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Summary of 2020 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule

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Executive Summary

On November 13, 2020, the Centers for Medicare & Medicaid Services (CMS) released the Final Rule for the 2020 Medicaid and Children's Health Insurance Program (CHIP), CMS-2408-F[1], otherwise referred to as the "2020 Final Rule." The regulations contained in the 2020 Final Rule were effective on December 14, 2020, except for the additions of §438.4(c) (instruction 4) and §438.6(d)(6) (instruction 7), pertaining to certification of managed care capitation rate ranges and special contract provisions, which are effective July 1, 2021.

Following is a brief summary of the key items reflected in the 2020 Final Rule.

Setting Actuarially Sound Capitation Rates

There are several important aspects pertaining to establishing actuarially sound capitation rates as instructed in the 2020 Final Rule. The regulations related to rate ranges are likely to have the greatest actuarial considerations. The 2020 Final Rule provides states with the option to develop and certify a rate range, by rate cell, that is limited to 5%. Furthermore, states can choose ***either*** the new rate range option ***or*** certify rates without rate ranges to maintain the availability of the 1.5% de minimis option. States electing to use rate ranges are able to adjust previously developed rates by up to +/-1.0% without recertification being required.

Pass-Through Payments

The Pass-Through Payments portion of the 2020 Final Rule is effective July 1, 2021, and reinforces the elimination of pass-through payments over a prescribed schedule and provides clarification of terminology and methodology for calculating the allocation of total fee for service (FFS) pass-through payments.

State-Directed Payments

Definition of key terminology was provided and clarified in the 2020 Final Rule, and the distinction between state-approved rates and non-state approved rates was made, differentiating state-directed payments and supplemental payments to providers. For payment arrangements that are based on state plan approved rates, CMS has eliminated the prior approval requirement to reduce the administrative burden for many states, and avoid unnecessary and duplicative Federal approval processes.

[1] 2020 Final Rule: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care

Network Adequacy Standards

The 2020 Final Rule furthers the objective of granting the states' flexibility in designing their own network adequacy standards. Three new updates include: generalizing standards are based on "quantitative" measures instead of "time and distance" measures, clarifying that states are to define the "Specialist" provider type, and removing "Additional Provider Types...as determined by CMS" as a Provider Type subject to Network Adequacy Standards.

Risk Sharing Mechanisms

As declared in the 2020 Final Rule, risk-sharing mechanisms must be documented in the contract and rate certification documents prior to the start of the rating period. Furthermore, retroactively adding or modifying risk-sharing mechanisms will be explicitly prohibited after the start of the rating period. CMS notes they are not foreclosing retroactive rate adjustments when appropriate (that is, changes to the rates themselves as opposed to changes to a risk-sharing mechanism). CMS agrees that it would be appropriate to implement retroactive rate adjustments to accommodate unexpected programmatic changes; however, they do not believe modifying existing risk-sharing mechanisms, or adding new risk-sharing mechanisms, after claims experience for a rating period is known, is the appropriate tool for states to use to address such concerns.

Quality Rating System

State alternative quality rating systems (QRS) will be required to include the mandatory measures identified in the CMS MAC QRS framework. CMS proposed this change to facilitate comparable ratings across states while continuing to allow states to include additional measures based on their own quality goals. In addition, the CMS-developed QRS will create alignment, where appropriate, with the Qualified Health Plan (QHP) quality rating system, the Medicare Advantage 5-Star Rating System, and other related CMS quality rating approaches.

Appeals and Grievances

The revised rule specifies that a whole or partial denial of a payment for a service, because the claim does not solely meet the definition of a clean claim, is not an adverse benefit determination. It also eliminates the requirement that an oral appeal be submitted in writing to be effective. Lastly, the timeframe for an enrollee to request a state fair hearing after receiving an adverse decision from a managed care plan would be no less than 90 calendar days and no more than 120 calendar days after the date of notice of resolution.

Requirements for Beneficiary Information

The 2020 Final Rule incorporates the following requirements: 1) revises tagline requirements for the size of print and limits the requirement of including taglines to certain materials, 2) requires that a managed care plan must make a good-faith effort to provide notice of the termination of a contracted in-network provider to each affected enrollee within 30 calendar days prior to the effective date of termination or 15 calendar days after the receipt or issuance of the notice, whichever is later, 3) requires information in the directory to include a provider's culture and linguistic capabilities 4) modifies the requirements for updating a paper provider directory that would permit updates to be less frequent than monthly if the managed care plan offers a mobile-enabled, electronic directory.

The remainder of this summary includes many details discussed at length in the 2020 Final Rule.

Section I: Setting Actuarially Sound Capitation Rates

History of Recent Regulation

Prior to the 2016 Medicaid Mega-Reg (CMS 2390-F[2]), CMS considered any capitation rate paid to a managed care plan that fell within the certified rate changes as actuarially sound. The Mega-Reg implemented new criteria under §438.4 to require that states develop and certify each individual rate paid for a specified rate cell as actuarially sound.

