April 2024

CMS Medicaid Managed Care Final Rule – Financial Requirements

Overview

On April 22, 2024, CMS issued the Medicaid Managed Care Final Rule with significant changes impacting payment, operations, oversight, and compliance standards. This rule pairs with two other final rules published in April 2024 focused on improving Medicaid eligibility and access to services and includes some notable differences from the April 2023 proposed rule, particularly on how our clients use state directed payments (SDPs). The effective date of this rule is July 9, 2024, and compliance dates for the highlighted provisions are at the close of this Flash.

This Mercer Government Flash **focuses on financial topics, including In Lieu of Services (ILOS), SDPs, medical loss ratios (MLRs), and comparative rate analyses.** References to “Managed Care Organizations (MCOs)” include Prepaid Inpatient Health Plans and Prepaid Ambulatory Health Plans. Additionally, you can find our other published Flash focused on quality and access topics, including required appointment wait time and network adequacy standards, annual member experience surveys, new quality rating system (QRS) requirements, and state quality strategies here.

In Lieu of Services

In 2023, CMS released State Medicaid Director Letter 23-001 describing detailed requirements for ILOS. States with existing ILOS were required to comply with the new guidance, including a 5% cap on ILOS expenditures, by the contract rating period beginning on or after January 1, 2024. States adding new ILOS were required to comply with the new guidance immediately. The Final Rule codifies these policies with one substantive change. Instead of requiring ILOS transition plans to be submitted to CMS within 15 calendar days of the decision to terminate an ILOS, states must submit such plans within 30 calendar days.

State Directed Payments

SDPs have grown in number and cost since first codified in the 2016 Medicaid Managed Rule. In 2022, CMS received almost 300 SDP preprint submissions. In the Final Rule, CMS is finalizing a host of changes to SDP requirements, including the following.

Funding Details and Limits

- **Remove the ability** of states to use a separate payment term and requires that SDPs are built into the capitation rate as an adjustment.
- **Limit the ability** of states to complete retroactive changes to the rate certification unless an SDP was added or amended or there were material errors in the initial rate certification related to the SDP.

- Require all directed payments subject to a preprint, including amendments, **be submitted prior to the specified start date** and removes the ability to make changes retrospectively.
- Require states to report to CMS the **total dollars expended for each SDP** and the SDP cost percentage for SDPs subject to prior approval.
- Establish several regulatory standards for when the total payment rates for certain SDPs are reasonable, appropriate, and attainable.
- Require states to comply with all **Medicaid financing** rules and be able to document that providers receiving SDPs are not participating in unallowable "hold harmless" arrangements associated with **provider taxes**. Compliance will include a new requirement for provider attestations, or a rationale for why providers will not sign an attestation, as part of CMS' review of the SDP.
- Codify existing CMS expectations that payment levels for certain providers (inpatient hospital services, outpatient hospital services, qualified practitioner services at an academic medical center, and nursing facility services) not exceed the **average commercial rate** (ACR). These proposals would require an ACR demonstration and a total payment rate comparison to the ACR annually.
- Eliminate CMS written prior approval for SDPs that use 100% of the Medicare reimbursement rate as the minimum fee schedule.
- Require SDP payments to be made on the delivery of services within the rating period and **prohibits a post-payment reconciliation process.**

MCO Contract Requirements

- Allow states to apply SDP requirements to **out-of-network provider** arrangements.
- Require MCO contracts to detail SDP dates, amounts, fees, procedure codes, provider classes, and other SDP details as applicable.
- Require that **MCO contracts and rate certifications** be updated and submitted no later than 120 days after the start date of the arrangement or amendment.
- Grant states **appeal rights for SDPs** that are not approved.

Value-Based Payments and Evaluations

- Provide additional regulatory pathways for approval of value-based payment (VBP) initiatives (e.g., population- or condition-based SDPs).
- Allow for payment in a VBP SDP for **maintenance or improvement over baseline performance** as opposed to only increase in performance.
- Require states to evaluate SDPs every three years if the SDP exceeds 1.5% of the total capitation payments, and CMS may request **SDP evaluation reports** from states at any time. CMS will allow external quality review organizations to perform this evaluation as a new optional activity eligible for 75% enhanced federal match.
- **Require an evaluation plan be submitted with every SDP**.

