

H. Conditions for Federal Financial Participation (Subpart J)

Subpart J of the proposed rule contains rules regarding the availability of Federal financial participation (FFP) in MCO contracts. In addition to setting forth recodified versions of existing regulations governing eligibility for FFP currently set forth in part 434, subpart F, the regulations in proposed subpart J reflected new provisions in the BBA affecting FFP (such as., the new restrictions on FFP in enrollment broker contracts), and set forth a proposed new limitation on FFP related to the actuarial soundness requirements in proposed §438.6(c).

1. Basic Requirements (Proposed §438.802)

Proposed §438.802 was based largely on the existing §434.70, and provided that FFP is only available in expenditures under MCO contracts for periods for which (1) the contract is in effect and meets specified requirements, and (2) the MCO, its subcontractors, and the State, are in substantial compliance with specified contract requirements and the requirements in part 438.

Comment: One commenter requested that we clarify what we meant by the requirement in §438.802 that the MCO and its subcontractors be in “substantial compliance” with physician incentive plan requirements and that the MCO and the State be in "substantial compliance" with the contract and these regulations, in order to qualify for FFP.

Response: Proposed §438.802 was based on the existing §434.70, which, in paragraph (b), specifically provided that FFP may be withheld for any period the MCO fails to comply with the physician incentive requirements, or the MCO or the State fail to

comply with the terms of the contract between them or the provisions of this regulation.

We understand the commenter's confusion regarding this requirement since this rule already requires states to monitor compliance with this rule and contracts executed under this rule and provides sanctions to be used where certain requirements are not met.

Further we would expect to initiate penalties such as corrective action plans in these situations where a state is found to be out of compliance with these rules. Finally, in considering the commenter's question, we realize the difficulty in issuing useful guidance as to what constitutes "substantial compliance" for purposes of putting FFP at risk.

Because we believe that the requirements on States and MCOs contained in §438.6 and elsewhere in this rule, and the mechanisms for monitoring and enforcement are sufficiently clear, the requirement for "substantial compliance" in §438.802 is potentially confusing and unnecessary, we have deleted it from this section.

2. Prior Approval (Proposed §438.806)

Proposed §438.806 was based on §434.71 (as affected by new threshold amounts for prior approval enacted in section 4708(a) of the BBA), and provided that FFP was not available in expenditures under contracts involving over a specified financial amount (\$1,000,000 for 1998, adjusted by the consumer price index for future years) unless the contracts were "prior approved" by CMS.

Comment: One commenter inquired whether §438.806 precludes the availability of FFP for a period that a risk contract was under review by CMS, and whether the prior approval requirement applied to all MCOs or just new MCOs. If applicable to all MCOs, the commenter asked whether the FFP limitation applied to the entire amount paid or just

the marginal difference from the previously approved contract amount?

Response: The requirement for prior approval of a new contract or new contract amendment applies to all comprehensive risk contracts, whether with a new or currently contracting MCO. FFP is not available for contracts that CMS has not approved. However, once we approve a contract, FFP is available for any period during which an approvable contract was under review. The limitation on FFP in this provision must be applied to the entire contract. FFP is not available for any portions of the contract unless it is approved.

Comment: One commenter questioned whether the requirement in §438.806(a)(2) meant that a State would lose FFP should it not reach its quality strategy goals.

Response: Section 438.806(a)(2) requires that the written *contract* with the MCO meets the requirements specified as a condition for FFP. The contract would not be approved if it did not meet all the requirements of the law and regulations, including establishing the quality assessment and performance improvement program required by §438.240. However, this is different from the issue of the MCO's or State's performance in implementing this contractually required program. A failure on the part of an MCO or State to meet a particular quality goal would not apply to the conditions in §438.806(a)(2).

Comment: Several commenters pointed out that the reference in §438.806(a)(1) to entities described in §438.6 (a)(2) through (a)(5) should instead refer to §438.6(b)(2) through (b)(5).

Response: We appreciate the commenters' assistance and have made the appropriate changes.

3. Exclusion of Entities (Proposed §438.808)

Proposed §438.808 reflects the limitation on FFP in section 1902(p)(2) of the Act, under which FFP in payments to an MCO is conditioned on the State excluding from participation as an MCO any entity that could be excluded from Medicare and Medicaid under section 1128(b)(8) of the Act, that--

? Has substantial contractual relationship with an entity described in section 1128(b)(8)(B) of the Act.

