

Comparison of Existing Managed Care Plan Requirements and Preferred Requirement Standards for Financial Alignment Demonstration Plans (as of 12.20.11)

The chart below adapts information from the May 16, 2011 Federal Register Notice, Vol. 76, No. 94, which outlined, among other items, key differences between Medicaid and Medicare managed care administration requirements. This chart also describes pre-established parameters articulated in the July 8, 2011 Medicaid Director Letter, as well as MMCO's position on preferred requirements for States and plans participating in the capitated model, and authority needed to carry out this preferred position.

Issue	Federal Medicaid Requirements	Existing State Medicaid Requirements (State to complete)	Medicare Requirements	Pre-Established Parameter and/or Preferred Requirement Standard	Authority Needed to Implement Requirement	State-Specific Negotiated Standard (To be jointly completed)
1. Payment to Health Plans	<p>States must pay rates that meet CMS actuarial soundness requirements. States may also establish additional requirements, e.g. risk adjustment, quality incentives, and risk corridors. States have flexibility in their rate-setting methodology; most set rates, but some do require plans to submit bids. 42 CFR 436.6</p> <p>Plans may cover services above those required in the contract, but the cost of these may not be included in the payment rate. 42 CFR 438.6</p>		<p>Plans must submit Part C bid for monthly aggregate amount (Part C covered services and supplemental benefits) that meet CMS actuarial guidelines. Part C payments are linked to benchmarks connected to FFS experience and the plan's quality rating (see "Prescription Drug" row for Part D payment). Plans must share Part C rebates (a portion of savings for bids below the benchmark) with beneficiaries via premium reduction or supplemental benefits. CMS risk adjusts the bid and rebate payments for each plan. Plans are fully at risk and are not subject to risk sharing. 42 CFR 422 Subparts F and G.</p>	<p>Pre-Established Parameter: Plans will be paid on a capitated basis for the full continuum of Medicaid and Medicare Part C benefits provided to Medicare-Medicaid enrollees. No Part C or D premiums will be charged to beneficiaries.</p> <p>Rates for participating plans will be developed based on baseline spending in both programs and anticipated savings that will result from integrated managed care (SMD MOU template sec. III.I). As designed, aggregate savings compared to baseline costs will be "shared" proportionally by both States and CMS. Rates will be subject to OACT review.</p> <p>[Please see #3 below for additional payment information on Part D benefit]</p>	<p>Waiver of Medicare Advantage payment rules</p> <p>Waiver of Medicaid actuarial soundness</p>	

<p>2. Plan Selection</p>	<p>There is no Federal requirement that States accept all qualified plans, which means that States may limit the number of plans that can participate (though if there is mandatory enrollment they must generally assure a choice of at least two managed care entities). They may identify when new plans may seek to participate (e.g., may choose how often procurement happens). 42 CFR 438.52</p>		<p>Medicare has an annual contracting process, in which MA plans that apply and meet specified requirements may participate. Medicare generally cannot limit the number of plans an MA organization may offer, but does require that plans of the same type (e.g., HMO, PPO, PFFS) submitted by a given MA organization have “meaningful differences,” as well as minimum enrollment levels to renew. 42 CFR 422 Subpart K</p>	<p>Pre-Established Parameter: Utilize joint plan selection process, either procurement or certification process (where approved) to select limited number of qualified plans. (SMD MOU template sec. III.2)</p> <p>Preferred Requirement Standard: The joint selection process will take into account previous performance in Medicare and Medicaid.</p>	<p>Medicare waiver to do selective contracting</p>	
<p>3. Prescription Drugs</p>	<p>For non-dual eligible Medicaid beneficiaries, States may provide prescription drug coverage through FFS or managed care. States may use utilization management tools such as prior authorization or formularies. There is no Federal financial participation for prescription drug coverage for dual eligible beneficiaries who are eligible to enroll in a Medicare Part D plan (even if they are not actually enrolled).</p>		<p>Plans are paid four types of Part D subsidies: a direct subsidy, a reinsurance subsidy and two subsidies to cover premium and cost-sharing expenses for low-income beneficiaries. Plans submit bids for the direct subsidy, which are risk adjusted and subject to risk sharing. The reinsurance and low-income subsidies are 100% cost reconciled. Details on the Part D benefit may be found in:</p> <p>Part D Manual: https://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage</p> <p>Part D Applications: https://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage (Note: Applications are not currently posted.; the 2013 application will be posted at this link in early January)</p> <p>Part D Regulations 42 CFR</p>	<p>Preferred Requirement Standard: Participating health plans will be paid according to the regular Part D payment rules, with the exception that the direct subsidy will be based not on a bid submitted by each plan, but on the standardized national Part D average bid amount. This national average bid amount will be risk adjusted according to the same rules that apply for all other Part D plans.</p> <p>Plans participating in the demonstration would be required to meet all other Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data. However, they would not be required to submit a bid. Beneficiaries in the demonstration would not be subject to any Part D premiums, but would continue to be subject to standard LIS copayment levels.</p> <p>Part D requirements can be located at the following links:</p> <p>Part D Manual: https://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage</p>	<p>Medicare waiver of Part D payment</p>	

