Analysis of the CMS Managed Care Final Rule

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MANAGED CARE FINAL RULE

Final Rule Release

On April 22, 2024, CMS released the Managed Care Final Rule for public inspection with final publication in the Federal Register on May 10, 2024.

The final rule adopts new standards for **access to care** for services delivered through a **managed care model**, and new and **enhanced requirements** related to program quality and finance.

CMS largely adopted the rules as proposed, with key revisions to state directed payment, quality provisions, and effective dates based on its request for public comment.

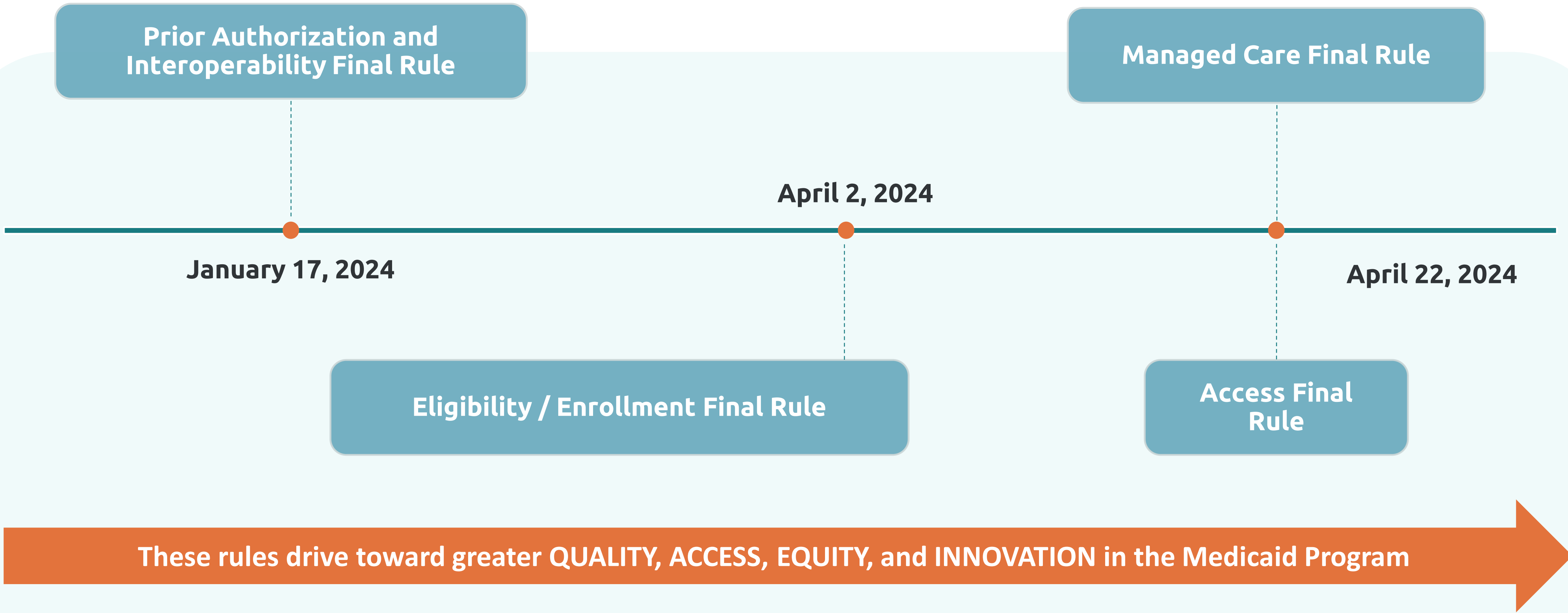
Effective dates vary, with some provisions applicable on the effective date of the rule (July 9, 2024), and other provisions with longer implementation periods.

PROPOSED RULE

The proposed rule was published in the Federal Register on May 3, 2023. CMS accepted public comment on the proposed rulemaking through July 3, 2023. CMS received a total of 415 timely comments, including comments from nineteen state Medicaid agencies and numerous managed care organizations, hospital systems, providers, and other stakeholders.

