

Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)
Frequently Asked Questions (FAQs)

November 10, 2016

This FAQ document addresses common questions related to the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) (hereinafter “Final Rule”). We encourage states, managed care plans, and other stakeholders to submit questions to ManagedCareRule@cms.hhs.gov to inform future guidance and FAQs. In addition, presentations from past webinars and additional guidance documents are available on Medicaid.gov at <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>.

Note that references to pages in the Final Rule below are to the version published in the Federal Register on May 6, 2016, available at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

- Q1. A number of provisions in the Final Rule were not subject to substantive changes but were redesignated in a new section in 42 CFR part 438 and have an implementation date of July 5, 2016. Will states be required to amend regulatory citations in approved contracts or contracts currently under CMS review?**
- A1.** CMS understands that many managed care contracts include a general provision that incorporates changes in federal law during the course of the contract term. Amendments to approved contracts, or contracts under CMS review, for the purpose of updating regulatory citations is not necessary. However, the citations will need to be updated for the next contract year. Outdated regulatory citations in contracts without such a general provision will need to be updated for the next contract year.
- Q2. Will states need to modify already approved contracts to add the final capitation rates to the contract to comply with §438.3(c), which requires that the payment term be included in the contract?**
- A2.** Yes. We remind states that the requirement that the final capitation rate be specified in the contract is not a new requirement, see §438.6(c)(2)(ii) of the 2002 final rule. The amount of payment for performance—in this context, the final capitation rate—is a primary component of any contract and must be included for purposes of verifying claims for Federal Financial Participation (FFP) on the CMS-64. In the Final Rule at page 27595, in the context of risk adjustment, CMS suggested that the payment terms under the contract could be identified in an appendix, or additional supporting documentation, to the contract for ease of updating the information when risk adjustment is applied. The state must submit a formal contract amendment when the final capitation rates differ from the payment terms in an approved contract.

Q3. Do all states need to submit contracts and rate certifications to CMS 90 days prior to the effective date of the contract pursuant to §438.3(a)?

A3. No. If a state does not have a state law or policy that requires CMS approval of the contract and capitation rates prior to the effective date of the contract, the 90 day timeframe is not applicable. However, as a general matter, states should submit the contracts and rates 90 days prior to the start of the contract term. CMS intends to provide future guidance on the prior approval requirements as a condition of claiming FFP in §438.806, which are distinct from the requirements at §438.3(a).

Q4. It appears that §438.210(a)(2), which addresses the amount, duration, and scope of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) under managed care, incorrectly cross-references “subpart B of part 440” rather than “subpart B of part 441.” In addition, the Omnibus Budget Reconciliation Act of 1989 broadened the statutory requirements for EPSDT beyond those reflected in 42 CFR part 441. Please clarify how this error will be addressed.

A4. There is a technical error in §438.210(a)(2) as the cross-reference should have incorporated subpart B of part 441 rather than subpart B of part 440. All Medicaid beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or they are in fee-for-service. Under section 1905(r) of the Social Security Act (the Act), EPSDT services must include “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the State plan.” CMS intends to issue a regulatory correction to address this error. We also want to remind readers that sections 1902(a)(43) and 1905(r)(5) of the Act are applicable to the provision of EPSDT, despite not being expressly incorporated in part 441. Detailed guidance on EPSDT can be found in “EPSDT – A Guide for States: Coverage in the Medicaid benefit for Children and Adolescents,” June 2014, available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

Q5. Does the requirement in §438.4(b)(5) that payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell mean that the actuary must use assumptions that are unique to each rate cell?

A5. No. CMS addressed this provision at page 27569 of the Final Rule. Section 438.4(b)(5) does not require there to be different assumptions (such as trend or age, gender, or regional rating) for each rate cell and does not prevent the use of the same assumptions across more than one rate cell. The prohibition on cross-subsidization among rate cells under the contract is to ensure prudent fiscal management and that the capitation rate for each rate cell is independently actuarially sound.

Q6. Are managed care plans permitted to maintain more than one level of appeal?

A6. No. For the rating periods for contracts starting on or after July 1, 2017, managed care plans may not maintain more than one level of appeal. Section 438.402(b) requires that MCOs, PIHPs, and PAHPs “may have only one level of appeal for enrollees.” Note that states may modify managed care contracts to require managed care plans to provide one level of internal appeal in advance of the rating period for contracts starting on or after July 1, 2017, as subpart F in the 2002 final rule permitted states flexibility as to the number of internal appeals. Please see page 27509 of the Final Rule for additional explanatory information.

Q7. Can states elect to permit enrollees to request a State fair hearing without first exhausting the managed care plan’s appeal process?

A7. No, not for the rating period for contracts starting on or after July 1, 2017. Section 438.402(c)(1)(i) requires that the enrollee exhaust the internal level of appeal before requesting a State fair hearing. Note that if the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in §438.408, §438.402(c)(1)(i)(A) provides that the enrollee is deemed to have exhausted the internal level of appeal and may request a State fair hearing. States may modify managed care contracts to require exhaustion of the internal level of appeal in advance of the rating period for contracts starting on or after July 1, 2017, as subpart F in the 2002 final rule permitted states flexibility to determine whether exhaustion would be required. Please see page 27509 of the Final Rule for additional explanatory information.

Q8. The Final Rule at §438.2 defines a rating period as the 12 month period for which actuarially sound capitation rates are set, but there may be legitimate reasons why a state may want to set capitation rates for a time period that is less than or greater than 12 months. Will states have any flexibility in this area?