Stakeholders subsequently expressed concern that this requirement has the potential to limit states' ability to obtain the best rates when contracts are procured through competitive bidding. The changes implemented in the 2020 Final Rule are in response to these concerns and aim to increase rate setting flexibility for states.

What's New in the 2020 Final Rule (§438.4(c)))

Actuarial rate ranges: The 2020 Final Rule provides states with the option to develop and certify a rate range, by rate cell, within specified parameters. Notable aspects of these parameters, which are considerably more limiting than requirements in place prior to 2016, include:

- The rate certification must identify and justify the assumptions, data, and methodologies specific to both the upper and lower bounds of the range
- Both the upper and lower bounds must be certified as actuarially sound
- The width of the certified range is limited to 5%
- The rate certification documents the state's criteria for paying entities at different points within the rate range
- States must comply with specified limits on their ability to pay managed care plans at different points within the range. Specifically, states are prohibited from paying entities at different points within the range based on their willingness to enter into intergovernmental transfer agreements (IGTs).

Additionally, states are required to document the rates payable to each entity prior to the start of the specified rating period. This requirement eliminates the potential for retroactive development of capitation rate ranges, except when adjustments to previously developed ranges are applied.

[2] 2016 Mega-Reg Rule: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf

In lieu of actuarial rate ranges, the 2016 Medicaid Mega-Reg allowed the use of de minimis changes of +/-1.5% without providing CMS with an updated actuarial certification. This provision was included to provide states with administrative relief related to small changes in capitation rates. Under the 2020 Final Rule parameters, states can choose ***either*** the new rate range option ***or*** certify rates without rate ranges to maintain the availability of the 1.5% de minimis option. States electing to use rate ranges are able to adjust previously developed rates by up to +/-1.0% without recertification being required. CMS notes that this permissible +/-1.0% standard is slightly smaller than the +/-1.5% de minimis range, which they believe is appropriate because the use of rate ranges already affords states additional flexibility.

The Final Rule requires recertification when states elect to modify capitation rates by more than 1.0% within the rate range during the rating year. Revised certifications must demonstrate:

- The criteria for initially setting the rate within the range were not applied accurately,
- That there was a material error in the data, assumptions, or methodologies used to develop the initial certification, and that the modifications are necessary to correct the error, or,
- That other adjustments are appropriate and reasonable to account for programmatic changes

These requirements around movements within the rate range are materially more stringent than those in place prior to 2016 when states frequently migrated within rate ranges without specific actuarial justification.

The 2020 Final Rule also allows states utilizing competitive bidding or individual negotiation procurement strategies to pay entities at different points within the range. In these circumstances, the rate certification must document reasons for variances, including how these variations produced different points within the rate range.

To increase rate range transparency, the 2020 Final Rule requires that states post relevant rate-related information on their website. This information includes:

- The upper and lower bounds for each rate cell
- A description of all assumptions that vary between the upper and lower bounds of each rate cell
- A description of all the data and methodologies that vary between the upper and lower bounds of each rate cell

CMS believes these requirements will ensure that rate ranges are appropriately based on programmatic experience and are actuarially sound since plans will have access to this information prior to executing managed care contracts.

Federal Financial Participation (FFP) (§438.4(b) (1) and (d))

The 2020 Final Rule also contains new requirements designed to prohibit variation in capitation rates due to different rates of FFP among the underlying populations. The new requirement states that:

"Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs."

It is notable that the language above is significantly less prescriptive than originally proposed by CMS. The original language specifically prohibited the use of higher margin assumptions, contractually required provider fee schedules, or medical loss ratio remittance thresholds for any populations than those assumed for populations with the lowest average rate of FPP. CMS ultimately removed these more specific requirements in the 2020 Final Rule due to feedback that they did not consider the potentially valid actuarial justification for variation in these assumptions that may be unrelated to FPP. Ultimately, CMS will require that rate setting certifications include an evaluation of any differences in assumptions or methodologies that increase federal costs, including substantiation that such differences are supported by valid rate development standards that represent programmatic cost differences in providing services to the various covered populations.

Section II: Pass-Through Payments (Medicaid))

CMS allows a state to establish provider payment requirements for its managed care plans (such as minimum or maximum fee schedules), provided the payments be based on the utilization and delivery of services. Pass-through payments do not meet this requirement.

Definition of a pass-through payment: CMS in its 2017 Final Rule[3] said the distinguishing characteristic of a pass-through payment is that a managed care plan is contractually required by the state to pay providers (hospital, physicians, or nursing facilities) an amount that is disconnected from the amount, quality, or outcomes of services delivered to enrollees under the contract during the rating period of the contract.

[3] 2017 Final Rule: https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery

Most pass-through payments are made to facilities. CMS estimated that in 2016 at least 16 states had $3.3 billion in pass-through payments for hospitals annually, at least eight (8) states had $105 million for physicians, and at least three (3) states had $50 million for nursing facilities.