MANAGED CARE FINAL RULE

Simultaneous Release of Final Rules Impacting Medicaid is Significant



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FINAL MANAGED CARE RULE

Access | Key Provisions

State contract requirements for MCOs to conduct rate payment analysis
July 9, 2026

For outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology – **compare to Medicare rates for the same services**

For homemaker services, home health aide services, personal care services, and **habilitation services – compare to fee-for-service (FFS) rates for the same services**

Administer surveys to collect and report annual enrollee experience
July 9, 2027

Results submitted to CMS through the Managed Care Program Annual Report (MCPAR)

Federal appointment wait time standards for certain services
July 9, 2027

Including outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology, and one additional service to be defined by the State

Use independent "secret shoppers"
July 9, 2028

To validate provider networks

MANAGED CARE FINAL RULE

Medical Loss Ratio (MLR) | Key Provisions

Modifies statute to **remove the requirement for States to submit these amounts as separate line items in their annual MLR summary reports** to CMS

Requires **managed care plans submit actual expenditures and revenues for state directed payments as part of their MLR reports to States** as proposed

Effective September 7, 2024

Revises how **MCO provider incentives and bonus payments are counted in the MLR calculation** as proposed

Effective the first rating period beginning on or after July 9, 2025

Requires **managed care plans report any identified or recovered overpayments to States within 30 calendar days** rather than as proposed (10 business days)

Effective first rating period beginning on or after July 9, 2025

Requires **States to provide MLRs for each plan** as proposed

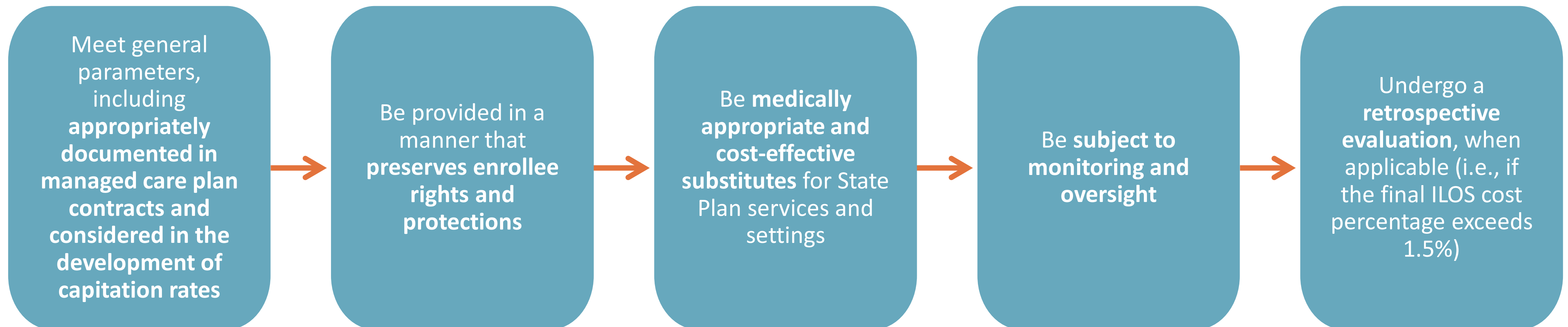
Effective September 7, 2024

MANAGED CARE FINAL RULE

In-Lieu of Service and Setting (ILOS) | Key Provisions

Formalizes CMS' **previous ILOS guidance** from State Medicaid Director Letter #23-001

Defines and provides key principles around ILOS. ILOS must:



Requires State actuary to **calculate both a projected ILOS cost percentage and a final ILOS cost percentage**

Requires States to **identify specific codes and modifiers for each ILOS and provide them to managed care plan**

MANAGED CARE FINAL RULE

Quality Assessment | Key Provisions

Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Reviews

Allows managed care **plans exclusively serving duals to use a Medicare Advantage Chronic Care improvement program in place of Quality Improvement Program** (QIP)

Requires States to **solicit public comment on their managed care quality strategy every 3 years**, and to **submit their quality strategy to CMS every 3 years**

Modifies scope of mandatory EQRO review to **remove PCCM entities**

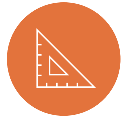
Expands the type of data included in EQRO reports by requiring any **outcomes data and results from quantitative assessments**, whether or not data has been validated, and **data from network adequacy validation**

STATE QUALITY STRATEGIES

States have historically varied in their timeliness and the complexity of state quality strategies. The final rule requires more administrative effort from states and greater awareness from MCOs and providers to support those areas.

MANAGED CARE FINAL RULE
Quality Rating System | Key Provisions

Establishes the **framework of a Medicaid Quality Rating System (QRS)**


Defines a **methodology for calculating the quality ratings** displayed

Requires states **publicly post QRS data to allow beneficiaries to compare plans**

Mandates **16 quality measures for QRS public reporting** *(initially 18)* and a defined process to add or change measures
Subset of mandatory measures must be ***stratified by demographic factors***

Broadens requirements to **promote more flexibility for states to implement an alternative QRS**

CMS is allowing states to submit a request for a one-time, one-year extension for the methodology requirements if the state would be unable to fully implement the requirements.