? Employs or contracts with individuals excluded from Medicaid.

We received no comments on this section.

4. Expenditures for Enrollment Broker Services (Proposed §438.810)

Proposed §438.810 reflects the conditions on FFP for enrollment broker services set forth in section 1903(b)(4) of the Act, which was added by section 4707(b) of the BBA. This section permits FFP in State expenditures for the use of enrollment brokers only if the following conditions are met:

? The broker is independent of any managed care entity or health care provider that furnishes services in the State in which the broker provides enrollment services (regardless of whether the entity or provider participates in Medicaid).

? No person who is the owner, employee, or consultant of the broker or has any contract with the broker:

+ Has any direct or indirect financial interest in any managed care entity or health

care provider that furnishes services in the State in which the broker provides enrollment services.

- + Has been excluded from participation under title XVIII or XIX of the Act.
- + Has been debarred by any Federal agency.
- + Has been, or is now, subject to civil monetary penalties under the Act.

In addition to reflecting the above statutory requirements from section 1903(b)(4), proposed §438.812 included the following proposed requirement:

? The initial contract or memorandum of agreement (MOA) or memorandum of understanding (MOU) for services performed by the broker must be reviewed and approved by CMS before the effective date of the contract or MOA.

Comment: One commenter felt that the proposed regulations were too broad for application in many States, and that States thus were required to create standards to ensure protective measures to support independent operations of enrollment brokers.

Response: We disagree with the commenter that the regulations are too broad. We believe that the language in section 1903(b)(4) of the Act, reflected in §438.810, is very specific about limitations as to who can serve as an enrollment broker. A broker either is independent of "any" MCO, PIHP, or PCCM and of "any health care providers" that provide services in the State, or it is not. Similarly, a broker either does or does not have an owner, employee, consultant or contract with a person who (1) has a direct or indirect interest in an MCO, PIHP, PCCM or provider, or (2) has been excluded, debarred or subject to civil money penalties. While these standards are "broad" in their reach, this was a decision made by Congress. We do not believe that significant additional

clarification is required. Moreover, §438.810 does contain some additional clarification, in that paragraph (a) contains definitions of "choice counseling," "enrollment activities," "enrollment broker," and "enrollment services." It is not clear what additional clarification the commenter thinks would be needed. We also note that States may set rules more stringent than the Federal rules if they wish.

Comment: One commenter questioned whether there was a conflict between §438.208(c), which provides for health screening assessments by an enrollment broker, and §438.810(b)(1), which requires that enrollment brokers be independent.

Response: There is no conflict between these two sections. The independence of enrollment brokers from MCOs, PIHPs, PCCMs and providers of services is a separate issue from the activities of the enrollment broker in assessing and screening special needs individuals. The latter activities are performed by the broker for the State, as part of its activities as an enrollment broker, and not as the agents of an MCO, PIHP, PCCM or provider.

Comment: A commenter asked whether it was CMS' intent to exclude all potential enrollment brokers who have any relationship with a health care provider, whether or not that health care provider serves the Medicaid population.

Response: CMS is bound by the statutory provision on enrollment brokers, and section 1903(b)(4)(A) of the Act specifically prohibits the availability of FFP for enrollment brokers who are not independent of any health care providers, "whether or not any such provider participates in the State plan under this title." Congress presumably believed that such independence was necessary to ensure that the Medicaid enrollment

process was free from even potential bias.

Comment: Several commenters noted that the independence requirement could prevent employees of a county from serving as enrollment brokers that operates an MCO, PIHP, or PCCM, or provides services or is affiliated with providers, from serving as enrollment brokers, and contended that this result would be detrimental to the enrollment process. Commenters also felt that MCOs should be able to assist in enrollments. One commenter believed that it was not feasible for States to rely only upon community-based or non-profit organizations to process enrollments.

Response: First, with respect to the comments on MCO involvement in enrollment, States may permit MCOs to process enrollments in their own plans. This provision only involves a State contract with an enrollment "broker" which processes enrollments in multiple plans. With respect to the issue of employees of counties that operate managed care entities or provide health care services, we believe that such an employee would not meet the statutory standard of being "independent" of such providers, and that Congress has prohibited them from serving as enrollment brokers. An enrollment broker might be a public or quasi-public entity with a contract or MOA/MOU with the State or county, as long as the entity does not furnish health care services in the State. For example, a State may not claim FFP for a contract with, or have an MOU with, a county health department to do managed care enrollment or choice counseling because the health department provides health services. A community organization that provides health services in the State, for example, an organization providing health care to homeless individuals, may contract or subcontract to perform

outreach and education, but not enrollment and choice counseling functions covered by the enrollment broker provisions in section 1903(b)(4).