CMS allows reimbursement rates to vary by facility. If a facility is reimbursed according to a fee schedule, then the reimbursement is determinable, a concept that is an important part of financial oversight.

CMS views pass-through payments as problematic and not consistent with standards for actuarially sound rates because they do not tie provider payments with the provision of services to Medicaid beneficiaries covered under the contract. CMS has been consistent in this view. Despite this conclusion, CMS acknowledged in the 2016 Final Rule that, for many states, pass-through payments have been approved in the past as part of Medicaid managed care contracts and served as a critical source of support for safety-net providers caring for Medicaid beneficiaries. CMS, therefore, adopted a transition period for states that had already transitioned services or eligible populations into managed care and had pass-through payments in their managed care contracts as part of the regulations that generally prohibit the use of pass-through payments in actuarially sound capitation rates.

Pass-through payments are theoretically not a financial issue for MCOs since they are just the conduit for the transmission of the payments. The regulations covering pass-through payments are an issue for state Medicaid agencies, rate setting actuaries, and recipients of the payments (primarily facilities). However, MCOs are impacted by the effort to administer the pass-through. In addition, MCOs are exposed to financial risk if they are required to make the payments before receipt of funding from the state.

History of Recent Regulation

The Medicaid Mega-Reg (CMS 2390-F)[4] in May 2016 established that pass-through payments had to be phased out over a ten (10) year period at 10% a year for facility contracts starting on or after July 1, 2017. For physicians and nursing facilities, the pass-through payments had to be eliminated by July 2022.

The CMS 2017 Final Rule[5] prohibited increases in pass-through payments and the addition of new pass-through payments beyond those in place when the pass-through payment transition periods were established in the 2016 final Medicaid managed care regulations.

[4] ibid

[5] ibid

In November 2018, CMS published the "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care" proposed rule (the 2018 proposed rule CMS 2408-P),[6] which included proposals designed to streamline the Medicaid and CHIP managed care regulatory framework. The proposed rule made it clear that a state could require pass-through payments for programs or populations transitioned to managed care. These new managed care populations had three (3) years to eliminate pass-through payments.

What does the 2020 Final Rule Provide? (§438.6(d))

There were relatively small changes with respect to pass-through payments from the proposed rule to the Final Rule. Changes included clarification of some terms and clarification of how to calculate the allocation of total FFS pass-through payments to the population transitioning from FFS to managed care.

The Final Rule does the following (effective July 1, 2021):

- Allows a state to require pass-through payments for programs or populations transitioned to managed care after the effective date of the 2016 Mega-Reg if certain criteria are met. The criteria are: 1) services will be covered for the first time under a Medicaid managed care contract and were previously provided in a Medicaid FFS delivery system 2) the state made supplemental payments to hospitals, nursing facilities, or physicians during the 12 month period immediately two (2) years prior to the first rating period of pass-through payment transition 3) aggregate amount of the pass-through payments for each rating period of the specified pass-through payment transition period that the state requires the managed care plan to make must be less than or equal to the payment amounts attributed to and actually paid as FFS supplemental payments during the 12 month period immediately two (2) years prior to the first rating period.
- For these new populations, the state has three years to eliminate the pass-through payments (pass-through payments existing when the Mega-Reg was effective to have a different elimination schedule).
- The elimination of the pass-through payments for the transitioned population does not have to occur over the three-year period; it could occur at the end of the transition period.
- Confirms that even though GME and DSH payments are not tied to the delivery of specific services to specific members, they are not considered supplemental pass-through payments.

[6] 2018 Proposed Rule: https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-plan-chip-managed-care

The Final Rule clarifies the limits on the use of pass-through payments for states and their rate development actuaries. The rule reinforces the trend to eliminate pass-through payments.

Section III: State Directed Payments (Medicaid)

Delivery System and Provider Payment Initiatives under MCO, PIHP, or PAHP Contracts

As finalized in the 2016 Final Rule, CMS permits states to direct a managed care plan's expenditures within the contract under the following circumstances (§438.6(c)(1)(i) through (iii)):

(i) The state may require plans to implement value-based purchasing models for provider reimbursement intended to recognize value or outcomes over volume of services.

(ii) The state may require plans to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

(iii) The state may require plans to:

a. Adopt a minimum fee schedule for network providers that provide a particular service under the contract; or

b. Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

c. Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

Among other requirements, a state must demonstrate in writing that the arrangement satisfies a series of criteria laid out in the rule. One such criterion is that the arrangement is expected to advance at least one of the goals and objectives in the state's quality strategy for its Medicaid managed care program.

CMS has been receiving, reviewing, and approving directed payment arrangements submitted by states since the 2016 Final Rule, and several of these requests for approval require managed care plans to adopt minimum rates. Frequently, these minimum rates are those specified under an approved methodology in the Medicaid state plan.