MANAGED CARE FINAL RULE

State Directed Payments (SDPs) | Key Provisions

Average Commercial Rate (ACR) as Upper Limit

For SDPs in 4 service areas (IP/OP/nursing facility/qualified practitioner-AMC)

ACR must be state-specific, should also be specific to service type, but does *not* need to be specific to provider class

Applicability Date
FIRST RATING PERIOD
Beginning on or after
July 9, 2024

Revised Submission and Approval Timeframes

Requires that all SDP preprints are submitted to CMS before program effective date or ineligible for approval

Programs must be approved by CMS before payments begin to flow

Applicability Date
FIRST RATING PERIOD
Beginning on or after
July 9, 2026

Updated SDP Quality and Evaluation Requirements

CMS has authority to disapprove SDPs that repeatedly pay providers despite failure to meet identified quality measures

Confirms multi-approval up to 3 years for value-based payment programs (effective now)

Applicability Date
FIRST RATING PERIOD
Beginning on or after
July 9, 2027

Separate Payment Terms & Historical Utilization Reconciliation Prohibited

Prohibits use of separate payment terms and limits reconciliation to actual utilization in current rating period

Requires all state directed payments to be included in actuarially sound capitation rates

Applicability Date
FIRST RATING PERIOD
Beginning on or after
July 9, 2027

Provider Attestations Related to Hold Harmless Arrangements

States required to collect written provider attestations to ensure they do not participate in any hold harmless arrangement for any health care-related tax

CIB issued alongside the rule reinforces the extended timeline considering ongoing litigation in TX and FL

Applicability Date
FIRST RATING PERIOD
Beginning on or after
January 1, 2028

CMS is NOT finalizing total expenditure limit for SDPs *due to potential for unintended consequences to States' efforts to further their overall Medicaid program goals and objectives.*

MANAGED CARE FINAL RULE
Average Commercial Rate as Upper Limit

DEFINITION:
The average rate paid for services by the highest claiming third-party payers for specific services as measured by claims volume

CMS approved the recommendation of the use of the average commercial rate (ACR) as the upper limit for total payment rates for four specific areas only: inpatient hospital services, outpatient hospital services, nursing facilities, and "qualified practitioner services at an academic medical center."

CMS clarifies that "although we are only finalizing the total payment rate limit at ACR for four provider types and services, in practice we intend to use ACR as the fiscal benchmark by which we will evaluate whether **all** SDP total payment rates are reasonable, appropriate, and attainable."

ACR **must be specific to the state** (no national or regional ACRs that cross state lines)

States have **flexibility to calculate ACR by type of service or by provider class**

Reference: Excerpts from f. Standard for Total Payment Rates for each SDP, Establishment of Payment Rate Limitations for Certain SDPs and Expenditure Limit for All SDPs (§ 438.6(c)(2)(ii)(I) and (c)(2)(iii), pgs. 201 – 212)

MANAGED CARE FINAL RULE
Provider Attestations (Hold Harmless)

TWO NEW SEPARATE REQUIREMENTS

1. **Ensure that providers receiving payment under an SDP attest that they do not participate in any hold harmless arrangement for any health care-related tax**

2. **Ensure either that, upon request, written attestations from each participating provider are available OR States provide an explanation** that is satisfactory to CMS about why specific providers are unable or unwilling to make such attestations.

CMS notes that while they can disapprove the SDP even with attestations if prohibited hold harmless appears to be in place , they also note that failure of one or a small number of providers to submit an attestation would not necessarily lead to disapproval of the State's proposed SDP preprint.

Reference: g. Financing (§ 438.6(c)(2)(ii)(G) and (c)(2)(ii)(H), pg. 232 – 242

CIB AND ONGOING LITIGATION

Note accompanying Informational Bulletin provides additional guidance and reinforces **extended timeline to collect attestations by January 1, 2028**

Ongoing litigation in TX and FL could further impact this timeline and this provision language.

MANAGED CARE FINAL RULE

Interim Payments and Reconciliation

States cannot condition payment from the managed care entity to the provider on utilization and delivery of services outside of the rating period for which the State is seeking written prior approval and then require that payments be reconciled to utilization during the rating period.

Does not prohibit all reconciliation processes such as standard provider payment processes. Claims can be paid by plans to providers after end of rating period so long as they are based on utilization from within the rating period.

The regulation at § 438.6(c)(2)(vii)(B), as proposed and finalized, does not prohibit reconciliation of payments to actual utilization during the rating period when interim payments were also based on utilization during the rating period.

