Program Accountability, Integrity, and Data

Federal and state spending on Medicaid and CHIP total more than $400 billion a year, accounting for more than 15 percent of U.S. health care spending (MACPAC 2011). Given the magnitude of these programs, federal and state governments have a statutory obligation to know whether or not they are paying appropriately for quality care and whether enrollees have adequate access to necessary care.

For states seeking to use managed care in their Medicaid programs, the federal government sets broad operational and administrative requirements related to payment rates to providers, provider availability in the plan network, provision of covered health care services, and quality of care for enrollees. Within these parameters states have flexibility in how they design and administer their programs and monitor participating plans. Subject to federal approval, states determine what covered services should be the responsibility of the managed care plans, which Medicaid enrollees should have managed care as an option, and whether enrollment is mandatory or voluntary. Both the federal and state agencies that oversee Medicaid are responsible for ensuring that mechanisms are in place to assure appropriate use of services and to detect and deter fraud, waste, and abuse.

This section describes:

- broad federal authority and program accountability requirements in states' Medicaid managed care programs;
- federal and state tools to improve program integrity; and
- some of the available data used for program accountability and integrity, and the data limitations that can hamper those efforts.

Broad Federal Authorities for Managed Care in Medicaid

States can implement managed care in their Medicaid programs under multiple federal authorities (Box F-1). The Social Security Act (the Act) allows states to mandate managed care enrollment and to waive certain other federal Medicaid requirements through a program waiver, a demonstration waiver, or a state plan amendment.[1] Twenty states and the District of Columbia now operate at least some aspect of their managed care program using this state plan option—up from 10 states in 2002 (KCMU 2010). For additional details on Medicaid managed care waiver and state plan authorities, see Table FA-1 in Section F Annex 1 of this Report.

Program Accountability

In order to receive federal Medicaid funds, states must meet numerous requirements regarding the proper and efficient administration of their Medicaid programs, including states' use of managed care in Medicaid. Over time, as the Congress has altered federal Medicaid law to provide new flexibilities for states' use of managed care, it has also added provisions to ensure that the federal government holds states accountable and that the states hold managed care plans accountable for the services they have agreed to provide to enrollees.

Under fee-for-service (FFS) Medicaid, the state pays providers directly for the services they provide. Under managed care, states often pay plans a fixed amount and allow the plans to pay providers a negotiated rate. Doing so, however, does not permit the state to shift to plans its federally mandated responsibility to ensure appropriate payment, access, and quality as required under federal law and regulations.

Indeed, the use of managed care brings some additional responsibilities to the state. The state must now ensure its contracts with plans meet relevant federal requirements and that appropriate safeguards are put in place for monitoring plan performance. In addition, as states move to managed care, the skill sets of staff may need to change. For additional details on managed care contracts, see Section F Annex 2 of this Report.

Key Federal Program Accountability Requirements in Managed Care

Federal law stipulates that states can receive federal Medicaid reimbursement for their payments to Medicaid managed care entities only if their contracts include certain provisions.[2] Federal statutory requirements on state contracts with these plans include, but are not limited to, the following (§1903(m)(2)(A)):

- The federal Department of Health and Human Services (HHS) and the state shall have the right to audit and inspect any books and records of the entity.
- The plan may not discriminate on the basis of enrollees' health status.
- Individuals can disenroll within the first 90 days without cause and then at least every 12 months thereafter.

[1] The Balanced Budget Act of 1997 (P.L. 105-33) gave state Medicaid programs the authority to mandate managed care enrollment without a waiver, except for certain children with special needs, Medicare beneficiaries, and American Indians. There are also federal requirements related to the enrollment of American Indians into Medicaid managed care. For example, a state may not require tribal members to enroll in managed care or a PCCM program, except when the entity is the Indian Health Service; an Indian health program operated by a tribe or a tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service; or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

[2] See §1903(m)(2)(A) of the Act. This subparagraph also links to applicable requirements of §1932 per §1903(m)(2)(A)(xii).

