MEDICAID MANAGED CARE FINAL RULE - NOVEMBER 2020 - MHPA COMMENTS/CMS ACTIONS – TOPLINE SUMMARY

Issue	MHPA Comments/ CMS Action	CMS Finalized Policy
Standard Contract Requirements (§ 438.3(t))	MHPA generally supported with note of caution related to potential state actions that could increase administrative costs. **Finalized with one modification.**	CMS finalized its proposal with one modification to clarify that when a state elects not to require its managed care plans to enter into COBAs with Medicare, the remittance advice issued by the state must indicate that the state has not denied payment but that the claim has been sent to the MCO, PIHP, or PAHP for payment consideration.
Actuarial Soundness Standards (§ 438.4) ***a. Option to Develop and Certify a Rate Range 438.4(c)***	MHPA recommended a narrower band limiting the width to lesser of: 2 % or 2x underwriting gain; also called for greater transparency. **Finalized with modifications**	CMS finalized the policy that the upper bound of a rate range does not exceed the lower bound of the rate range multiplied by 1.05 (5%) (438.4(c)(1)(iii)). CMS believes that 5 percent, or +/-2.5 percent from the midpoint, rate range will permit increased flexibility in rate setting, while the specific conditions proposed will also ensure that the rates are actuarially sound. Rate range certifications must document the capitation rates payable to each managed care plan prior to the start of the rating period for the applicable MCO, PIHP or PAHP under § 438.4(c)(2)(i). States that use rate ranges are not permitted to modify the capitation rates under § 438.7(c)(3). States are permitted to either use the rate range option under § 438.4(c)(1) or use the de minimis +/- 1.5 percent range that is currently codified in § 438.7(c)(3), but states are not permitted to use both mechanisms in combination. (§ 438.4(c)(2)(ii)). States have the authority to make changes to the capitation rates within the permissible rate range of up to 1 percent of each certified rate within the rate range without the need for the state to submit a revised rate certification. § 438.4(c)(2)(iii). Any changes of the capitation rate within the permissible +/- 1 percent amount must be consistent with a modification of the contract as required in § 438.3(c) and are subject to the requirements at § 438.4(b)(1). Any modification to the capitation rates within the rate range greater than the permissible +/- 1 percent amount will require states to provide a revised rate certification for CMS approval and to meet the requirements listed in paragraphs (c)(2)(iii)(A) through (C).

		States developing and certifying a range of capitation rates per rate cell as actuarially sound must post the following specified information on their public websites: (A) the upper and lower bounds of each rate cell; (B) a description of all assumptions that vary between the upper and lower bounds of each rate cell, including for the assumptions that vary, the specific assumptions used for the upper and lower bounds of each rate cell; and (C) a description of the data and methodologies that vary between the upper and lower bounds of each rate cell, including for the data and methodologies that vary, the specific data and methodologies used for the upper and lower bounds of each rate cell. (§ 438.4(c)(2)(iv)) The effective date of this provision is the first contract rating period beginning on or after July 1, 2021. States that elect to adopt rate ranges must comply with § 438.4(c) as amended effective July 1, 2021 for Medicaid managed care rating periods starting on or after July 1, 2021.
Actuarial Soundness Standards (§ 438.4) ***b. Capitation Rate Development Practices that Increase Federal Costs and Vary with the Rate of Federal Financial Participation (FFP) (§ 438.4(b)(1) and (d))***	MHPA did not support the list of prohibited rate development practices. **Partially finalized**	Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations; 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. § 438.4(b)(1). The evaluation of compliance with § 438.4(b)(1) is on a program-wide basis, including all managed care contracts and covered populations. The final rule will require an evaluation of any differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs that increase Federal costs and vary with the rate of FFP associated with the covered populations. CMS also has the authority to require a state to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations. CMS did NOT finalize the text proposed in paragraph (d)(1) to address the concerns from commenters that proposed § 438.4(d)(1) was too restrictive and overlooked scenarios where the proposed list of prohibited rate development practices may be actuarially appropriate.