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MANAGED CARE FINAL RULE

Separate Payment Terms | Background

DEFINITION:
Separate payment term is defined as a pre-determined and finite funding pool that the State establishes for an SDP where payments to MCOs are made separately and outside of capitation rates.

STATES CURRENTLY HAVE TWO OPTIONS TO ACCOUNT FOR SDPS IN THE MANAGED CARE RATE CERTIFICATION:

1. Adjustments to the base capitation rate, where states incorporate the SDP in the prospective, per-member per-month (PMPM) payment made to plans, or
2. A separate payment term, where an aggregate pool of funding is reserved for the SDP, separate from the base capitation rate.

Many of the approved programs do not require the MCOs to pay the enhanced rate on a claim-by-claim basis. Rather, payments are typically made retroactively on a monthly, quarterly, or annual basis, tied to utilization of services during the period and paid separately from their monthly capitation payments.

BENEFITS:
Paying outside of claims payments and separately from the capitation payments greatly enhances the ease of administering the programs, for the state, for the MCOs, and for the providers.

Reference: l. Including SDPs in Rate Certifications and Separate Payment Terms (§§ 438.6(c)(2)(ii)(J) and (c)(6), and 438.7(f), pg. 329-349)

MANAGED CARE FINAL RULE
Phasing Out Use of Separate Payment Terms

CMS RATIONALE:
Payments that flow outside of capitation rates are inconsistent with risk-based managed care
Note that we are assessing the potential impact of the rule provisions that prohibit separate payment terms

Rule requires that all SDPs be incorporated into Medicaid managed care capitation rates as adjustments to base capitation rates **by July 9, 2027**.

States are prohibited from either withholding a portion of the capitation rate to pay the plans separately for a State directed payment or requiring a plan to retain a portion of the capitation rate separately to fulfill the contractual requirement of a State directed payment.

Additional **guidance from CMS is expected to help inform implementation of these provisions.**

Mitigation approaches, including risk corridors, can help to address potential concerns around shifts in utilization and have been successfully implemented for select SDPs to date.

Reference: I. Including SDPs in Rate Certifications and Separate Payment Terms (§§ 438.6(c)(2)(ii)(J) and (c)(6), and 438.7(f), pg. 329-349)

MANAGED CARE FINAL RULE
Preprint Submission and Approval Timeframes

SUBSTANTIALLY EARLIER THAN CMS' CURRENT PRACTICE (BY THE END OF THE RATING PERIOD)

SUBMISSIONS → Due before program effective date

States must complete and **submit all required documentation (completed preprint, total payment rate analysis, ACR demonstration)** for all SDPs and associated amendments for which written approval is required before the specified start date/effective date of the program, as noted in the preprint or preprint will not be eligible for approval.

Revised timeline applies to renewals, amendments and new submissions – no approvals would be made if the timeline is not met.

APPROVALS → Required before dollars flow

States are at risk for disallowance of FFP if SDP preprint is not approved before first payment to provider.

Reference - e. SDP Submission Timeframes (§§ 438.6(c)(2)(viii) and 438.6(c)(2)(ix)), pg. 158 - 171

MANAGED CARE FINAL RULE
Changes in SDP Quality

Quality Considerations for Renewals:

CMS asserts authority to disapprove SDPs that repeatedly pay providers despite failure to meet identified quality measures.

Timing of Evaluations:

The first evaluation report must include 3 years of data and be submitted no later than year 5 (PY6 submission)

Evaluation Components:

All SDPs must have an evaluation plan with at least two metrics, including one performance metric

Multi-year Approval:

Up To 3 years for 100% value-based programs

VBP Recoupment:

States may recoup unspent funds allocated for value-based programs which do not payout all funds

MANAGED CARE FINAL RULE

Other Important Changes in SDP Provisions

Effective July 9, 2024

Requires specific information regarding implementation of SDP be documented in each managed care contract

Must be documented in contract no later than 120 days after start date of SDP

SDP Implementation in Managed Care Contracts

Effective July 9, 2024

NUMERATOR: SDPs made by a managed care entity to a provider should be counted as incurred claims

DENOMINATOR: Payments from State to managed care entity for SDPs should be counted as premium revenue

Inclusion of SDPs in Medical Loss Ratio (MLR) Reporting

Effective July 9, 2024

States must submit revised rate certification for any changes in the capitation rate per rate cell for any SDPs regardless of size of change

Rate certifications must be submitted within 120 days of the SDP start date

Rate Certification Involving SDPs