BOX F-1. Key Federal Medicaid Managed Care Waiver Authorities

Section 1115 Research and Demonstration Waivers (17 states)	Allows states to test an "experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs" covered by the Social Security Act, including: ► Waiving statewideness requirements related to eligibility, benefits, and service delivery and payment methods used by the state to administer the managed care program. ► Identifying savings in the demonstrations to offset the cost of any program change, which can include managed care savings, to maintain budget neutrality.
Section 1915(b) Managed Care/Freedom of Choice Waivers (25 states)	Allows states to implement managed care and to limit individuals' choice of providers under Medicaid. States can also: ► Waive statewideness requirements (e.g., provide primary care case management or comprehensive risk-based managed care in a limited geographic area). ► Waive comparability requirements (e.g., provide enhanced benefits to managed care enrollees).
Combined Section 1915(b)/(c) Waivers (8 states)	Allows states to use two waiver authorities to provide home and community-based services to elderly or disabled Medicaid populations through their managed care programs, or to use a limited pool of providers to provide these services. Some states use combined 1915(b)/(c) waivers to implement limited-benefit plans for specific services, such as prepaid inpatient health plans for behavioral health services. Other states use these waivers to provide integrated acute and long-term care services through a managed care delivery system for elderly and/or disabled Medicaid populations. To implement concurrent 1915(b)/(c) waivers, states must meet all federal requirements, such as cost neutrality in the 1915(c) and cost effectiveness in the 1915(b) waiver.

Note: Section 1915(c) Home and Community-Based Services waivers allow states to provide home and community-based services as an alternative to institutional care in nursing homes, intermediate care facilities for the mentally retarded (ICFs/MR), and hospitals. States can provide targeted sets of services to specific populations including, for example, people with physical disabilities or HIV/AIDS, people with developmental disabilities, and people with traumatic brain injuries.

Source: The number of states operating managed care waivers from CMS 2010

- The plan must maintain patient encounter data and provide the data to the state at a frequency and level of detail specified by HHS.

In addition to states' own provisions to address plans' noncompliance, federal law stipulates that if a plan fails to provide the agreed-upon medically necessary services, charges premiums in excess of those permitted, or incurs other specified violations, the HHS Secretary may impose certain penalties, "in addition to any other remedies available under law." These include civil monetary penalties on the plan, as well as denial of federal Medicaid payments to the state for amounts paid under the contract (§1903(m)(5)(B)).

As discussed in greater detail in Section F Annex 2 of this Report, federal requirements related to states' contracts with plans pertain to the adequacy of provider networks, actuarial soundness, and other requirements. States are often given considerable flexibility in how they operationalize these requirements and determine how the plans meet them. For example, states vary considerably in how they measure, monitor, and evaluate the adequacy of provider networks. Common requirements include specific enrollee-to-provider ratios, travel time and distance standards, and other metrics such as wait times for appointments. States may require managed care plans to submit routine network adequacy reports (e.g., updated ratios, provider panel status, geographic analyses) or ad hoc data in the event of a suspected network access issue.

To establish an adequate network, plans must consider:

- anticipated Medicaid enrollment;
- expected service use, taking into consideration the specific characteristics and health needs of the Medicaid enrollees who will be enrolled in the plan;
- the number and types of providers required to provide the contracted services;
- the number of network providers who are not accepting new Medicaid patients; and
- the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation generally used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

Other examples of federal managed care requirements include:

- standards for timely access to care and services, taking into account the urgency of the need for such services;
- network providers who offer hours of operation that are no fewer than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS providers;
- making contracted services available 24 hours a day, seven days a week, when medically necessary; and
- mechanisms to ensure compliance by providers through monitoring and applying corrective actions for noncompliance.

States are required to provide enrollees and prospective enrollees with information explaining the managed care program, including basic features such as benefits covered, cost sharing and carve outs, and populations excluded or exempted from managed care enrollment (42 CFR 438.10).

Federal requirements also address enrollees' rights (42 CFR 438 Subpart C). Plans must have written policies regarding enrollees' rights, including but not limited to receipt of easily understood materials and information on treatment options and alternatives, participation in health care decisions, request and receipt of personal medical records, and ability to receive health care services in accordance with federal laws. All information such as enrollment notices and instructional materials must be communicated in a manner and format that is easily understood and takes into consideration the special needs of the certain populations (e.g., persons with limited vision or those with limited reading proficiency).