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<p>4. Enrollment -- General</p>	<p>Permits voluntary or mandatory enrollment into health plans, with CMS approval. States that mandate enrollment into managed care entities must permit one chance to change plans within first 90 days of enrollment; an annual opportunity to change plans; and disenrollment for cause at any time (but these changes are usually limited to changing among plans rather than back to FFS). States vary in entities they permit to accept enrollment (for example, enrollment brokers). 42 CFR 438.56</p>		<p>Permits voluntary, beneficiary-initiated enrollment into MA and Part D plans, generally with lock-in through the end of the year thereafter, and with an annual coordinated election period each fall during which plans may be changed effective January 1. There are Special Election Periods that permit individuals to change plans outside that timeframe, including a continuous SEP that permits dual eligible beneficiaries to change MA or PDP plans or disenroll back to Original Medicare at any time. Permits CMS to conduct passive enrollment into Part C and D plans in specific, limited circumstances, (e.g., to prevent beneficiary harm or as a result of immediate plan termination). Requires auto-enrollment of new dual eligibles into zero-premium Part D plans on a random basis (though they may disenroll at any time). 42 CFR 422 and 423 Subpart B</p>	<p>Pre-Established Parameter: For Medicare, States participating in the demonstration may request CMS approval for a passive enrollment process to enroll dual eligible beneficiaries into participating health plans. Passive enrollment will require advance notice and an option upfront for beneficiary to opt out (or switch health plans) as well as an opportunity for the beneficiary to disenroll after enrollment is effective (SMD MOU template sec. III.C.2). Existing Medicaid authorities and protections will be maintained. This includes the option to submit waiver requests and/or plan amendments, requiring CMS review and prior-approval.</p> <p>Eligible population is full duals (SMD MOU template sec. III.C.1).</p> <p>Preferred Requirement Standard: All enrollments must be operationalized in CMS' systems or through an alternative mechanism that ensures there is no duplication of coverage or payment.</p>	<p>Medicare waiver necessary for passive enrollment in absence of beneficiary harm</p> <p>Medicaid waiver necessary for mandatory enrollment</p>	

