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Medicaid Managed Care 2020 Final Rule

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On November 9, 2020, CMS released a new Medicaid/CHIP managed care regulation that finalizes its November 14, 2018 proposed rule. This rule is part of CMS' stated efforts to streamline the Medicaid and CHIP managed care regulatory framework.

The rule is effective December 14, 2020 and was formally published in the Federal Register on November 13, 2020. While CMS made most provisions effective as of December 13, 2020, some rate setting and reporting requirements will have a delayed effective date for contracts and rating periods beginning July 1, 2021. Some provisions of the final rule will require changes to managed care contracts while other provisions provide states the discretion to change policies required under the 2016 Medicaid and CHIP managed care final rule, which were modified by this final rule.

With any change in administration, there is the possibility for the new President and Congress to overturn a regulation issued by the previous administration under the Congressional Review Act. Regulations published in the Federal Register near the close of an administration, referred to as "midnight rules", are subject to reconsideration under the Congressional Review Act in the next session of Congress. The Congressional Review Act may only be used to invalidate the entirety of a final rule. For more information, see Congressional Research Service Reports R42612 and R43992.

We will share additional information as our analysis of the rule continues.

Rate Setting Provisions

Provisions Effective December 13, 2020

Rate development differences and FMAP: 438.4(b)(1) and (d) — CMS reiterated its intent to review rate setting assumptions, methodologies and factors to ensure any differences are not based on FMAP. However, CMS did **not** finalize their proposed itemized list of factors that cannot vary by population, but will use that list in interpreting policy while reviewing rates.

No Retroactive Risk Sharing: 438.6(b) — States are not able to change risk sharing mechanisms after the start of the rating period and those mechanisms must be documented prior to the start of the rating period. While CMS ultimately wants signed contracts and final rate certifications submitted to CMS prior to the start of the rating period as evidence of documentation, for states with calendar year 2021 rates, CMS may provide some flexibility where documentation will include draft contract language and an attestation from the state's actuary addressing only the risk mitigation strategies used. States should reach out to CMS to discuss these possible flexibilities.

+/- 1.5% Flexibility: 438.7(c)(3) — States using the 1.5% flexibility must do so based on contractual changes consistent with the rate change and not on factors related to cost shifting or FFP population differences. CMS also clarified that *de minimis* rate changes need to be within the rating period.

Provisions Effective for Rating Periods On or After July 1, 2021

Rate ranges: 438.4(c) — States can permit actuaries to develop and certify a 5% rate range per rate cell instead of certifying to a specific rate as long as the following guardrails are in place:

- The Actuary must certify both the upper bound and the lower bound of the rate range
- Certifications must be submitted **prior** to the start of the rating period
- States must document the capitation payments per plan to demonstrate they are within the range and describe the criteria used to select the rate for each of the plans, which could be negotiation with plans or competitive bidding
- Payment differences between plans cannot be based on the plan or network provider payment of an intergovernmental transfer (IGT)
- Rate ranges must include all costs under the program consistent with existing actuarial soundness and rate development requirements (see 42 CFR 438.4–42 CFR 438.7), which includes pass-through payments, administration fees, taxes and benefit costs. The rate ranges does not include the impact of an applicable risk adjustment methodology, incentive arrangements with the plans, or state budget factors
- States can change rates within the rate range up to 1.0% from the initial rate during the rating period without submission of a new certification as long as the change is consistent with a change in the contract; changes more than 1.0% will require a rate certification
- States must post specific information prior to executing a contract or contract amendment that includes or modifies a rate range on their website:
  - The upper and lower bound of each rate cell
  - A description of all assumptions that vary between the upper and lower bounds of each rate cell including the specific assumptions used for the upper and lower bounds
  - A description of the data and methodologies that vary between the upper and lower bounds of each rate cell including the specific data and methodologies used for the upper and lower bound
- States cannot use the +/- 1.5% capitation adjustment flexibility with the rate range option

Directed Payments and Pass-Through Payments

Provisions Effective December 13, 2020

Directed Payments: 438.6(a) and (c) — As expected, CMS finalized its proposal to exempt directed payments that rely on state plan-approved rates from the prior approval requirements and clarified the definition of a state plan approved rate. However, all other requirements, including the evaluation plan, continue to apply.

