Medicaid and CHIP Managed Care Final Rule CMS-2408-F

All-State Call

November 17, 2020

Center for Medicaid & CHIP Services

Publication Dates

- NPRM Publication Date: 11/14/2018
- Final Rule Publication Date: 11/13/2020
- Link to Federal Register: https://www.federalregister.gov/public-inspection/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care

CMS Goals for the Final Rule

The Final Rule is intended to improve the balance of federal oversight and state flexibility while maintaining critical beneficiary and quality of care protections, including the following goals:

1. Reducing Administrative Burden on States
2. Supporting State Flexibility
3. Promoting Transparency and Innovation
4. Fostering Accountability
5. Maintaining and Enhancing Program Integrity

Setting Actuarially Sound Capitation Rates (1/3)

- Proposed: Permit states to develop and certify a rate range up to 5 percent within certain limitations when both the upper and lower bounds of the rate range are actuarially sound.
  - Final Status: Finalized with modifications:
    1. Permit states to move rate cells within the rate range a *de minimis* amount (+/- 1 percent).
    2. Require states to post on their public websites certain information prior to executing a managed care contract that includes a rate range:
       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; 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.

Setting Actuarially Sound Capitation Rates (2/3)

- Proposed: Specify that 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 and that any differences in the assumptions, methodologies, or factors cannot vary with the rate of federal financial participation.
  - Final Status: Finalized with modifications to remove the list of prohibited rate development practices but allowing CMS 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.

Setting Actuarially Sound Capitation Rates (3/3)

- Proposed: Maintain the ability to adjust rates up or down by 1.5 percent during the rating period without a revised rate certification for states not utilizing the rate range option.
  - Final Status: Finalized as proposed.
- Proposed: Codify requirements for CMS to issue annual sub-regulatory guidance to help streamline rate review processes and to address updates or developments in the rate review process to reduce state burden and facilitate prompt actuarial rate reviews.
  - Final Status: Finalized as proposed.
- Proposed: Prohibit states from adding or modifying risk-sharing mechanisms after the start of the rating period.
  - Final Status: Finalized as proposed.

Pass-Through Payments and State Directed Payments

- Proposed: Permit states that are newly transitioning Medicaid populations or services from fee-for-service to managed care a three year transition period to require managed care plans to make pass-through payments at an amount that is less than or equal to the amount of existing supplemental payments under fee-for-service.
  - Final Status: Finalized as proposed.
- Proposed: Permit state directed payments that utilize a State Plan approved fee schedule to be implemented without prior approval.
  - Final Status: Finalized as proposed.
- Proposed: Allow multi-year approval (instead of annual approval) for state directed payments that are designed to pursue value-based purchasing.
  - Final Status: Finalized as proposed.
- Proposed: Acknowledge additional types of state directed payment arrangements and remove the prohibition on specifying the amount and frequency of state directed payments.
  - Final Status: Not finalized.

Network Adequacy Standards

- Proposed: Replace the requirement for states to establish time and distance network adequacy standards with a more flexible requirement that states establish quantitative network adequacy standards.
  - Final Status: Finalized as proposed.
- Proposed: Clarify that states have the authority to define “specialists” for the purpose of establishing network adequacy standards in the most appropriate way for their programs.
  - Final Status: Finalized as proposed.

Appeals and Grievances

- Proposed: Eliminate the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted.
  - Final Status: Finalized as proposed.
- Proposed: Revise the timeframe for enrollees to request a state fair hearing to no less than 90 calendar days and no greater than 120 calendar days to better align with Medicaid fee-for-service requirements.
  - Final Status: Finalized as proposed.
- Proposed: Revise the definition of an adverse benefit determination to exclude administrative claim denials and thus eliminate the requirement for unnecessary written notices to enrollees.
  - Final Status: Finalized as proposed.

Requirements for Beneficiary Information

- Proposed: Replace the requirement for taglines to be in 18-point font with the adoption of the "conspicuously-visible" font size standard.
  - Final Status: Finalized as proposed.
- Proposed: Eliminate the requirement to print taglines on all written materials and instead only require taglines on materials that are critical to obtaining services.
  - Final Status: Finalized as proposed.
- Proposed: Permit paper provider directories to be updated quarterly rather than monthly if the managed care plan offers a mobile-enabled provider directory.
  - Final Status: Finalized as proposed.
- Proposed: Provide managed care plans with more flexibility by permitting notices of provider terminations to be sent by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of a termination notice.
  - Final Status: Finalized as proposed.

Quality Rating System (QRS)

- Proposed: Add to the QRS framework development process a requirement for CMS to develop a minimum set of mandatory performance measures that will apply equally to the federal QRS and alternative QRS. CMS will continue to align the QRS and this minimum set with the Medicaid Scorecard initiative and other CMS managed care rating systems, as appropriate.
  - Final Status: Finalized as proposed.
- Proposed: Make more explicit that CMS will consult with states and other stakeholders in developing the QRS including sub-regulatory guidance on the "substantially comparable" standard for an alternative QRS.
  - Final Status: Finalized as proposed.
- Proposed: Eliminate the requirement that a state receive approval from CMS prior to implementation of an alternative QRS while maintaining CMS oversight authority.
  - Final Status: Not finalized.

Application to CHIP

- CHIP continues to align with Medicaid when appropriate.
- CHIP adopts many of the revisions to 42 CFR 438, including network adequacy standards, medical loss ratio standards, quality rating system and other quality standards, and appeals and grievances.
  - Final Status: Adopts finalized Medicaid provisions that apply to CHIP via cross-reference in 42 CFR 457.
- CHIP proposed several minor technical or clarifying changes to the CHIP managed care provisions, primarily to clarify that certain Medicaid managed care requirements do not apply to CHIP.
  - Final Status: Finalized as proposed, with some revisions in response to comments.

Compliance Dates

- States must comply with all provisions of the Final Rule by December 14, 2020, with the following exceptions:
  - 42 CFR § 438.4(c) – Rate Ranges: These provisions are effective on July 1, 2021 for contract rating periods beginning on or after July 1, 2021.
  - 42 CFR § 438.6(d)(6) – Pass-Through Payments: These provisions are effective on July 1, 2021 for contract rating periods beginning on or after July 1, 2021.
  - 42 CFR § 438.340 – Quality Strategies: These provisions apply to all quality strategies submitted on or after July 1, 2021 (applies to CHIP through an existing cross-reference in § 457.1240(e)).
  - 42 CFR § 438.364 – External Quality Review Technical Reports: These provisions apply to all external quality review technical reports submitted on or after July 1, 2021 (applies to CHIP through an existing cross-reference in § 457.1250(a)).

Questions