In addition, federal regulations (42 CFR 438 Subparts D-E) provide states with a baseline set of requirements for monitoring and assessing the quality of care provided to Medicaid managed care enrollees. States are required to have in place strategies for monitoring plans' quality and performance in order to assess the quality and appropriateness of care and services provided to all Medicaid enrollees under managed care contracts. For example, as described in Section E of this Report, many states require plans to provide quality and performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS)[3] and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).[4] Although there is an effort underway for states to report such measures voluntarily to the federal government for children enrolled in Medicaid and CHIP, results are not currently available for cross-state comparisons of Medicaid managed care programs.

States must also require each plan to have an ongoing quality and performance improvement program for the services it provides to its enrollees. At least annually states must review the impact and effectiveness of each plan's quality assessment and performance improvement program. Finally, each state must ensure that a qualified external quality review organization (EQRO) performs an annual external quality review (EQR) for each contracting plan. States are required to report to CMS the EQRO's validation of certain measures, not the results of the measures themselves. Moreover, an analysis by CMS found that states' EQROs used a variety of measures such that no nationally standardized information is currently available from EQROs (HHS 2010).

Program Integrity

As an integral component of program accountability, program integrity (PI) efforts seek to ensure proper payment for appropriate, high quality services in both FFS and managed care. This includes addressing not only fraud, waste, and abuse by providers and enrollees, but also program management issues.

Federal Program Integrity Efforts

To address concerns about the program's vulnerability to financial losses and previously low levels of resources devoted to PI, the Congress has provided new requirements and funding for these activities in recent years. The Deficit Reduction Act of 2005 (P.L. 109-171) provided additional dedicated funding for Medicaid PI activities, including the establishment of a Medicaid Integrity Program (MIP), which supports states in their efforts to combat fraud, waste, and abuse. MIP also conducts provider audits, identifies overpayments, and educates providers and others about PI issues.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) created additional requirements to increase uniformity and improve Medicaid PI activities. These efforts include additional provider screening requirements, creating an integrated Medicare and Medicaid data repository to enhance data sharing among federal and state agencies and law enforcement officials, requiring states to contract with recovery audit contractors to identify underpayments and overpayments and to recoup overpayments, and strengthening requirements related to the termination of providers participating in Medicaid if they have been terminated under Medicare or other state health care programs.

[3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[4] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, which oversees the survey.

State Program Integrity Efforts

State efforts to address PI issues include both designing and managing Medicaid programs to prevent fraud, waste, and abuse and also having appropriate systems in place to identify problems when they occur. Program management efforts can include, for example, data systems coordination to prevent inappropriate payments for their enrollees in managed care (e.g., not paying FFS claims for an enrollee who is in managed care or not making capitation payments to multiple plans for one enrollee).

Program integrity efforts also include utilization management, such as requiring prior authorization of certain services, prospective and retrospective service reviews, and outreach to providers and enrollees to correct inappropriate utilization practices. Because Medicaid is the payer of last resort, PI also includes taking reasonable measures to determine legal liability of third parties and, if third party liability (TPL) exists, attempting to ensure that the provider bills the third party before sending the claim to Medicaid or recovering money from the third party when the state discovers it has paid a claim in error (42 CFR 433.138).

As part of federal efforts to identify improper payments,[5] states must submit information to CMS for estimating improper payments in the FFS and managed care components of their Medicaid program and determining whether eligibility decisions were made correctly. This process, known as Payment Error Rate Measurement (PERM), uses a statistically valid random sample of claims and eligibility determinations to determine error rates.[6] Each state must develop a corrective action plan to reduce improper payments based on the error causes identified and is required to return the federal share of overpayments to CMS (42 CFR 431 Subpart Q).

A state's ability to detect fraud and abuse once it has occurred requires adequate data and information, including encounter data. Under federal regulations, states must have methods and criteria for identifying suspected fraud and abuse. They must have established procedures for affording due process and for protecting the legal rights of those involved, but also for referring cases to law enforcement officials when appropriate (42 CFR 455.13).

Upon receipt of a complaint of fraud or abuse or identification of questionable practices, the state Medicaid agency must conduct a preliminary investigation. If there is a sufficient basis to warrant a full investigation, depending on the circumstances, the agency may conduct the investigation itself, refer the case to the Medicaid Fraud Control Unit (MFCU),[7] or to the appropriate law enforcement agency. An investigation will continue until appropriate legal action is initiated, the case is closed or dropped because of insufficient evidence, or the matter has been resolved between the agency and the individual or entity under investigation (42 CFR 455.14-16).