What was proposed? (§438.6(a) and (c))

CMS proposed to amend the rule to add definitions for:

- "State plan approved rates" - amounts calculated as a per-unit price of services described under CMS-approved rate methodologies in the state Medicaid plan.
- "Supplemental payments" - amounts paid by the state in its FFS Medicaid delivery system to providers that are described and approved in the state plan or under a waiver and are in addition to the amounts calculated through an approved state plan rate methodology.
- CMS also proposed to specifically reference a directed payment arrangement that is based on an approved state plan rate methodology as a known circumstance in which CMS permits states to direct a managed care plan's expenditures (in the section where it states adoption of a minimum fee schedule is allowed).
- CMS explained that supplemental payments contained in a state plan are not, and do not constitute, state plan approved rates. Since supplemental payments are not calculated or paid based on the number of services rendered on behalf of an individual beneficiary, they are considered separate and distinct from state plan approved rates.
- CMS proposed to distinguish a minimum fee schedule for network providers that provide a particular service using rates other than state-approved rates from those using state plan approved rates.
- To encourage states to continue developing payment models that produce optimal results for their local markets and to clarify how the regulatory standards apply in such cases, CMS proposed to allow states to require managed care plans to adopt a cost-based rate, a Medicare equivalent rate, a commercial rate, or other market-based rate for network providers that provide a particular service under the contract. They believe that allowing these additional types of payment models for states to implement would allow more flexibility for states.
- For payment arrangements that are based on state plan approved rates, CMS proposed to eliminate the prior approval requirement to reduce the administrative burden for many states and avoid unnecessary and duplicative Federal approval processes.
- For state-directed payment arrangements, the current rule forbids states to direct the amount or frequency of expenditures by managed care plans. CMS believes that this provision may have created unintended barriers to states pursuing innovative payment models. CMS proposed to delete this restriction, thereby permitting states to direct the amount or frequency of expenditures made by managed care plans.
- Some arrangements, particularly value-based purchasing arrangements, or those tied to larger delivery system reform efforts, can be more complex, and may take longer for a state to implement. CMS proposed a set of criteria that would provide a multi-year approval for a payment arrangement. The criteria for approval are 1) state has explicitly identified and described the payment arrangement in the contract as multi-year and included a

description of the payment arrangement by year (if it varies by year), 2) state has developed and described its plan for implementing a multi-year payment arrangement, including plan for multi-year evaluation, impact of multi-year payment on state's goals and objectives in the state's quality strategy, and 3) state affirms that it will not make any changes to the payment methodology or magnitude of payment without CMS' prior approval. CMS explained, however, that more traditional payment arrangements and fee schedules should continue to be reviewed and evaluated on an annual basis.

What was approved in the Final Rule?

Based on feedback received via public comments, CMS decided NOT to finalize two of the above proposals:

- CMS decided not to finalize its proposal to allow states to require managed care plans to adopt a cost-based rate, a Medicare equivalent rate, a commercial rate, or other market-based rate for network providers that provide a particular service under the contract.
- Additionally, CMS decided not to delete the restriction that disallows states to direct the amount or frequency of expenditures made by managed care plans.
- Other proposals were solidified in the Final Rule.

Section IV: Network Adequacy Standards

History of Recent Regulation

The 2016 Medicaid Mega-Reg[7] created new criteria under §438.68 that are specific to the development of network adequacy standards for medical services and LTSS. These updates had the goal of maintaining state flexibility in determining standards while ensuring access to care. The rule specifies a list of provider types,[8] at minimum, for which a state must develop its network adequacy standards. The standards must also be based on "time and distance" measures, with the exception of LTSS services where the provider travels to the enrollee. The rule does not prescribe any national guidelines for these "time and distance" measures (e.g., 30 miles or 30 minutes) but instead gives the state's flexibility in determining their own requirements as they deemed appropriate for their programs and populations.

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[7] ibid

[8] The list of provider types in the 2016 Mega-Reg include (i) Primary care, adult and pediatric; (ii) OB/GYN, (iii) Behavioral health (mental health and substance use disorder); (iv) Specialist, adult and pediatric; (v) Hospital; (vi) Pharmacy; (vii) Pediatric dental; and (viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS. The rule further specifies the standards criteria for LTSS provider types.

The rule further requires that network standards include all geographic areas covered by the managed care program or, if applicable, the contract between the state and managed care plan. It also lists minimum considerations for the state when developing network standards, outlines an exceptions process for the included requirements, and sets standards for publishing the standards online and making them available in alternate formats to enrollees with disabilities or hearing impairment.