Medical Loss Ratio

CMS finalized several Medicaid and Children's Health Insurance Program (CHIP) MLR provisions to improve the transparency and accuracy of MLR reports and remittances, if applicable. The regulations will:

- Limit inclusion of **provider bonuses or incentives in incurred claims** to such arrangements that meet the private market regulations for quality or performance metrics, have a performance period aligned with the MLR reporting year, and had executed MCO-provider contracts prior to the performance period.
- Require MCOs to follow the private market requirement at 45 CFR 158.170(b) for the **methodologies used to allocate expenses to the Medicaid and CHIP lines of business**, including incurred claims, quality improvement expenses, Federal and state taxes and licensing or regulatory fees, and other non-claims costs.
- Require all SDP expenditures and revenues be included in plan-level and state summary MLR reports. However, separate MLR reporting lines in the numerator and denominator for each SDP will not be required, as set forth in the proposed rule.
- State MLR Summary Reports must be provided for each MCO contracted with the state.
- No longer hold CMS to updating **credibility factors** annually (initial 2017 credibility factors remain).

Comparative Rate Analysis

The Final Rule requires Medicaid and CHIP MCOs to complete and states to report to CMS annual provider payment rate analyses for: 1) primary care, OB/GYN, mental health, and substance use disorder (SUD) services relative to Medicare; and 2) homemaker, home health aides, personal care services, and habilitation services relative to Medicaid fee-for-services. The payment rate analyses must consider adult and pediatric rates separately, and if there is a difference in payment levels, MCOs are required to submit separate pediatric and adult reports. The comparative rate analyses will be based on paid claims data from the immediate prior rating period.

Effective Dates

Although the Final Rules go into effect 60 days post-publication (July 9, 2024), many provisions become effective at various points in the future. The table below is meant to be a shorthand for teams to reference when considering the impacts of the rules.

Policy	Effective Date
ILOS	
Codification of CMS' 2023 ILOS guidance	First contract/rating period after September 9, 2024 (i.e., January 1, 2025–July 1, 2025, depending on state-specific contracting/rating year)
SDPs	
Limited Retroactive Capitation Rate Adjustments for SDPs	July 9, 2024 (Effective Date of Rule)
SDPs following a Medicare fee schedule no longer require a preprint	
State appeal rights for SDPs not approved	
ACR analysis required for preprint approval	First contract/rating year period after July 9, 2024 (i.e., January 1, 2025–July 1, 2025, depending on the state-specific contract/rating year)
VBP measure selection and attribution methodologies	
Provider taxes-related hold harmless attestations required	First contract/rating year period on or after January 1, 2028
VBP payment requirements	First contract/rating year period after July 9, 2026 (i.e., January 1, 2027–July 1, 2027, depending on state-specific contract/rating year)
SDPs described in MCO contracts	
SDP preprint submission timing	
Separate Payment Terms no longer permitted	First contract/rating year period after July 9, 2027 (i.e., January 1, 2028–July 1, 2028, depending on state-specific contract/rating year)
Payment Reconciliation prohibited outside of the contract/rating year	
SDP cost percentage reporting	
Evaluation Plan Requirements	
Contract and Rate Certification submission timeframes	First contract/rating year period after July 9, 2028 (i.e., January 1, 2029–July 1, 2029, depending on state-specific contract/rating year)
MLR	
Provider Incentives in Incurred Claims	First contract/rating year period after July 9, 2025 (i.e. January 1, 2026–July 1, 2026, depending on state-specific contract/rating year)
Expense Allocation Methodology	July 9, 2024 (Effective Date of Rule)
Comparative Rate Analyses	
Comparative rate analysis for primary care, OB/GYN, mental health, and SUD services relative to Medicare	First contract/rating year period after July 9, 2026 (i.e., January 1, 2027–July 1, 2027, depending on state-specific contract/rating year)
Comparative rate analysis or homemaker, home health aides, personal care services, and habilitation relative to Medicaid FFS	

Caveats and Limitations

Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commentary on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Mercer recommends that readers secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this document or otherwise.

Questions for your specific state?

Please contact your Mercer consultant to discuss the impact for your specific state programs. You may also email us at: mercer.government@mercer.com.

Visit our Website

For more information on our insights and services, visit our website: https://www.mercer.com/government.