As a way to initially screen and provide ongoing monitoring of providers, the Medicaid state plan must ensure that providers and fiscal agents disclose certain information for each person with at least a 5 percent ownership or controlling interest in the entity and agree to provide information related to business transactions upon request (42 CFR 455 Subpart B).

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[5] Improper payments are defined as any payment that should not have been made or that was made in an incorrect amount. The Improper Payments Information Act of 2002 (P.L. 107-300) requires federal agencies to review and identify annually those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments, report such estimates to the Congress, and submit a report on actions the agency is taking to reduce erroneous payments.

[6] PERM is usually conducted on a rotating basis in 17 states annually.

[7] MFCUs investigate and prosecute Medicaid fraud, as well as review complaints of abuse and neglect in health care facilities.

Managed Care Plan Program Integrity Efforts

In states with managed care programs, PI efforts extend to the plans, as they are required to follow all applicable federal and state PI requirements. States generally include specific PI requirements in their contracts with plans. Although states monitor plan PI efforts, plans have their own incentives to identify and address possible fraud and abuse because they are paid a capitated rate for each enrollee in their plan. In the event that there is undetected fraud, waste, and abuse in managed care, however, this cost could be passed on to the state in the form of increased future capitation payments.

Data for Program Accountability and Policy Development

Data reported by managed care plans and states provide important information for answering key policy and program accountability questions. For example, data are necessary to monitor trends and make projections on spending, service use, and the quality and appropriateness of care. However, data submitted by managed care plans to states and by states to CMS vary in their consistency, availability, and timeliness. This variability creates challenges for analyzing and monitoring managed care programs and limits the ability to compare states. Section 4 of MACStats provides more information on issues that should be noted when examining managed care statistics from different data sources.

Managed Care Encounter Data

All states that contract with managed care plans collect encounter data that provide a record of the services furnished to Medicaid enrollees. However, many states do not report these data to the federal government in the Medicaid Statistical Information System (MSIS) as required (OIG 2009). Among states that do report encounter data in MSIS, the quality of the data are largely unknown. CMS recently began a project to explore this issue and provide technical assistance to states. It is also developing a regulation on the submission of encounter data in MSIS. As discussed in MACPAC's March 2011 Report to the Congress, these data could be used for a number of purposes, including national and cross-state comparisons of the care received by enrollees in FFS versus managed care systems—which some states already do on an individual basis.

Managed Care Enrollment Report

States report information on their managed care programs through the Medicaid Managed Care Data Collection System (MMCDCS). From this, CMS produces an annual Medicaid Managed Care Enrollment Report that provides national, regional, and state-level point-in-time enrollment statistics for enrollees in managed care programs of various types (CMS 2010).[8] In addition to higher-level enrollment data, this report also includes the following plan-specific data: plan name, managed care entity, reimbursement arrangement, operating authority, geographic area served, number of enrollees by plan, and number of dual eligibles by plan.

[8] Reports are based on data for June 30 of each year.

Medicaid Statistical Information System (MSIS)

MSIS is a data source compiled by CMS from detailed eligibility and claims information reported by all states since FY 1999. Previously, states were only required to provide aggregate statistics on Medicaid enrollment, service use, and spending in an annual report. States now must submit five MSIS files every quarter: one file containing eligibility-related information on each person enrolled in the state Medicaid program (e.g., months of Medicaid enrollment, basis of eligibility, dual enrollment in Medicare, demographics such as age, sex, and race/ethnicity), and four files containing information on paid claims for inpatient hospital, institutional long-term care, drugs, and other services (e.g., type of service, place of service, amount paid by Medicaid, and diagnoses).

With regard to managed care, MSIS contains the following information for each enrollee:

- plan ID numbers and types for up to four managed care plans under which the enrollee is covered during each month;
- the waiver ID number, if enrolled in a Section 1915(b) or other waiver;
- claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan, which are generally referred to as capitated claims; and
- claims that provide a record of each service received by the enrollee from a provider under contract with a managed care plan, which generally do not include a payment amount and are referred to as encounter or "dummy" claims. As noted earlier, all states collect encounter data from their Medicaid managed care plans, but some do not report it in MSIS.