What's New in the 2020 Final Rule? (§438.68(b)(1))

The 2020 Final Rule furthers the objective of granting the states flexibility in designing their own network adequacy standards. The three updates from the 2016 Mega-Reg include the following:

- **Generalizing standards based on "quantitative" measures instead of "time and distance" measures.** Time and distance standards may not be appropriate in some situations (e.g., a state with a heavy reliance on telehealth may need a provider-to-enrollee ratio). Other potential measures include minimum provider-to-enrollee ratios, minimum percentage of contracted providers accepting new patients, maximum wait times for appointments, and hours of operation requirements (e.g., extending evening or weekend hours). States are encouraged to use these measures in combination, and not separately, to ensure availability in services to enrollees, and there are no gaps in access.

  The 2016 Mega-Rule further prescribed the use of "time and distance" standards for LTSS provider types when the enrollee travels to the provider and standards other than "time and distance" when the provider travels to the enrollee. These LTSS requirements have similarly been revised in the 2020 Final Rule to be based on the general "quantitative" standards, allowing for greater state flexibility, which is particularly beneficial for LTSS, which has a wide variation in plan designs, often very limited supply of providers, and potential functional limitations of the population.

- **Clarifying that states are to define the "Specialist" provider type.** As mentioned earlier, the 2016 Mega-Reg provides a list of provider types, at minimum, for which the state must determine network adequacy standards, including a "Specialist, adult and pediatric" provider type. The 2020 Final Rule clarifies that states have the authority to determine what qualifies as a "Specialist" based on what they deem most appropriate for their program.[9]

- **Removing "Additional Provider Types...as determined by CMS" as a Provider Type subject to Network Adequacy Standards.** The 2016 Mega-Reg list of provider types for

[9] The list of provider types in the Final Rule will replace "Specialist, adult and pediatric" with "Specialist (as designated by the state), adult and pediatric"

which network adequacy standards apply also includes “Additional Provider Types when it promotes the objectives of the Medicaid program, as determined by CMS.” This provider type was initially included to allow CMS latitude to address future national workforce shortages and network adequacy standards. The provider type is removed from the 2020 Final Rule due to concerns that managed health plans will have to assess network adequacy and possibly build network capacity with insufficient time. It will also remove an unnecessary level of administrative burden and makes it clear that designating any additional provider types subject to network adequacy standards are the states’ responsibility.

Section V: Risk-Sharing Mechanisms (Medicaid)

History of Recent Regulation

In the 2015 proposed rule, CMS proposed a non-exhaustive list of risk-sharing mechanisms (for example, reinsurance, risk corridors, and stop-loss limits) and required that all such mechanisms be specified in the contract. CMS intended to apply this requirement to any arrangement that had the effect of sharing risk between the MCO, PIHP, or PAHP, and the state.

In the 2016 Final Rule, CMS added that risk-sharing mechanisms must be computed on an actuarially sound basis. As risk-sharing mechanisms are inherently tied to the capitation rates paid to plans, CMS suggests these mechanisms should be developed in conjunction with the capitation rates and use the same actuarial principles and practices.

Some states have applied new or modified risk-sharing mechanisms retrospectively; for example, some states have sought approval to change rates or revise a medical loss ratio (MLR) requirement after the claims experience for a rating period became known to the state and managed care plans.

CMS has acknowledged that despite a state’s best efforts to set accurate and appropriate capitation rates, unexpected events can occur during a rating period that necessitates a retroactive adjustment to the previously paid rates.

What was proposed? (§438.6(b))

CMS proposed to amend the rule to require the following:

- Risk-sharing mechanisms must be documented in the contract and rate certification documents prior to the start of the rating period. (§438.6(b)(1))

- Retroactively adding or modifying risk-sharing mechanisms will be explicitly prohibited after the start of the rating period.

This means that states electing to use risk-sharing mechanisms must submit contracts and rate certifications to CMS prior to the start of the rating period.

Responses to comments

- CMS clarifies the differences between risk mitigation strategies/risk sharing mechanisms and risk adjustment:
    - Risk mitigation strategies such as risk adjustment are a means to protect the state, or the managed care plan, against the risk that assumptions (not only based on the health status of enrollees) underlying the rate development will not match actual experience. Risk-sharing mechanisms are any means, mechanism, or arrangement that has the effect of sharing risk between the MCO, PIHP, or PAHP, and the state.
    - Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for retrospectively evaluating the experience of MCOs, PIHPs, or PAHPs contracted with the state.
    - "Risk sharing" is about the aggregate actual experience, while "risk adjustment" is about paying based on the health status of enrollees at the individual level and how a less healthy status is assumed to result in higher costs.
- The changes CMS is proposing to risk-sharing mechanisms do not have any impact on risk adjustment:
    - CMS clarifies that changes to a risk-sharing mechanism are not changes to the capitation rates themselves; they are changes to an arrangement or mechanism that results in a separate payment from a state to a managed care plan or a remittance to a state from a managed care plan.
- The following is a non-exhaustive list of risk-sharing mechanisms:
    - Medical loss ratios (MLR) with a remittance
    - Risk corridors
    - Risk-based reconciliation payments
    - Reinsurance

- Stop-loss limits
- Risk Pools

- CMS notes they are not foreclosing retroactive rate adjustments (that is, changes to the rates themselves as opposed to changes to the risk-sharing mechanism) when appropriate, such as when substantial coverage changes occur mid-year, adjustments are necessary to address disease outbreaks, launches of high-cost prescription drugs, or other unforeseen circumstances that increase benefit costs. CMS agrees that it would be appropriate to implement retroactive rate adjustments to accommodate unexpected programmatic changes; however, they believe modifying existing risk-sharing mechanisms or adding new risk-sharing mechanisms after claims experience for a rating period is known is not an appropriate tool for states to use to address such concerns.