Neither the statute nor these rules specifically address the use of non-profit or community-based organizations to fulfill the enrollment broker function, but these entities would be subject to the same requirements for independence and prohibitions on conflict of interest as any other prospective brokers. We note that the regulations also would permit for-profit enrollment brokers if they met the conditions in §438.810.

5. Costs Under Risk and Nonrisk Contracts (Proposed §438.812)

Proposed §438.812 was transferred in its entirety from previous §§434.74 and 434.75. It provides that States receive Federal matching for all costs covered under a risk contract at the medical assistance rate, while under a non-risk contract, only the costs of medical services are matched as medical assistance, while all other costs are matched at the administrative rate. We received no comments on this provision.

6. Limit on Payments in Excess of Capitation Rates (Proposed §438.814)

Section 438.814 proposed limitations on the availability of FFP in contracts, which contain incentive arrangement or "risk corridors." As described in proposed §438.6(c)(5) on rate setting for risk contracts, under this proposal, FFP was only available in contract payments to the extent they did not exceed 105 percent of the payment rate determined to be "actuarially sound." The theory for this limitation was that rates too far in excess of those established to be actuarially sound were not actuarially sound, and therefore did not meet the condition for FFP in section 1903(m)(2)(A)(iii).

Comment: Many commenters disagreed with the proposal to limit Federal

matching at 105 percent of approved capitation rates in contracts with risk corridors. Some commenters questioned the rationale for setting the limit at 105 percent, while others questioned how it was determined that this limit would be appropriate for every contracting situation, State and contractor. Most commenters felt that the limit on risk corridors was inappropriate and arbitrary; would discourage States from using this mechanism, which the commenters felt could be an effective tool in setting rates for populations with little or no managed care experience, including the chronically ill and disabled; would prevent the State and Federal governments from sharing in profits and being protected from overpayments; and would discourage MCOs from taking the risk to cover these populations.

Other commenters pointed out that risk corridors are an important mechanism to address unforeseen costs to MCOs during contract periods from these factors as changes in case mix, enrollment patterns, utilization patterns, or provider networks, or coverage of populations with little or no managed care history. A 105 percent cap on these arrangements constrains States' flexibility to effectively address these issues without administratively cumbersome mid-year rate adjustments and could, in the commenters' view, result in over-projection of capitation rates in order to remain under the ceiling. Commenters suggested CMS either: (1) accept an actuarial certification that the amount paid to an MCO after settlement is actuarially sound, and permit FFP for that entire amount; (2) permit a "good cause" exception to the 105 percent limit; or (3) or raise the limit to 110 percent. One commenter supported CMS' acknowledgment of risk sharing and risk corridors as acceptable payment mechanisms up to 105 percent of capitation

rates.

Response: We understand the commenters concerns and upon consideration of these comments, agree that the 105 percent limit on FFP on contracts, or portions of contracts with risk corridors, is too restrictive to permit the continued use of this important risk sharing mechanism. We agree that is inappropriate to place a specific percentage limitation on FFP where risk corridors are used in a contract.

The purpose of this mechanism is to share both the risk and the profits between the contractor and the State (and the Federal government by virtue of its matching of State expenditures.) One potential risk that can be addressed in risk corridors is the risk of fluctuations in utilization based on the changing demographics of a population (such as, the high costs of an increased percentage of disabled enrollees.) A fixed percentage limit does not take such risks into account. In considering the commenters' concerns, we have determined that a more appropriate outer limit on the actuarial soundness of payments under a risk corridor methodology would be a limitation based on what Medicaid would spend for the specific services utilized, plus an amount to cover the managed care plan's reasonable administrative costs. Such a limit would be similar to the "non-risk upper payment limit" in §447.362, except for the recognition of administrative costs. The reason we did not simply adopt the rule in §447.362 is because the amount allocable to administrative costs under that section of the regulations is not based on a managed care entity's reasonable administrative costs, but rather on the amount the Medicaid agency "saves" in *its* administrative costs by not having to pay fee-for-service claims for the beneficiaries enrolled in the managed care plan. We believe this amount is likely to be