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Section F Annex 1

Key Federal Authorities Allowing Medicaid Managed Care

The Social Security Act (the Act) provides multiple authorities under which states may operate Medicaid managed care programs (with federal approval)—through a state plan amendment (SPA), Section 1915(b) program waiver, or a Section 1115 research and demonstration waiver. These authorities differ in what options they allow states to use in the design of their managed care programs, including populations enrolled, service delivery, and benefits covered, as well as in the processes for CMS review and approval of the proposed managed care program. Table FA-1 below highlights key features of each authority.

TABLE FA-1. Characteristics of Key Medicaid Managed Care SPAs and Waivers

	1932(a) SPAs	Section 1915(b) Program Waivers	Section 1115 Research and Demonstration Waivers
General Authority	Exempts states from state plan requirements for: ▶ **Statewideness** (i.e., managed care program does not have to be operational statewide) ▶ **Comparability** (i.e., benefits for managed care enrollees can differ from those provided to non-managed care enrollees) ▶ **Freedom of choice** (i.e., ability of enrollees to receive services from any qualified provider); used to require enrollment in a managed care program and limit choice of provider to those in the health plan's network.	Provides states a waiver from state plan requirements for: ▶ **Statewideness** ▶ **Comparability** ▶ **Freedom of choice** Authority can also be used to provide additional services that are not otherwise provided to non-enrollees, as well as to limit the number of providers with which the state contracts to provide services.	Section 1115 authority is broad, potentially permitting all of the flexibility allowed under 1915(b) waivers as well as the waiver of other federal Medicaid requirements contained in Section 1902 of the Act. Further, under this authority, the Secretary can provide federal matching funds for services /activities/ costs not otherwise matchable (CNOM).

TABLE FA-1, Continued

	1932(a) SPAs	Section 1915(b) Program Waivers	Section 1115 Research and Demonstration Waivers
Approval Period[1]	Indefinite.	Initially approved for two years.	Initially approved for five years.
Populations That Can Be Mandatorily Enrolled	All state plan populations except certain children with special needs, Medicare beneficiaries, and American Indians.	All state plan populations.	All state plan populations, as well as any individuals not otherwise eligible for Medicaid (authorized through CNOM).
Application Requirements	Completion of mandatory CMS state plan preprint.	Completion of CMS application template.	No CMS standard preprint form or template available, but must submit proposal describing design features of program (e.g., populations covered, design of Medicaid managed care program).
Federal Budget Requirements	No required budget or cost analysis.	Demonstrate cost effectiveness and efficiency of program (actual expenditures cannot exceed projected expenditures for approval period).	Demonstrate budget neutrality (federal expenditures cannot be greater during the approval period with the waiver than without the waiver).
CMS Review Timeframe	Approved within 90 days of CMS receipt unless written disapproval or request for additional information. If additional information requested, 90-day period begins again on day CMS receives additional information.	Approved within 90 days of CMS receipt unless written disapproval or request for additional information. If additional information requested, 90-day period begins again on day CMS receives additional information.	No required timeframe for CMS review or approval.
Renewal Period[1]	No renewal needed.	Customarily up to two years; CMS has discretion to approve for five years if enrollees dually eligible for Medicare and Medicaid are served by the waiver.	Customarily up to three years; CMS has the discretion to approve for five years if enrollees dually eligible for Medicare and Medicaid are served by the waiver.

[1] Section 2601 of the Patient Protection and Affordable Care Act provides for a 5-year approval or renewal period for certain Medicaid waivers impacting demonstration programs under Section 1115 of the Act and waivers under Sections 1915(b) and 1915(c) of the Act, through which a state serves individuals who are dually eligible for Medicare and Medicaid. At the Secretary's discretion, a waiver that provides medical assistance for dually eligible beneficiaries can be approved for an initial period of up to 5 years and renewed for up to 5 years, at the state's request.

TABLE FA-1, Continued

	1932(a) SPAs	Section 1915(b) Program Waivers	Section 1115 Research and Demonstration Waivers
Program Documentation	Contained within overall CMS state plan preprint.	Contained within CMS application template.	Special terms and conditions negotiated between CMS and states and documented.
Monitoring/ Evaluation	CMS monitors implementation of SPA to ensure requirements are met; state required to conduct separate evaluation of managed care entities.	CMS monitors implementation of waiver to ensure requirements are met; state required to conduct separate evaluation of managed care entities.	CMS monitors implementation of waiver to ensure requirements are met; required periodic evaluation of the project (often conducted by the state).