What was approved in the Final Rule?

CMS is finalizing the changes pertaining to risk-sharing mechanisms as proposed.

Section VI: Quality Rating System (Medicaid and CHIP)

History of Recent Regulation

In the 2016 Final Rule, CMS established the authority to require states to operate a Medicaid managed care quality rating system (QRS) and incorporated this provision in its entirety into CHIP. Based on consultation with states and other stakeholders, CMS will identify performance measures and a methodology for a Medicaid and CHIP managed care quality rating system. States have the option to use the CMS-developed QRS or establish an alternative state-specific QRS ("state alternative QRS"), provided that the state alternative QRS produces substantially comparable information about plan performance. Any state alternative QRS is subject to CMS approval.

In the 2016 Final Rule, CMS used the acronym Medicaid Managed Care Quality Rating System QRS (MMC QRS). In the 2020 Final Rule, CMS refers to the Medicaid and CHIP Managed Care Quality Rating System ("MAC QRS"), as both Medicaid and CHIP are subject to the QRS regulations.

What was proposed? (§438.334)

The revised rule only requires state alternative QRS to yield information to the extent feasible. CMS would engage with states and other stakeholders to develop sub-regulatory guidance on what it means for alternative QRS to yield substantially comparable results and how a state would demonstrate that it meets that standard.

CMS will develop a MAC QRS framework, including the identification of a set of mandatory performance measures and a methodology.

CMS proposed to require a state alternative QRS to include the mandatory measures identified in the CMS MAC QRS framework. CMS proposed this change to facilitate comparable ratings across states while continuing to allow states to include additional measures based on their own quality goals.

CMS also proposed that the CMS-developed QRS would align where appropriate with:

- the Qualified Health Plan (QHP) quality rating system developed in accordance with 45 CFR 156.1120,
- the Medicare Advantage 5-Star Rating System, and
- other related CMS quality rating approaches

Alignment will be determined as part of the ongoing development of the proposed measures and methodologies and will be addressed in the MAC QRS-specific rulemaking. Since MAC QRS, Medicaid, and CHIP Scorecard[10] serve related goals, CMS expects to coordinate the measures selected for the Scorecard and those selected for the CMS-developed QRS.

Finally, CMS proposed to eliminate the requirement that states obtain prior approval from CMS before implementing a state alternative QRS. The intention behind this change is to reduce the upfront administrative burden on states and expedite implementation. Instead of prior CMS approval, states would submit the following information to CMS to demonstrate compliance with CMS regulations:

- The state's alternative QRS framework, including the performance measures and methodology to be used in generating plan ratings
- Documentation of the public comment process, including issues raised by the Medical Care Advisory Committee and the public, any policy revisions or modifications made in response to the comments, and the rationale for comments not accepted
- Other information specified by CMS.

[10] Information about Scorecard: https://www.medicaid.gov/state-overviews/scorecard/index.html.

What was approved in the Final Rule?

CMS did not finalize the removal of prior approval for state alternative QRS, but otherwise, the rule finalized as proposed with a few minor modifications to correct technical errors and add clarification where needed.

Section VII: Appeals and Grievances (Medicaid and CHIP)

Statutory Basis and Definition (§438.400(b))

In the 2016 Final Rule (§438.400(b)(3)),[11] "adverse benefit determination," means denials in whole or in part of payment for service. Managed-care plans are required to give enrollees timely notice of adverse benefit determination in writing. This results in managed care plans generating a notice for claims denied even for administrative reasons, which causes additional administrative and economic burdens for plans and confusion for enrollees who often mistake these notices as financial liability.

The revised rule specifies that a partial or complete denial of a payment for a service, because the claim does not *solely* meet the definition of a clean claim,[12] is not an adverse benefit determination. The change is not expected to expose enrollees to financial liability without notice or jeopardize their access to care or rights of appeals. Notice requirements for all future claims (including resubmission for the same claim) would have to be independently determined. The rule only addresses claims that do not meet the definition of a clean claim. Whether a claim denial "impacts the enrollees" is not part of the definition of an adverse benefit determination and does not affect a managed care plan's responsibility for sending the notice.

Plans need to apply the definition consistently and reasonably and have an obligation to comply with their responsibilities in connection with adverse benefit determinations.