Special Contract Provisions Related to Payment (§ 438.6) ***a. Risk-Sharing Mechanism Basic Requirements (§ 438.6(b))***	MHPA requested that CMS clarify that retroactive rate adjustments are permissible. **Finalized as proposed**	To address the practice of adopting or amending risk-sharing mechanisms retroactively, risk-sharing mechanisms must be documented in the contract and rate certification documents prior to the start of the rating period; this policy explicitly prohibits retroactively adding or modifying risk-sharing mechanisms described in the contract or rate certification documents after the start of the rating period. CMS clarified that risk-sharing mechanisms, which can include a risk mitigation strategy, are a distinct and separate concept from risk adjustment. Section 438.6(b)(1) applies to any and all mechanisms or arrangements that have the effect of sharing risk between the MCO, PIHP, or PAHP, and the state on an aggregate level. Common risk mitigation strategies include a medical loss ratio (MLR) with a remittance, a risk corridor, or a risk-based reconciliation payment. The proposed change to § 438.6(b)(1) does not impact states' ability to revise or adjust capitation rates retroactively under § 438.7(c)(2) when unexpected events or programmatic changes occur during a rating period that necessitate a retroactive change or adjustment to the previously paid rates. Examples include substantial coverage changes occurring mid-year, adjustments needed to address disease outbreaks, launches of high-cost prescription drugs, or other unforeseen circumstances that increase benefit costs. CMS references the policy at § 438.7(c)(2) that the retroactive adjustment (or change) to capitation rates must be supported by an appropriate rationale and that sufficient data, assumptions, and methodologies used in the development of the adjustment must be described in sufficient detail and submitted in a new rate certification along with the contract amendment.
Special Contract Provisions Related to Payment (§ 438.6) ***b. Delivery System and Provider Payment Initiatives under MCO, PIHP, or PAHP Contracts (§ 438.6(a) and (c))***	MHPA recommended that CMS allow for market-based negotiations related to value-based provider payment reforms. **Partially finalized and with modifications.**	CMS made several modifications to regulatory text related to the definition of supplemental payments and state plan approved rates including: • Definition of supplemental payments. Clarified that states DSH and GME payments are not, and do not constitute, supplemental payments; also included a technical change to the definition of supplemental payments by revising the phrase "amounts calculated through an approved State plan rate methodology" to "State plan approved rates." § 438.6(a) • Definition of state plan approved rates. Provided that a state's supplemental payments contained in a state plan are not, and do not constitute, state plan approved rates under our definition. § 438.6(a),

		CMS finalized elimination of the requirement that states obtain written prior approval for payment arrangements that have already been approved by CMS in the Medicaid state plan. (§ 438.6(c)(2)(ii)) CMS did not finalize several proposals related to state directed payment policies. (§ 438.6(c)(1)(iii)(E) and (c)(2)(ii)(C)).
Special Contract Provisions Related to Payment (§ 438.6) ***c. Pass-Through Payments under MCO, PIHP, and PAHP Contracts (§ 438.6(d))***	MHPA recommended a 5 year transition period. **Finalized with modifications**	CMS finalized a transition period for up to 3 years from the beginning of the first rating period in which the services were transitioned from payment in a FFS delivery system to a managed care contract, provided that during the 3 years, the services continue to be provided under a managed care contract with an MCO, PIHP, or PAHP. CMS modified regulatory text to include the following sentence, "Both the numerator and denominator of the ratio should exclude any supplemental payments made to the applicable providers" and using the phrase "State plan approved rates" instead of "payment rates" to clarify how those ratios do not include supplemental payments. (§ 438.6(d)(iii)(A) through (C)) The effective date was delayed for this provision - States that are initially transitioning populations and services from fee-for-service to managed care must comply with § 438.6(d)(6) as amended effective July 1, 2021 for Medicaid managed care rating periods starting on or after July 1, 2021
Special Contract Provisions Related to Payment (§ 438.6) ***d. Payments to MCOs and PIHPs for Enrollees that are a Patient in an Institution for Mental Disease (IMD) (§ 438.6(e))***	**No proposals/no changes**	No proposals/no changes.

Rate Certification Submission (§ 438.7)	MHPA suggested considerations related to the annual guidance and the rate review process. MHPA recommended transparency for any de minimis rate change and that CMS only allow rates to change (without a revised certification) by no more than the lesser of: a) the risk margin or b) 1.5%. **Finalized with technical correction.**	Section 438.7(c)(3) gives states flexibility to make *de minimis* rate adjustments during the contract year by enabling states to increase or decrease the capitation rate certified per rate cell by 1.5 percent without submitting a revised rate certification. The +/- 1.5 percent is to be calculated as a percentage of the certified rate. CMS noted that states cannot use both the *de minimis* rate adjustment under § 438.7(c)(3) and the newly proposed 5 percent, or +/-2.5 percent from the midpoint, rate range under proposed § 438.4(c). As proposed and finalized, § 438.4(c)(2)(ii) prohibits a state that is using a rate range from also modifying capitation rates under § 438.7(c)(3) by +/- 1.5 percent (CMS refers to section I.B.2.a. of the final rule for a discussion of §438.4(c)). CMS declined to add new regulation text requiring states to document *other* changes made during the year that may not have changed rates because any changes would have to be included as modifications to the managed care plan contract and submitted to CMS for approval under § 438.3(a). Technical correction (with policy implications) to Regulatory text: CMS finalized a revision to § 438.7(c)(3) to include the language "during the rating period" as part of the standard for using the 1.5 percent adjustment. CMS noted retroactive adjustment to the capitation rate must meet the requirements in § 438.7(c)(2) as there is no regulatory provision carving *de minimis* rate changes out of the scope of § 438.7(c)(2) and the preamble discussions in the 2016 final rule and 2018 proposed rule limited the *de minimis* rate changes to those changes made during the contract year or rating period.
Non-Emergency Medical Transportation PAHPs (§ 438.9)	**Correction**	CMS corrected an error from the 2016 final rule and added regulatory text language to exempt NEMT PAHPs from complying with MLR standards. (§ 438.9(b)(2)).
Information Requirements (§ 438.10)	MHPA generally supported the proposed beneficiary information changes. **Finalized with modifications**	CMS finalized the deletion of the definition of large print as "no smaller than 18-point" and adopted the "conspicuously visible" standard for taglines that is codified at 45 CFR 92.8(f)(1). (§ 438.10(d)(2)).