CMS also allowed for multi-year approval of directed payments if the below are met:

- It is described as a multi-year arrangement
- The state has described its plan for implementing a multi-year arrangement including a multi-year evaluation and how that impacts the quality of goals and objectives
- No changes will be made during the course of the approval without prior approval

Provisions Effective for Rating Periods On or After July 1, 2021

Pass Through Payments: 438.6(d) — States can make pass through payments under new managed care contracts during a three-year transition period if certain criteria are met:

- The services will be covered for the first time under managed care and were previously in FFS
- The state made supplemental payments during the 12-month period immediately two years prior to the first rating period
- The aggregate amount of the pass through payments that the state requires the managed care plan to make is less than or equal to the amounts calculated based on the historical supplemental payments

Quality and EQRO

Provisions Effective July 1, 2021

- 438.334 — In consultation with stakeholders, CMS will develop a minimum set of mandatory performance measures aligned with existing CMS initiatives for the CMS-developed or state alternative Quality Rating System (QRS). Contrary to the 2018 proposed rule, a state alternative QRS will be subject to CMS approval
- 438.340 — States are required to define disability status in their quality strategy to be either the minimum standard in the regulatory text or additional individuals
- 438.358 — CMS made technical corrections to clarify all External Quality Review (EQR) areas are reviewed at least every three years. These provisions are in the EQR protocols so to the extent those are followed, no changes needed to the EQR review and technical report process
- 438.362 — States must identify each MCOs exemption status from the EQR process and beginning date of exemption, if applicable. MCO exemption status must be posted on their website and included in the EQR technical report

Enrollee Protections, Network Adequacy and Other Provisions

Enrollee Protections Effective December 13, 2020

- 438.10 — CMS changed the large print requirement of 18-point font to "conspicuously visible" and only requires taglines on documents that are critical to obtaining services for potential enrollees
- 438.10(f) — CMS changed the timeframe for notice to a member when a provider is terminating to the later of 30 days prior to the termination or within 15 days of notice from the provider
- 438.10(g) — CMS removed the requirement that the provider directory note that the provider completed cultural competency training
- 438.10(h) — Plans can make quarterly updates to paper provider directories if they have mobile enabled provider directories available
- 438.400 — Limited the definition of an adverse benefit determination based on denial of payment to denials of clean claims
- 438.402 and 438.406 — CMS removed the requirement that oral appeals need to be followed up in writing
- 438.408 — CMS revised the 2016 final rule to require the timeframe to request a state fair hearing to be no less than 90 calendar days and no more than 120 days to align with state FFS appeals processes

Network Adequacy Effective December 13, 2020

- 438.68(b)(1) — States may use any quantitative standard for network adequacy instead of just time and distance and to remove the additional provider types as determined by CMS as a provider type that needs to have a standard associated with it and allows states to determine which providers should be included in the specialist category

Other Effective December 13, 2020

- 438.3(t) — States have more options for meeting the Coordination of Benefits requirements, but are not required to make changes if their current process is working. States now have the option to develop an alternate system where the state receives all crossover claims and forwards these claims to the appropriate plan
- CMS made a number of other minor changes and technical corrections

For More Information

If your state is interested in learning more about this final rule and potential impacts to rate development and managed care contracts, Mercer Government and its actuaries are ready to help. Our team is ready to support the financial, policy, quality and contract decisions required by these regulations.

Email us at mercer.government@mercer.com if you have additional questions or to speak to a client leader. You may also be added to our distribution list to ensure you receive our white papers, flash updates and webinar invites.

Visit our website at www.mercer-government.mercer.com to view our experience, services and client feedback.

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