<p>5. Enrollment Effective Date</p>	<p>There are no federal requirements on when a contract year must start, so it varies by State. States with lock-in must offer an annual chance to change plans.</p>		<p>The contract year starts January 1. For individuals subject to lock-in, there is an “open enrollment” period October 15-December 7 in which they can change plans, for an effective date of January 1 of the following year.</p> <p>Dual eligibles’ Special Enrollment Period permits them to change up to monthly, with an effective date of the first of the following month.</p>	<p>Preferred Requirement Standard: For purposes of minimizing beneficiary disruption and confusion, ensure that passive enrollment process coincides with the underlying MA and Part C/D timeline such that beneficiary notice of demonstration options occurs prior to the annual coordinated election period (October 15 –December 7) in 2012.</p>		
<p>6. Medical Loss Ratio (MLR)</p>	<p>There is no federal Medicaid requirement for MLR.</p>		<p>Beginning in 2014 contract year MA plans will be required to maintain an MLR of at least 85%.</p>	<p>Pre-Established Parameter: There will not be a minimum MLR requirement in the demonstration. However, participating plans will be required to report on costs to ensure transparency and facilitate evaluation, so we expect to have MLR information to determine what portion of premium participating health plans are spending on medical costs.</p>	<p>Consider any necessary Medicare exemption from MLR</p>	
<p>7. Solvency</p>	<p>Plans must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the entity’s debts if the entity becomes insolvent. Several types of entities are not subject to this requirement, including Federally qualified HMOs, as defined in section 1310 of the Public</p>		<p>Defers to State licensure requirement (i.e., requires the MA plans to meet State solvency and licensure standards).</p> <p>Each MA organization must be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers one or more MA plans. If not commercially licensed, it must obtain certification from the State that the organization meets a level of financial solvency and such</p>	<p>Preferred Requirement Standard: Medicaid, as Medicare requirements already cede to State licensure and solvency requirements. However, in other areas related to the operation of an MA plan, federal law preempts state law (42 CFR 422.402)</p>	<p>Potential waiver Medicare requirement related to timing (i.e., to meet solvency standard)</p>	

	<p>Health Service Act, public entities, entities whose solvency are guaranteed by the State, Federally qualified Health Centers or Rural Health Centers receiving grants from HRSA (or entities controlled by these centers) or entities who had prepaid risk contracts with States prior to 1970.</p> <p>Except as noted above, entities must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. 1903(m)(1)(A) and (B); 42 CFR 438.116</p>		<p>other standards as the State may require for it to operate as an MA organization. 42 CFR 422.400</p>			
<p>8. Network adequacy</p>	<p>Medicaid managed care contracts must require the plan gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.</p> <p>Among other requirements, plans must maintain a network of providers that is sufficient in number, mix, and</p>		<p>Medicare Advantage requires that plans must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.</p> <p>Also, plans must provide or arrange for necessary specialty care. The MA organization arranges for</p>	<p>Preferred Requirement Standard: Use State Medicaid standards for long term care networks and use Medicare standards for medical services and prescription drugs.</p> <p>Demonstration plans will be able to utilize an exceptions process in areas where Medicare network standards may not reflect the number of dual eligible beneficiaries. Plans will be required to use Medicare network adequacy standards and review processes during plan selection process and network adequacy will be subject to confirmation through readiness reviews.</p> <p>For areas of overlap where services are covered under both Medicaid and Medicare, the appropriate network adequacy standard will be determined via MOU negotiation and memorialized in</p>	<p>MA deadline to have demonstrated network adequacy may need to be extended consistent with the plan selection process in the demonstration.</p>	