a. Language and Format (§ 438.10(d))		CMS also finalized the requirement for taglines only on materials for potential enrollees that "are critical to obtaining services." (§ 438.10(d)(2)) and revised the list of information required in taglines to include how enrollees can requests auxiliary aids and services and to correct the regulatory text to make "language" plural in § 438.10(d)(2).
Information Requirements (§ 438.10) ***b. Information for All Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: General Requirements (§ 438.10(f))***	MHPA generally supported the proposed beneficiary information changes. **Finalized as proposed**	CMS finalized policy change to the requirement that managed care plans issue notices within 15 calendar days after receipt or issuance of the termination notice to the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the notice. (§438.10(f)(1).
Information Requirements (§ 438.10) ***c. Information for All Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbooks (§ 438.10(g))***	**Correction**	Reference correction related to 2016 final rule.
Information Requirements (§ 438.10) ***d. Information for All Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Provider Directories (§ 438.10(h))***	MHPA suggested that CMS limit paper directory updates to once a year. **Finalized as proposed**	CMS finalized several updates to its requirements for provider directories including alignment of the requirements for Medicaid managed care directories with the FFS directories and requiring only quarterly updates to paper provider directories if mobile enabled directories are available.

Network Adequacy Standards (§ 438.68)	MHPA supported the state flexibility related to time or distance requirements. **Finalized as proposed**	Finalized removal of the requirements for states to set time and distance standards and added a more flexible requirement that states set a quantitative network adequacy standard for specified provider types. States may elect to use, but are not limited to: minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (for example, extended evening or weekend hours); and combinations of these quantitative measures. CMS encouraged states to use the quantitative standards in combination – not separately – to ensure that there are not gaps in access to, and availability of, services for enrollees. States have the authority to designate "specialists" to which network adequacy standards will apply under § 438.68(b)(1) and CMS declined to identify additional specific specialties or provider types for states to include in this category believing states are best suited to identify the provider types for which specific access standards should be developed in order to reflect the needs of their populations and programs.
Medicaid Managed Care Quality Rating System (MAC QRS) (§ 438.334)	MHPA supported state flexibility. **Finalized with some modifications**	CMS finalized the changes to the MAC QRS regulations at § 438.334 as proposed with mostly technical modifications. The MAC QRS framework is to include performance measures, a subset of minimum mandatory measures, and methodology, that apply to CMS-developed QRS or state alternative QRS. MAC QRS and the minimum measure set should be aligned with the Medicaid Scorecard Initiative and other CMS managed care rating systems, including Medicare Advantage. The policy includes consideration of feasibility factors for the substantial comparability standard for a state alternative QRS and does not require CMS prior-approval of state alternative QRS with one language modification to change the phrase "in consultation" to "after consultation."

Exemption from External Quality Review (§ 438.362)	**Finalized with modifications.**	Information on state exemption of MCOs be included as an element of the annual EQR technical reports or provide that no MCOs are exempt, as appropriate.
Grievance and Appeal System: Statutory Basis and Definitions (§ 438.400) ***Statutory Basis and Definitions (§ 438.400)*** ***General Requirements (§§ 438.402 and 438.406)*** ***Resolution and Notification: (§ 438.408)***	MHPA supported the proposed changes and recommended that CMS select one time period rather than a range for clarity. **Finalized as proposed with minor addition for clarity**	CMS finalized the definition of "adverse benefit determination" in § 438.400(b) to clarify treatment of denials of claims on the basis that they are not clean claims and added the word "solely" for clarity CMS eliminated the requirements that an oral appeal be submitted in writing to be effective. CMS changed the timeframe requirement for an enrollee to request a state fair hearing after receiving an adverse decision from a managed care plan to no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.
Effective Dates/Compliance Dates	*Effective Date*: These regulations are effective 30 days after the date of publication in the **Federal Register**, except for the additions of: • §438.4(c) - **Actuarial soundness: Option to develop and certify a rate range;** and • §438.6(d)(6) – **Special contract provisions related to payment- Pass through Payments.** which are effective July 1, 2021 for Medicaid managed care rating periods starting on or after July 1, 2021. *Compliance Dates*: States must comply with the requirements of this rule beginning 30 days after the date of publication in the **Federal Register**, *except for two provisions referenced above* **AND**: • §438.340 - **Managed care State quality strategy;** and • §438.364 - **External quality review results.** States must comply with § 438.340 as amended for all Quality Strategies submitted after July 1, 2021. States must comply with § 438.364 for all external quality reports submitted on or after July 1, 2021.	

CHIP	Many of the updates to the Medicaid regulations apply to CHP including: • Network Adequacy Standards • MLR • QRS and other Quality standards • Appeals and Grievances • Beneficiary Information requirements