations (MCOs) providing comprehensive medical benefits and services to more than 70 percent of Medicaid enrollees.

Medicaid MCOs facilitate the delivery of quality care and services and are a critical source of health care coverage for people of color, individuals with disabilities, and additional underserved groups.

Subject to substantial federal and state oversight, Medicaid MCOs work to meet the needs of Medicaid enrollees by focusing on the delivery of care and services, quality, program integrity, and financial accountability, while ensuring compliance with statutory, regulatory, and contractual obligations.

Some examples of policies and processes that must be met by Medicaid MCOs are discussed below.

Federal Government Oversight

The Center for Medicaid and CHIP Services (CMCS) is the organization within the Centers for Medicare & Medicaid Services (CMS) responsible for administering the Medicaid program.

Withhold of Federal Financial Participation (FFP). CMS may withhold payment to the state due to either noncompliance of the state plan, or noncompliance by the state regarding federal requirements. Withheld funds can include payments for the federal share of payments to Medicaid MCOs. For states that are not in compliance with federal rules and regulations, CMS may require corrective action. Federal agencies work closely with states to monitor and oversee key aspects of Medicaid managed care arrangements such as network adequacy, quality measurement, and reporting requirements.

Standards & Processes

State plan amendments & waivers. States can implement a managed care delivery system via state plan authority or waiver authority. Under this delivery model, states pay Medicaid MCOs a capitation payment – a fixed periodic payment per beneficiary enrolled in an MCO, typically, per member per month.

Contracts. Each state choosing to engage with Medicaid MCOs must enter into a contractual arrangement with each participating Medicaid MCO for the contracting period, which is typically three to five years. Federal law establishes standards and processes for states opting to require managed care plan enrollment for all or some of the state's Medicaid beneficiaries. The Social Security Act sets forth

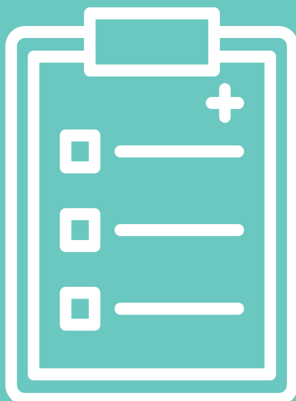
specific requirements for inclusion in these contracts and both the federal government and the contracting state have the right to audit and inspect the contract.

Federal regulations also require the inclusion of program integrity provisions in addition to other minimum standards and reporting requirements. States often include state-specific provisions, such as "customer service requirements, detailed provider network standards, state-specific financial solvency requirements, data collection and reporting requirements, claims processing and payment standards, and corrective actions."[i] These contracts, and any contract amendments, are subject to federal review by CMS.

Access to Care & Services

Network Adequacy and Access Assurances Report. Federal regulations require that Medicaid MCOs meet the state's requirement for network adequacy and access to care related to its provider network. The report is submitted to CMS at the same time as a state submits the associated managed care contract to CMS for approval. To protect against fraudulent providers, MCO network providers must be screened before enrolling in the state Medicaid program.

Prior authorization. Federal regulations require that Medicaid MCOs must send prior authorization decisions within three days for urgent requests and seven days for standard requests beginning in 2026. Medicaid MCOs must also give patients and providers a reason for denying a prior authorization request, as well as providing instructions on how to resubmit the request or appeal the decision.



External medical review and state fair hearing. Medicaid MCOs are required to establish an appeal process for enrollees to appeal an adverse benefit determination or claim denial, and some states provide for an external medical review of the adverse benefit determination. Under federal law, a state fair hearing can be requested for issues related to notice and timing requirements. Data and information on these policies are included in the Managed Care Program Annual Reports submitted to CMS.

Quality of Care & Services

Quality strategies and assessments. Federal law sets out the quality assessment and performance improvement requirements for Medicaid MCOs, which include having a managed care quality strategy, quality assessment and performance improvement program, and provisions for external quality review (EQR) and accreditation reporting.

Quality metrics. Medicaid MCOs must report to states on the core set of health care quality measures for children enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) and the core set of behavioral health measures for adults enrolled in Medicaid. Other quality information collected by state Medicaid programs to monitor and measure performance in Medicaid MCOs include the Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. These surveys allow states to monitor the performance of Medicaid MCOs and empower beneficiaries to choose health plans that fit their needs.