	<p>geographic distribution to meet the needs of the anticipated number of enrollees in the service area. 42 CFR 438.207</p>		<p>specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. 42 CFR 422.112</p> <p>Exceptions to the Criteria CMS recognizes that in certain cases, an applicant's contracted network may not meet the provider network adequacy criteria. In such cases, the applicant may request an exception, from a pre-defined list created by CMS, for a specific provider/facility type in a specific county. These exceptions are detailed in the CMS Health Services Delivery Tables Exceptions Guidance.</p> <p>Plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies. 42 CFR 423.120</p>	<p>three-way contracts with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.</p> <p>Note: Part D requirements will continue to be applied; see #3 for details.</p>		
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<p>9. Out of Network Reimbursement</p>	<p>With the exception of Emergency services, for which hospitals are required to accept the Medicaid state plan rate, Medicaid does not impose requirements on plans related to out-of-network payment levels, which sometimes results in plans being at risk for high payments, e.g. if imposed by highly specialized providers.</p>		<p>Medicare requires out of network coverage for urgent/emergent services. 42 CFR 422.113(b)(2). For those services, plans must pay non-contract providers (and those providers must accept payment) at Medicare FFS level. 42 CFR 422.214</p>	<p>Preferred Requirement Standard: FFS payment rate is required to be paid by plan and accepted by provider, as provided for in federal regulation and applicable State law and regulations.</p> <p>Note: Part D requirements will continue to be applied; see #3 for details.</p>	<p>No Federal authority necessary.</p>	
<p>Appeals: Pre-Established Parameter: the demonstration will include a uniform appeals process. We recognize that in some States this may require regulatory changes or legislative approval, which could take some time; all contracts will require changes to be undertaken as expeditiously as possible. We also recognize that there are other circumstances (e.g. court orders) that may make certain aspects of a uniform appeals process a challenge. Note: Unless indicated otherwise, Part D appeal standards will remain unchanged.</p>						
<p>10. Appeals – Timeframes for filing an appeal related to benefits</p>	<p>Appeals may be filed via the State fair hearing process (sometimes after exhaustion of plan appeals) anywhere between 20 and 90 days (varies by States). 42 CFR 438.408.</p>		<p>Part C: Appeals must be filed within 60 days. 42 CFR 422.582 (reconsideration) 42 CFR 422.592 (IRE), 42 CFR 422.602 (ALJ).</p>	<p>Preferred Requirement Standard: Medicare – 60 days to file an appeal. If it is not possible for State to change Medicaid time frames currently in State regulation by 2013, use Medicare standard unless State Medicaid standard is more generous (i.e. allowable timeframe is greater than 60 days).</p>	<p>None, assuming State can make needed regulatory changes for Medicaid. If those regulatory changes are not instituted during the demonstration timeline, a waiver of Medicare statutory timeframe requirements would be needed to follow State requirements are more generous than Medicare standards (e.g. allowable filing time greater than 60 days).</p>	

<p>11. Appeals – Access to State level or external review</p>	<p>All States must provide access to a State Fair Hearing, either directly or (if the State requires exhaustion of the health plan level of appeal) after an initial appeal to the health plan. 42 CFR 431.205 and §438.408; and section 1902(a)(3) of the Act. Some States provide access to Ombudsman or Independent Review Entities for those enrolled in managed care.</p>		<p>Part C and D: Medicare allows beneficiaries in private health plans to access Independent Review Entities, but only after the filing of an initial appeal to a plan. 42 CFR 422.578, 422.592 for Part C; 42 CFR 423,580, 423, 600 for Part D.</p>	<p>Preferred Requirement Standard: Medicare – internal appeals should ideally go through the plan first, and then external appeals should go through the Medicare qualified independent contractor.</p> <p>However, some States enable beneficiaries to bypass plan internal appeal processes and seek out external appeals immediately. Absent regulatory change– the MMCO will not have the authority to prevent beneficiaries from seeking out external appeals through these channels prior to internal appeals processes in such States. Accordingly, States will be encouraged to provide—via contract, regulation or both—for initial appeals to be made via the plan first.</p>	<p>None, assuming regulatory changes on the State Medicaid side, if applicable.</p>	
<p>12. Appeals – Continuation of benefits pending appeal</p>	<p>Medicaid benefits generally continue and are paid for pending a timely appeal (FFP is available for these costs), when the appeal is requested within a certain timeframe. Note: this standard applies to reduction or termination of items or services. States also may reinstate benefits if requested within 10 days of the date of action (States vary). 42 CFR 431.231. Section 1902(a)(3) of the Act; 42 CFR 431.205; §438.420 (managed care). The State may seek recovery against the beneficiary if he or she loses the appeal.</p>		<p>Other than terminations of inpatient hospital care or other services by a “provider of services” (such as a nursing home or home health agency, which are covered regardless of the outcome of the initial level of appeal), benefits do not continue during the pendency of a Medicare appeal involving reduction or termination of items or services.</p>	<p>Preferred Requirement Standard: Hybrid – during internal plan review, benefits should be continued (per Medicaid standard), however once appeals reach external level, benefits not continued (per Medicare standard). Note: only benefits that are initially provided and subsequently reduced or terminated may continue pending an initial appeal.</p>	<p>Medicare waiver to require plan to pay for service during internal appeal</p>	

