DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

September 4, 2020

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) expects states to include the contract language below in their Medicaid and Children's Health Insurance Program (CHIP) managed care plan contracts. States should execute contract amendments to include the additional language in managed care plan contracts no later than December 31, 2020. The executed contract amendments should be submitted to CMS for review and approval. We are issuing this guidance as part of our ongoing effort to provide greater transparency and consistency across CMS' managed care plan contract review process.

CMS must review and approve initial and amended contract actions that states enter into with Medicaid Managed Care Organizations (MCO), Health Insuring Organizations (HIO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), and Primary Care Case Management (PCCM) Entities per 42 Code of Federal Regulations (C.F.R.) §438.3(a), §438.3(p), and §438.3(r). Under section 1903(m)(2)(A) and 42 C.F.R. §438.806, CMS approval of MCO contracts is a precondition for capitation payments under the contract to be eligible for federal financial participation (FFP). The CHIP regulation at 42 C.F.R. §457.1201(a) imposes a requirement for CMS to review MCO, PIHP, PAHP, and PCCM Entity contract actions.

State Medicaid or CHIP program features are sometimes invalidated by courts of law, or by changes to federal statutes, regulations, or approvals. CMS has a responsibility to ensure that federal matching funds are provided only for state expenditures that are consistent with federal legal requirements. Accordingly, we expect states to include language in their managed care plan contracts that will help to ensure that CMS is not matching expenditures on unauthorized programs or activities. States should therefore specify in managed care plan contracts (and amend existing managed care plan contracts to specify) that if any Medicaid or CHIP program or activities reflected in the contract are no longer authorized by law, all work must stop on the no-longer-authorized program or activity and the state must submit an amendment to remove costs associated with that program or activity from the rates paid to the managed care plans under contract with the state in its Medicaid and CHIP managed care delivery systems. This policy applies to both risk and non-risk contracts. Again, states should execute contract amendments to include the additional language in managed care plan contracts no later than December 31, 2020 and submit to CMS for review and approval.

The following contract language should be incorporated into existing managed care plan contracts via amendment and should be included in any new base contracts the state executes with a managed care plan:

> "Should any part of the scope of work under this contract relate to a state program that is

no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), {*managed care plan*} must do no work on that part after the effective date of the loss of program authority. The state must adjust {*capitation rates*} [replace with "*payments*" for non-risk contracts] to remove costs that are specific to any program or activity that is no longer authorized by law. If {*managed care plan*} works on a program or activity no longer authorized by law after the date the legal authority for the work ends, {*managed care plan*} will not be paid for that work. If the state paid {*managed care plan*} in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if {*managed care plan*} worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to {*managed care plan*}, {*managed care plan*} may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority."

CMS will post this new guidance on the Medicaid.gov website and has reflected necessary documentation for rate development in our annual Medicaid Managed Care Rate Development Guide. The Division of Managed Care Operations staff will also share this guidance with your state managed care staff when it is available.

If you have questions concerning this letter, please contact Bill Brooks, Director, Division of Managed Care Operations, at Bill.Brooks@cms.hhs.gov.

Sincerely,

[redacted]

Courtney Miller
Group Director
Medicaid and CHIP Operations Group