Quality Rating System. While federal regulations will require all states to issue annual quality ratings for each health plan to be displayed on the state's Medicaid website beginning in 2028, 13 states currently use rating systems for their Medicaid managed care programs.

State Monitoring System

Managed Care Program Annual Report (MCPAR). States are required to establish a monitoring system for all managed care programs and to submit a Managed Care Program Annual Report (MCPAR) after each contract year. The MCPAR focuses on Medicaid MCO performance in a minimum set of areas including:

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services (including the activities of the beneficiary support system)
- finance (including medical loss ratio reporting)
- information systems (including encounter data reporting)
- marketing
- medical management (including utilization management and case management)
- program integrity
- provider network management (including provider directory standards)
- availability and accessibility of services (including network adequacy standards)
- quality improvement
- areas related to the delivery of long-term services and supports (LTSS) not otherwise covered in other areas
- all other provisions of the MCO contract, as appropriate

Program Integrity

Compliance Program. Federal regulations require Medicaid MCOs to have in place a compliance program designed to guard against fraud, waste, and abuse. The compliance program must include:

- written policies, procedures, and standards to comply with all applicable federal and state standards
- a compliance officer and a compliance committee
- effective training and education for the compliance officer and the organization's employees
- effective lines of communication between the compliance officer and the organization's employees
- enforcement of standards through well-publicized disciplinary guidelines
- internal monitoring and auditing
- provisions for promptly responding to and correcting detected offenses

Medicaid Fraud Control Units. Under federal law, Medicaid Fraud Control Units (MFCUs) must investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in facilities or noninstitutional or other settings. MFCUs operate in each of the 50 States, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands. Medicaid MCOs must promptly report any issues related to potential fraud, waste, or abuse to the MFCU and the state Medicaid agency.

Financial Standards & Accountability

Capitated Rate Setting. Mandated by statute and codified in regulations, capitated payments to risk-based managed care plans must be made on an actuarially sound basis that typically apply for a 12-month rating period; these rates are reviewed and approved by CMS each year.

Medical Loss Ratio (MLR). Federal regulations enable states to establish a minimum federal MLR of 85 percent and to rescind a portion of payments to MCOs that fail to meet this standard, with 28 MCO states requiring MCOs to pay remittances when minimum MLR requirements are not met.[ii] This is sometimes referred to as a mandatory MLR.

Under the federal MLR rules, 85 percent of Medicaid MCO expenditures must be spent for the delivery of care, services, and quality improvement. States must report MCO MLRs with their annual rate certification to CMS regardless of whether they have in place a mandatory MLR. States are also required to use the MLR data to inform capitation rate-setting for future years. States have the option, however, to implement their own MLR threshold that exceeds the federal minimum. A 2021 Office of Inspector General Data Brief found that 92 percent of all plans achieved MLRs that met or exceeded the federal MLR standard of 85 percent.[iii]

State Enforcement Mechanisms

Quality Withhold. States may withhold a portion of a Medicaid MCO's capitation payment and release it fully or in part to the Medicaid MCO depending on its performance regarding the quality outcomes outlined in the Medicaid MCO contract.

Sanctions. A state may impose intermediate sanctions if it determines that a Medicaid MCO is not in compliance with federal regulations. These intermediate sanctions may include:

- civil monetary penalties.
- appointment of temporary management of an MCO.
- granting enrollees the right to terminate enrollment without cause.
- suspension of new enrollment, including default enrollment, in the MCO.
- suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the state is satisfied that the MCO is in compliance and likely to remain in compliance.

Termination of the Medicaid MCO contract. A state may terminate a Medicaid MCO's contract if certain conditions are met or not met as set forth in the contract.

[i] MACPAC, website, Key federal program accountability requirements in Medicaid managed care, at: https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/

[ii] Kaiser Family Foundation. Strategies to Manage Unwinding Uncertainty for Medicaid Managed Care Plans: Medical Loss Ratios, Risk Corridors, and Rate Amendments, at https://www.kff.org/medicaid/issue-brief/strategies-to-manage-unwinding-uncertainty-for-medicaid-managed-care-plans-medical-loss-ratios-risk-corridors-and-rate-amendments/

[iii] OIG Data Brief, Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets, August 2021, at: https://oig.hhs.gov/documents/evaluation/2813/OEI-03-20-00230-Complete%20Report.pdf