<p>13. Appeals – Document notifying beneficiaries of appeal rights</p>	<p>Various documents may be used to notify beneficiaries of their appeal rights depending upon the State. Regulations require that information about appeals be included at the time of application, with a notice of adverse action on a claim, at the time of transfer or discharge from a SNF. 42 CFR 431.206. Also there are requirements of providing notice to beneficiaries enrolled in managed care organizations during terminations, suspensions, reductions in service, denial of payment, among others. 42 CFR 438.404.</p>		<p>Medicare Part C: Various denial notices are sent for specific coverage denials, and the Evidence of Coverage contains specific enrollee guidance regarding appeal rights.</p> <p>Medicare Part D: Various denial notices are sent for specific coverage denials, and the Evidence of Coverage contains specific enrollee guidance regarding appeal rights.</p>	<p>Preferred Requirement Standard: Hybrid – one document that explains integrated appeals process.</p>	<p>Note: certain States may be under court order that requires a specific form to be used, and those will be addressed on a case-by-case basis.</p>	
<p>14. Appeals – Timeframes for resolution of an appeal related to benefits</p>	<p>Standard appeals must generally be handled within 45 days, with extensions available in certain circumstances. Expedited appeals are to be handled within 3 working days, with extensions up to 14 calendar days in certain circumstances. 42 CFR 438.402, and §438.408.</p>		<p>Part C and D: Standard plan reconsiderations must be resolved within 7 days (Part D) or 30 days (Part C). Expedited reviews are to be conducted within 72 hours.</p>	<p>Preferred Requirement Standard: Medicare -- 30 days for standard appeals per the Medicare Part C standard, and 72 hours for expedited appeals per the Medicare standard.</p>	<p>States have the authority under Federal Medicaid regulations to make these changes, but doing so may require regulatory or contractual changes at the State level.</p>	

<p>15. Benefits/ Medical Necessity</p>	<p>Each State must ensure that all services covered under the State plan and are included in the plan contract are available and accessible to enrollees to the extent they are in FFS, and using a medical necessity definition that is no more restrictive than that used in the State's Medicaid program. 42 CFR 438.210(a)(4)</p>		<p>Medicare covers medically necessary Part A and B services, i.e., those that are necessary for the diagnosis or treatment of illness or injury or to improve the functioning of malformed body members. If there is a question about new services, CMS will issue a national coverage determination or local decisions will be articulated in Local Medical Review policies. MA plans may also offer supplemental benefits beyond those required under Medicare Parts A and B (e.g., dental care and vision benefits). Section 1862(a)(1)(A) of the Act. 42 CFR §422.101 and §422.102.</p>	<p>Pre-Established Parameter: CMS and State may choose to allow for greater flexibility in supplemental benefits than currently permitted under either program, provided that they are in the blended rate. (SMD MOU template sec III.D.1).</p> <p>Preferred Requirement Standard: Medicare standards for acute services and prescription drugs and Medicaid standards for long term care services and supports, where there is overlap coverage will be determined by contract.</p>	<p>None on the Medicare side or Federal Medicaid side.</p>	
<p>16. Marketing/ Beneficiary Information</p>	<p>Medicaid defines marketing as communication to non-enrollees with intent to persuade them to enroll. Cold calls are prohibited. Marketing materials must be prior approved by State. States may prohibit plan marketing altogether. 42 CFR 438.104</p> <p>Plans must also provide specified information to potential enrollees as well as to enrollees (these are not considered "marketing."). The State must specify language and readability thresholds. 42 CFR 438.10</p>		<p>Medicare defines marketing as communications to potential enrollees as well as enrollees (certain ad hoc communications to enrollees are exempted). MA organizations and Part D sponsors must meet certain minimum requirements with respect to disclosure of plan information and marketing limitations. CMS must prior approve most marketing material (though there is a "file and use" process for plans that does not require prospective CMS review of certain marketing materials). CMS may require plans to use certain standardized model marketing materials and notices. Plans must translate materials if language is spoken by 5% of enrollees at plan benefit package level. 42 CFR 422.111, §423.128, Subpart V of Part 422, Subpart V of Part 423.</p>	<p>Pre-Established Parameter: Flexibilities include unified marketing requirements/review process. Enrollee materials shall be integrated to the extent possible, and be required to be accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency. CMS and State will prior approve all outreach and marketing materials, subject to single set of rules (SMD MOU template sec. I; III.C.4; III.E.2).</p> <p>Note: Part D requirements will continue to be applied; see #3 for details.</p> <p>Preferred Requirement Standard: A flexible approach to both minimum marketing requirements and review processes. Consistent set of required beneficiary information. For readability and translation standards, defer to whichever standard is more beneficiary-friendly.</p>	<p>None, unless specific Medicare statutory or regulatory requirements need to be waived</p>	