Section F Annex 2

Comprehensive Risk-based Contract Requirements

The contractual obligations placed on managed care plans in Medicaid can be important to the success or failure of a Medicaid managed care program. Managed care provides states with an opportunity to delegate financial risk for the care of enrollees to participating plans. However, states are ultimately responsible for the performance of their Medicaid programs. Clearly outlined responsibilities and requirements, appropriate financing arrangements, and diligent oversight are essential to establishing an accountable and efficient program.

The contract constitutes a legal agreement between the state and a managed care plan for the delivery of services to enrollees and functions as a mechanism to enforce the standards specified by states and the federal government. Managed care plan contract terms and conditions vary among states in the level of specificity of plan requirements, but all include a basic set of activities, many mandated by federal law.[1] (In Sections E and F of this Report, we outline the federal requirements that serve as the basis for these contracting provisions.) Contracts and plan responsibilities are subject to CMS oversight, including review and approval by CMS staff. As states move to managed care, the staff skill sets may need to change.

Key elements of state managed care contracts may include, but are not limited to:

- **Network development and maintenance.** In comprehensive risk-based managed care programs, rather than dealing directly with individual providers, states delegate the responsibility of establishing and maintaining provider networks to the plans. To ensure that plans contract with a sufficient number and type of providers, including specialists, states often include network requirements in their plan contracts. Plans must also guarantee that providers meet certain credentialing requirements.
- **Care management and coordination.** States often require plans to assign each enrollee to a designated primary care provider who will coordinate an enrollee's care across providers and services. Plans may also be required to assign certain enrollees to care managers for additional assistance with the coordination of services

[1] Part 438 of the Code of Federal Regulations outlines the following managed care requirements: General Provisions, State Responsibilities, Enrollee Rights and Protection, Quality Assessment and Performance Improvement, External Quality Review, Grievance System, Certifications and Program Integrity, Sanctions, and Conditions for Federal Financial Participation.

as well as provide services such as general health education and disease management to enrollees.

- **Customer service and member education.** Plan contracts must ensure that enrollees receive necessary information about obtaining services and have a way to contact their respective plans with questions or concerns. Toll-free hotlines and ombudsman programs are commonly used tools.
- **Quality standards and reporting.** In addition to enforcing federal requirements for external quality reviews and reporting, states may also include their own requirements for ensuring that quality services are provided to enrollees. Section E of this Report provides additional information on the types of quality monitoring activities that Medicaid managed care plans are required to conduct as part of federal requirements.
- **Data collection.** States and the federal government have various data collection requirements that plans must comply with when serving Medicaid enrollees including but not limited to requirements on enrollment data, encounter data, and reporting of certain quality measures.
- **Monitoring and evaluation.** To determine if plans are meeting contract requirements, states monitor and evaluate plan performance. Some Medicaid programs are very prescriptive in the types and frequency of reports required from plans. Other states may have less structured contract requirements, allowing the state to request information from plans on an ad hoc basis.
- **Payment.** Capitation payment amounts are typically part of the contract language. Contracts also typically stipulate that plans have a specified amount of time to process claims and make payments to providers.[2] Contracts may also contain requirements and standards for reporting encounter and financial data to the state.
- **Corrective action.** The contract specifies how corrective action plans will be developed and implemented when issues or problems are identified with plan performance.

In addition to these areas, CMS regulations outline a number of other requirements that must be contained in plan contracts, such as compliance with federal and state contracting rules, inspection and audit of financial records, and prohibition of enrollment discrimination (42 CFR 438.6).

There is a wide range of variation in the level of detail of contract requirements across states and in the overall plan contracting process, and states may update their contracts as they learn more about effective contracting mechanisms to improve quality and oversight. There is currently no central source at the federal level that allows for the analysis of how states use the contracting process for program accountability in their Medicaid programs. This may also make comparisons to FFS difficult.

[2] Section 1902(a)(37)(A) of the Act requires that 90 percent of claims for services provided by health care providers under a managed care plan must be paid within 30 days of receipt and that 99 percent of claims are paid within 90 days of receipt.