General Requirement (§438.402(c)(3)(ii) and §438.406(b)(3))

In the 2016 Final Rule, an oral appeal must be followed by a written and signed appeal. Managed-care plans must treat oral inquires seeking to appeal an adverse benefit determination as appeals, and such oral inquires must be confirmed in writing. Enrollees sometimes take too long to submit written signed appeals or do not submit anything at all. This results in enrollees waiting for an

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[11] ibid

[12] §447.45(b) defines clean claim as one that can be processed without obtaining additional information from the provider of the service or from a third party, and includes a claim with errors originating in a state's claim system; it does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

extended period as well as managed care plans investing resources with uncertainty about how to comply with handling grievances and appeals.

The revised rule eliminates the requirement that an oral appeal be submitted in writing to be effective. CMS believes this will reduce the barriers for enrollees who would not have to write, sign, and submit the appeals and will allow plans to resolve issues quickly while decreasing economic and administrative burdens. Furthermore, this is consistent with the state fair hearing process, which currently allows individual or authorized representatives to submit state hearing requests via different modalities without requiring subsequent written, signed appeal. The rule does not change the current requirement that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.

CMS clarified that eliminating the written requirement does not eliminate the option for enrollees to submit appeals in writing if they are uncomfortable with oral appeals over concern that it might not be documented or tracked appropriately. Additionally, it does not change any reporting, tracking documentation, or other requirements on managed care plans.

CMS agrees that oral appeals need to be documented accurately but does not require a specific method or specific requirements. Managed care organizations should comply with §438.416. Lastly, CMS will not provide what constitutes a verbal contact as an oral appeal.

Resolution & Notification (§438.408(f)(2))

Previously, after receiving an adverse decision from a managed care plan, enrollees could request a state fair hearing within 120 days. However, the 120-day requirement created an inconsistency in filing timeframes between Medicaid FFS (90-day timeframe) and managed care, which created administrative burdens for states and confusion for enrollees.

The revised rule requires the timeframe for an enrollee to request a state fair hearing after receiving an adverse decision from a managed care plan to be no less than 90 calendar days and no more than 120 calendar days after the date of notice of resolution. This allows states that wish to align managed care with FFS filing timeframes to do so without jeopardizing enrollees' ability to gather information and prepare for the state hearing.

Overall, CHIP regulation has similar updates as Medicaid regulation, except for the "services not furnished," which requires a state to pay for disputed services while an appeal is pending. This is a Medicaid standard that was incorporated inadvertently in the previous rule. "Services not furnished" is not included in the Final Rule for CHIP.

Section VIII: Requirements for Beneficiary Information (Medicaid and CHIP)

Language and Format (§438.10 (d))

The 2016 rule requires that states and managed care plans include taglines[13] in prevalent non-English languages and in large print[14] on all written materials for potential and current enrollees. However, this might increase overall document length, therefore decreasing the ease of use and eliminating the use of certain effective formats such as postcards and trifold brochures.

The revised rule deletes the definition of large print as "no smaller than 18 point" and adopts the "conspicuously visible" standard for taglines, which is consistent with what was implemented for the ACA. Additionally, it replaces the requirement to include taglines on "all written materials" with a requirement for taglines only on materials for potential enrollees that "are critical to obtaining services."

This aligns the documents that require taglines with the documents that must be translated into prevalent non-English languages and would facilitate the use of smaller, more user-friendly documents. CMS will not specifically define what is "conspicuously visible" but defers to managed care plans, stakeholders, and local experts on disabilities to gather input. Not requiring taglines on all written material is consistent with Medicare Advantage and ACA requirements. However, information on how enrollees can request auxiliary aids and services is on the list of information required to be included and on taglines.

Information for all Enrollees of MCOs, PHIPs, PAHPs, and PCCM entities (§438.10 (f)): General Requirement

Currently, the regulation requires that a managed care plan must make a good-faith effort to provide notice of the termination of a contracted in-network provider to each affected enrollee within 15 days of receipt or issuance of termination notice. However, plans or providers often send a termination notice to meet their contractual obligation while continuing to negotiate in an effort to resolve the issue(s). If the issues subsequently are resolved, then the notice is rescinded, and

[13] Taglines are required to be in large print and included on the materials that explain the availability of written translation or oral interpretation, how to request auxiliary aids and services for individuals who have limited English proficiency or a disability, and the toll-free phone number of the entity providing choice counseling services and managed care plan's member/customer service unit

[14] Large print is defined as no smaller than 18-point font

the provider remains in-network. This can cause alarm and confusion for enrollees who may think they need to locate a new provider.

The revised rule is to change from 15 calendar days after receipt or issuance of termination notice to the later of 30 calendar days prior to the effective date of termination or 15 calendar days after the receipt or issuance of the notice.

CMS clarifies that this is a minimum notification period; managed care plans are encouraged to provide enrollees more than the minimum required notification to reduce the possibility of disruption in care, and enrollees should be educated and encouraged to utilize resources that can assist them with locating providers.