			As specified in subregulatory guidance, there are a broad range of standardized and model documents under the MA and Part D programs, some of which apply generally to all MA plans, but some of which were designed specifically for SNPs.			
17. Quality - Reporting measures	Federal Medicaid regulations require States to have plans report performance measures (with State specifying the measures). States may require measures to be reported on State contracting cycles (which may differ from Federal cycles). 42 CFR 438.240(d)		<p>MA plans must generally: “measure performance under the plan, using the measurement tools required by CMS, and report its performance to CMS. The standard measures may be specified in uniform data collection and reporting instruments required by CMS.” 42 CFR 422.152</p> <p>Reporting requirements also detailed here: http://www.cms.gov/HealthPlansGenInfo/Downloads/PartCTechSpecs_Oct11.pdf</p> <p>SNPs have additional requirements to measure performance under the plan, using the measurement tools required by CMS, and report performance to CMS. They must also provide outcome measures that are reported as part of materials beneficiaries use to select plans. 42 CFR 422.152(b)(3).</p> <p>SNP HEDIS measure requirements, as of 2009, are available here: http://www.cms.gov/SpecialNeedsPlans/Downloads/2009_SNP_HEDIS_Reporting_Requirements.pdf</p> <p>CMS, together with the NCQA, has also developed six structure and process measures for SNPs.</p>	<p>Pre-Established Parameter: CMS and State shall determine applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process.(SMD MOU template sec. III.G.3, III.H.1 -3)</p> <p>Preferred Requirement Standard: Require strong, consistent quality oversight and monitoring requirements. Quality requirements will be integrated but will include some measures currently used by Medicaid and Medicare. The core set of measures will allow quality to be evaluated and compared with other plans in the model as well as other non-model plans.</p> <p>Prescription drug quality reporting measures will be at least consistent with Medicare Part D requirements.</p>	Could require waiver of certain Medicare and/or exemption from Medicaid reporting requirements	

