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Establishing regulatory principles to ensure quality of care in managed care organizations

by Julia Masser

Translating proposed regulatory changes into an easy-to-read format for your organization is often very tough. Having just finished a four-page executive summary on the Program of All-Inclusive Care for the Elderly (PACE) "plan of care," it is clear that managed care organizations (MCOs) are facing many difficulties with increased regulatory oversight.[1] Understanding how to build a compliance program to fit a specific organization requires lots of time and resources. Delivering a high quality of care and meeting regulatory oversight goals without sacrificing either is a challenge that MCOs everywhere are anticipating. Examining a PACE organization's recently proposed changes may put into perspective these difficulties and challenges.[2]

PACE program case study

MCOs are companies or plans that focus on keeping quality of care high while using managed care regulations as a baseline structure of organization, finances, and services provided. A PACE program derives from MCOs and serves the frail and elderly population. These individuals are often dually eligible for Medicaid and Medicare benefits and can apply for a PACE program near them to receive comprehensive social and medical services. PACE programs then receive a capitated amount as payment from Medicare and Medicaid per individual. There are a limited number of PACE programs countrywide due to the high levels of regulatory requirements, staffing, and patient population levels large enough to fund one. Each PACE program includes service areas for the population it serves; service area expansion is becoming more difficult due to higher regulatory demands from the Centers for Medicare & Medicaid Services (CMS) and state governments.

Recently, CMS sent out proposed rule changes for 2024 and asked for feedback on these rules. Just in plan of care alone, there are six newly added elements to the regulation, and many changes throughout that get more specific about each part.[3]While this change is welcomed—as many add verbiage and clarify responsibilities—the implementation plan will include more than just what is on paper. Gaining provider buy-in to these proposed regulation changes can be tough with such a large network of providers producing different levels of care. Changing participant schedules to accommodate more time for care planning could make them feel less cared for. The regulations will require better planning, more time, and more urgency. This could potentially lead to more hours worked, less time to spend directly with participants, and more resources used on staffing than actual participants. The question is, will the benefit outweigh the drawbacks?