much lower than even the administrative costs of a well run managed care organization. Thus, we are revising the requirement in proposed §438.814 to impose an upper limit on payments under risk corridors that is based on "what Medicaid would have paid on a fee for service basis for the services actually furnished to recipients" plus an allowance for the managed care plan's reasonable actual administrative costs. This limit reflects the fact that a risk corridor extended to its ultimate extreme would become a nonrisk contract, and that the rule governing FFP in nonrisk contracts (with the modification noted) is the most logical limit to apply. We are also moving this requirement to §438.6(c)(5) in order to have all of the payment provisions in one subpart of this rule.

Comment: Some commenters also believe the 105 percent limit was arbitrary and inappropriate for incentive arrangements, and could discourage programs intended to achieve quality-related goals (such as increases in EPSDT services and meeting quality improvement targets).

Response: We do not agree with commenters that the 105 percent limit is inappropriate and arbitrary for, and would discourage the use of, incentive arrangements. Under the new payment rules in §438.6(c), capitation rates are to be established to reflect the level of State plan services to be delivered under the contract. Further, States are free to combine financial withholds and incentives for such things as quality improvement targets. Thus, we do not believe it is necessary to establish financial incentives above a level at which FFP would be available under this provision. As with the provision on risk corridors, we are moving this provision to §438.6(c)(5).

Comment: One commenter asked that CMS define the term "risk corridors" as

used in this section and in §438.6(c).

Response: A risk corridor is a risk sharing mechanism in which States and MCOs share in both profits and losses under the contract outside of predetermined threshold amount. The amount of risk shared under this arrangement is usually graduated so that after an initial corridor in which the MCO is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

Comment: Several commenters asked whether this provision places a limit on any and all payments and payment mechanisms that are in excess of the capitation rate, or whether there are any payment mechanisms which would be excepted from the cap?

Response: Section 438.6(c) sets forth the requirements for payments under all risk contracts, and requires that these payments be identified and computed on an actuarially sound basis. This requirement applies to reinsurance, stop-loss limits, or other risk sharing mechanisms. We believe that amounts payable under these other arrangements (except for incentives and risk corridors) will be offset by actuarially determined amounts in determining the capitation rate to be paid. Thus, the limit in any of these arrangements will be predetermined based on the amount of the offset or deduction from the capitation rate. Since the potential payments under these risk-sharing mechanisms are determined in this manner, the limits in this provision do not apply. Section 438.6(c) does not authorize any other payment in excess of the capitation rates.

Comment: Several commenters asked that CMS define what is included in the term "aggregate amount of approved capitation payments" as used in this section.

Specifically, the commenters wanted to know whether this includes administration, profit and other expenditures. One commenter asked whether this provision applies when a State withholds a percentage of approved capitation rates and later distributes the pool of withheld funds based on some type of risk arrangement, and whether the amount of funds withheld would be considered part of the approved capitation amount, or would be capped under this provision.

Response: The term "aggregate amount of approved capitation payments" as used in this section refers to the total amount of the capitation rates approved under the contract that are attributable to the individuals and services covered by the incentive arrangement. This would include portions of the rate intended for administration, profit or any other purposes and would be determined prior to any withhold amount being deducted. Further, the 105 percent limit applies only to those portions of a contract, which apply to the individuals or services, governed by the incentive arrangement. For example, if the contract includes provisions to withhold a portion of the capitation payments for not meeting targets for initial screenings for enrollees, neither the payments nor any withheld amounts for these services would be part of the calculation for determining any incentive payments due the plan under a separate contract provision for meeting targets for childhood immunizations. To further clarify this distinction, we have eliminated the provision in §438.6(c)(5)(iii)(C) that required contracts with incentive arrangements to have withhold penalties for targets not met (proposed paragraphs (D), (E) and (F) have been redesignated as paragraphs (C)).

Comment: One commenter questioned whether the 105 percent limit is to be

applied in the aggregate, or is it applicable to each individual rating cell.

Response: This would be determined by the specific arrangement under the contract. In most contracts, we would expect a target established for specific populations who may comprise their own rate cells under the contract. In this case, the limit would have to be applied to each individual or groups of cells covered by the arrangement. If the incentive applies to the entire population covered under the contract, the limit would be applied in the aggregate.