A8. Yes. CMS acknowledges that states may have legitimate reasons to set capitation rates for a time period that differs from 12 months and will take unusual circumstances into account when reviewing compliance with the rating period duration requirements. CMS will approve a rating period other than of 12 months when a state transitions the contract term and rating period from a calendar year to a state fiscal year basis and setting capitation rates for a 6 month or 18 month period would facilitate that transition. There may be other reasonable justifications for such variations in the rating period that CMS would be open to considering. The rationale for a rating period that differs from 12 months as defined in the regulation in §438.2 should be specified in the rate certification required in §438.7 for such consideration.

Q9. A rating period is defined in §438.2 as the 12 month period for which actuarially sound capitation rates are set. The Final Rule ties implementation and compliance deadlines for some provisions to the rating period for contracts starting on or after a specific

date. Non-risk prepaid inpatient health plans (PIHPs) and non-risk prepaid ambulatory health plans (PAHPs), PCCMs, and PCCM entities do not have a rating period as defined in §438.2 because such arrangements are not subject to actuarial soundness requirements for the development of the per-member per-month (PMPM) amounts under the contracts. What is the implementation date for provisions tied to the rating period for contracts starting on or after a specified date for the aforementioned managed care arrangements?

- A9.** The implementation date for non-risk PIHPs and PAHPs, PCCMs, and PCCM entities for provisions tied to a rating period is the earliest date that a risk-based MCO, PIHP, or PAHP would need to comply. For example, the provisions in subpart F relating to appeals and grievances have an implementation date for risk-based contracts of the rating period for contracts starting on or after July 1, 2017. Non-risk PIHPs and PAHPs would need to implement those provisions by July 1, 2017.
- Q10. Can CMS please clarify if only audited financial statements that are done on a formal Generally Accepted Accounting Principles (GAAP) basis can be used to meet the requirements in §438.3(m)? Audits can also be done following statutory accounting principles or government auditing standards and it is not clear if states and managed care plans have flexibility in which standard to apply.**
- A10.** The regulation at §438.3(m) has a general reference to “generally accepted accounting principles” and “generally accepted auditing principles.” This means that states have the flexibility to specify the applicable generally accepted accounting and auditing principles for the audited financial reports in the managed care plan contracts. The federal regulation does not endorse a particular standard.
- Q11. Where can I find general information on the change in matching rates for External Quality Review (EQR)?**
- A11.** CMS released an Informational Bulletin (CIB) discussing the change in federal financial participation (FFP) for EQR that was effective May 6, 2016. The CIB includes revised claiming instructions for the CMS-64 and a sample form. It is available at [Medicaid.gov](https://www.medicare.gov) on the EQR webpage, under Technical Assistance Documents, and available at <https://www.medicare.gov/federal-policy-guidance/downloads/cib061016.pdf>.
- Q12. Under what circumstances can states claim the enhanced 75 percent match for EQR activities?**
- A12.** Under §438.370, the enhanced match of 75 percent is available for the EQR-related activities described in §438.358 if all of the following conditions are met:
- The EQR activity is performed on a managed care organization (MCO) by an entity meeting the requirements of a qualified EQRO in §438.354 or its subcontractor;

- The activity is performed pursuant to a contract approved by CMS; and
- The activity is performed in accordance with a protocol issued by CMS.

FFP at the 50 percent matching rate is available for mandatory and optional EQR-related activities for PIHPs, PAHPs, and affected PCCM entities, regardless of whether the activities were conducted by an EQRO or another entity. FFP at the 50 percent matching rate is also available for EQR and related activities performed for MCOs that are conducted by an entity that is not a qualified EQRO. This is a change from previous regulations, under which the enhanced match was available for EQR of PIHPs to the same extent as MCOs. This provision took effect May 6, 2016.

Q13. Does the May 6, 2016 effective date for the change in FFP for EQR-related activities apply based on the date of approval of the EQRO contract, the date the activity was performed, or the date of expenditure for the EQR activity?

A13. Regardless of whether an EQRO contract is approved before or after May 6, 2016, the change in FFP for EQR-related activities was effective May 6, 2016 for expenditures incurred by the state on or after May 6, 2016. Per general CMS-64 claiming principles, a state incurs an expenditure that may be claimed on the CMS-64 on the date the state pays the EQRO for the completed performance of the contracted EQR-associated activity.

The change to the FFP match rate for expenditure reporting takes effect in the middle of a quarter, which means that states must ensure that claims for expenditures for EQR activities affected by the change in FFP which were paid before May 6th and claims for expenditures which were paid on or after May 6th are reported separately. For only the quarter ending June 30, 2016, the CMS-64 EQRO Line 17 will allow states to report state expenditures associated with PIHP EQRO activities paid prior to May 6, 2016 and claim the enhanced 75 percent match. State expenditures associated with PIHP EQRO activities paid on or after May 6th must be claimed at the 50 percent matching rate.

Q14. My state is planning for our upcoming EQRO contracting. When does CMS plan to publish a protocol for the new activity relating to the validation of network adequacy?

A14. CMS expects to first issue revised protocols for the current mandatory and optional EQR-related activities in the Fall of 2017. We expect to issue the protocol for the new mandatory EQR activity relating to the validation of network adequacy later in 2017 or early 2018. States will have up to one year from the publication of the protocol to implement the new mandatory EQR activity.

Q15. Does the new mandatory EQR network adequacy validation activity have to be performed by the same EQRO that performs the other mandatory activities?

A15. No. Under §438.356 of the Final Rule, states can contract with one or more EQROs to conduct EQR activities and other related tasks (such as production of the EQR report).

Q16. If I have additional questions about EQR and claiming for EQR, who can I ask?

A16. For questions related to state expenditure reporting and claiming instructions for EQR activities, please contact your CMS regional office financial representative. For specific external quality review questions, including what activities qualify for enhanced match, please contact the Division of Quality and Health Outcomes at ManagedCareQualityTA@cms.hhs.gov.