Information for all Enrollees of MCOs, PHIPs, PAHPs, and PCCM entities (§438.10 (h)): Provider Directory

The previous rule required each managed care plan to include information in its provider directory indicating whether the provider had completed culture competence training. The revised rule requires information in the directory to include a provider's culture and linguistic capabilities, including languages spoken by the provider or by a skilled medical interpreter providing interpretation services at the provider's office. It does not require information on whether the provider has completed cultural competence training. This aligns with the Medicaid FFS directory rule.

The previous rule also required paper directories (available upon request) to be updated monthly and information in an electronic directory to be updated no later than 30 calendar days after the managed care plan received updated provider information. This results in many managed care organizations having to reprint the entire directory to get the savings.

The revised rule modifies the requirements for updating a paper provider directory that would permit less than monthly updates if the managed care plan offers a mobile-enabled electronic directory. Monthly updates are required if a plan does not offer a mobile-enabled directory, and only quarterly updates would be required for plans that do offer a mobile-enabled directory.

CMS explicitly reminded managed care plans that some individuals with disabilities, who are unable to access web applications or require the use of assistive technology to access the internet, may require auxiliary aids and services to access the provider directory. Individuals with disabilities should, upon request, be given the most current provider directories in the same accessible format (paper or electronic) that they receive other materials. CMS also encourages managed care plans to perform direct outreach to providers on a regular basis to improve the accuracy of their provider data and to ensure that all forms of direct enrollee assistance are effective, easily accessible, and widely publicized.

Section IX: Additional Changes and Clarifications

Managed Care State Quality Strategy (§438.340)

CMS proposed to add Primary Care Case Management entity (PCCM) to the list of managed care plans identified in quality strategy elements. This was finalized to §438.340(b)(2), (b)(3)(i) and (c)(1)(ii).

CMS proposed to remove this definition of "disability status" based on whether the individual would qualify for Medicaid on the basis of a disability. CMS believes this definition is too narrow and might exclude some individuals with disabilities. However, based on public comments, CMS did not finalize the proposal but revising the rule to provide states with flexibility to define "disability status" in their quality strategy. At a minimum, states' definition of disability status includes individuals who qualify for Medicaid on the basis of disability. This is effective July 1, 2021

Exemption from External Quality Review (§438.362)

A state may exempt an MCO from undergoing an external quality review (EQR) when certain conditions are met. Those conditions are: 1) MCO has current Medicare and Medicaid contract 2) The contracts cover all or part of the same geographic area within the state, 3) Medicaid contract must have been in effect for at least two consecutive years before the effective date of exemption, and during those two years, the MCO was subject to the Medicaid EQR, and meet the performance requirement for quality, timeliness, and access to health care services it provides to Medicaid beneficiaries.

States are not required to exempt plans from EQR, but have this option available. States also have the discretion to require all their MCOs to undergo EQR, even for those that could be exempted. To increase transparency, CMS proposed that states annually identify on their website and/or in the EQR technical report the names of the MCOs exempted from the process, when the current exemption period begins, or that no MCOs are exempt as appropriate. This is effective 7/1/2021.

Enrollee Encounter Data (§438.242(c))

Allowed and paid amount must be submitted as part of the encounter data since it is important to monitor and administer the Medicaid program, particularly for capitation rate setting and review, financial management, and encounter data analysis. Allowed amount reflects the amount the managed care plan or subcontractor expects to pay for a service based on its provider contracts, and the paid amount reflects the amount the managed care plan or subcontractor actually sends to the provider after adjudicating the claim.

Standard Contract Requirements (§438.3(t))

2016 rules require that MCOs, PIHPs, or PAHPs that covered Medicare-Medicaid dual-eligible enrollees sign a Coordination of Benefits Agreement (COBA) and participate in the automated crossover claim process administered by Medicare. This would allow providers to bill once for FFS claims under Medicare Parts A and B (not Medicare Advantage). However, it resulted in a managed care plan receiving claims for services that it is not responsible for, or claims were sent to the wrong plan when beneficiaries change plans. CMS removes this requirement and allows states to specify in their contracts with managed care plans the methodology to ensure that the plans receive all appropriate crossover claims. If the state elects to use a methodology other than COBA, the state's methodology would have to ensure that the submitting provider is informed that the claim has not been denied and been sent to the MCO, PHIP, or PAHP for payment consideration.

Standard Contract Requirements (§438.6(e))

Under the 2016 rule, CMS permitted FFP for a full monthly capitation payment on behalf of age 21-64 enrollees receiving inpatient treatment in an institution for mental disease (IMD) for 15 days or less. States and other stakeholders asked that FFP should be provided for capitation payments made for months that include stays longer than 15 days, especially for enrollees with substance use disorder (SUD). However, after reviewing the data and researches, CMS believes the 15 days is appropriate and did not change the regulation.