<p>18. Quality – Performance Improvement</p>	<p>Performance Improvement Plan: The State must require, through its contracts, that each managed care entity have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. 42 CFR 438.240</p> <p>Role of External Reviewer: States must contract with an External Quality Review Organization for each contract. 42 CFR 438.350</p>		<p>Performance Improvement Plan: Medicare requires the development of an ongoing quality improvement program, including submission of chronic care improvement programs and quality improvement projects for each MA plan. 42 CFR 422.152</p> <p>Role of External Reviewer: CMS is permitted to use quality improvement organization data for various functions. 42 CFR 422.153</p>	<p>Pre-Established Parameter: CMS and State shall determine applicable standards, and jointly conduct a single comprehensive quality management process. (SMD MOU template sec. III.H.1 -3)</p> <p>Preferred Requirement Standard: Advance an integrated quality/performance improvement program for plans, and have a single entity receive and review this integrated report and other quality measures. This reduces administrative burden on plans to have integrated reporting requirements; further, in some States the same contractor fulfills the EQRO and QIO function.</p>	<p>Could require Medicare waiver or exemption from existing Medicaid standard</p>	
<p>19. Quality Incentives</p>	<p>States may provide for incentive payments if plans meet certain targets (including quality). 42 CFR 438.6</p>		<p>MA has quality bonuses based on star ratings. 42 CFR 422.260</p>	<p>Pre-Established Parameter: Participating plans will not be eligible for star bonuses. Plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the demonstration). Plans will be able to earn back the capitation revenue if they meet quality objectives.</p>	<p>Will require waiver of Medicare bonus program</p>	
<p>20. Model of Care</p>	<p>Medicaid requirements do not specifically reference “model of care,” but do require State contracts with plans include primary care source, coordination of other services, and for special needs individuals, an assessment and treatment plan. 42 CFR 438.208</p>		<p>Under the MA program, a Special Needs Plan is required to have a model of care, in addition to standard MA requirements for care coordination. In addition, all plans that offer Part D are required to have a medication therapy management program.</p> <p>Starting in 2012, all SNPs’ models of care must be approved by NCQA based on CMS standards. 42 CFR §§ 422.4(a)(iv), 422.101(f), and 422.152(g),</p>	<p>Preferred Requirement Standard: Unified model of care requirements for participating health plans.</p>	<p>None</p>	

<p>21. Oversight Monitoring Auditing Program Integrity</p>	<p>CMS Medicaid regulations require generally a plan must comply with the applicable certification, program integrity and prohibited affiliation rules and requirements. 42 CFR 438.600 et. seq.</p> <p>CMS Medicaid regulations require State agencies to monitor plan operations, including, at a minimum:</p> <ul style="list-style-type: none"> - Recipient enrollment and disenrollment. - Grievances and appeals - Violations subject to intermediate sanctions - Violations of conditions for Federal payment. <p>42 CFR 438.66</p>		<p>Medicare contracts with plan specify inspection and auditing rights.</p>	<p>Pre-Established Parameter: CMS-State contract management team to ensure access, quality, program integrity, and financial solvency, including reviewing/acting on data/reports; conducting studies/ corrective action.</p> <p>Preferred Requirement Standard: Coordinated oversight, as negotiated and determined in MOU or contract. States may conduct auditing function and monitor plans for compliance with demonstration standards if they can establish to CMS' satisfaction that its standards meet or exceed Medicare's.</p> <p>Note: Part D requirements will continue to be applied; see #3 for details. States will be informed of results found and actions taken.</p>	<p>None (these processes are determined by CMS largely in the contract)</p>	
<p>22. Encounter Data: Collection and Validation</p>	<p>States must collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees, through an encounter data system or other methods as may be specified by the State. 42 CFR 438.242</p> <p>EQRO entities may perform encounter data validation functions for the State.</p>		<p>CMS has authority to collect information from MA plans to justify each item and service provided by plan, and has imposed specific encounter data reporting requirements on plans starting with contract year 2012. 42 CFR 422.310.</p>	<p>Preferred Requirement Standard: Uniform encounter reporting.</p> <p>Note: Part D requirements for reporting Prescription Drug Event (PDE) data will continue to be applied; see #3 for details.</p>	<p>None on the Medicare side or Federal Medicaid side</p>	

<p>23. Credentialing</p>	<p>Each State must establish a uniform credentialing and recredentialing policy that each plan must follow. These must include anti-discrimination provisions for providers that serve high-risk populations or specialize in conditions that require costly treatment. 42 CFR 438.214</p>		<p>MA organizations must have written policies and procedures for the selection and evaluation of providers that conform to Medicare requirements. "Providers of Services" must have a Medicare provider agreement in place.</p>	<p>Preferred Requirement Standard: Medicaid standards apply, i.e., plans can use Medicaid standards for certifying that participating providers are credentialed.</p>	<p>None on the Federal Medicaid side.</p>	
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