



Overview of CMS's New Proposed Rules

Ensuring Access to Medicaid Services

Managed Care Access, Finance, and Quality



All State Call

May 2, 2023

3:00pm-4:00pm

Agenda

- High level summary about points from the new NPRMs
 - Ensuring Access to Medicaid Services
 - Managed Care Access, Finance, and Quality
- Summary of CMS's access strategy
- Deeper dive into how each NPRM enhances access in Medicaid and/or CHIP
- Walk through of the managed care NPRM provisions that go beyond the topic of access
- Questions

NPRMs Released on April 27, 2023

- CMS released two notice for proposed rule making
 - **Ensuring Access to Medicaid Services**
 - **Managed Care Access, Finance, and Quality**
- The NPRMs support the Biden-Harris Administration’s efforts to advance groundbreaking, high-impact solutions to ensure greater access to Medicaid and CHIP services for all eligible individuals.
- If adopted as proposed, the rules would establish historic national standards for access to care regardless of whether that care is provided through managed care plans or directly by states through fee-for-service (FFS).
- Range of effective dates across the NPRMs: 60 days to 4 years from the publication date of the final rules, with proposed stratification of certain HCBS quality measures phased in over seven years

Summary of Provisions Across NPRMS, Part 1 of 2

- **Establishing national maximum standards for certain appointment wait times for Medicaid and CHIP managed care enrollees**, and stronger state monitoring and reporting requirements related to access and network adequacy for Medicaid or CHIP managed care plans, which now cover the majority of Medicaid and CHIP beneficiaries.
- **Requiring states to conduct independent secret shopper surveys** of Medicaid or CHIP managed care plans to verify compliance with appointment wait time standards and to identify where provider directories are inaccurate.
- **Creating new payment transparency requirements for states** by requiring disclosure of provider payment rates in both fee-for-service and managed care, and a comparison to Medicare rates for certain services, with the goal of greater insight into how Medicaid payment levels affect access to care.
- **Establishing additional transparency and interested party engagement requirements for setting Medicaid payment rates for home and community-based services (HCBS)**, as well as a requirement that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead or profit).

Summary of Provisions Across NPRMS, Part 2 of 2

- **Creating timeliness-of-access measures for HCBS** and strengthening necessary safeguards to ensure beneficiary health and welfare as well as promote health equity.
- **Strengthening how states use state Medical Care Advisory Committees**, through which stakeholders provide guidance to state Medicaid agencies about health and medical care services, to ensure all States are using these committees optimally to realize a more effective and efficient Medicaid program that is informed by the experiences of Medicaid beneficiaries, their caretakers, and other interested parties.
- **Requiring states to conduct enrollee experience surveys in Medicaid managed care annually for each managed care plan** to gather input directly from enrollees.
- **Establishing a framework for states to implement a Medicaid and CHIP quality rating system, a “one-stop-shop” for enrollees to compare Medicaid and CHIP managed care plans** based on quality of care, access to providers, covered benefits and drugs, cost, and other plan performance indicators.

Addressing Improvements to Access in Medicaid and CHIP Across the Two NPRMs

Access Strategy: Background

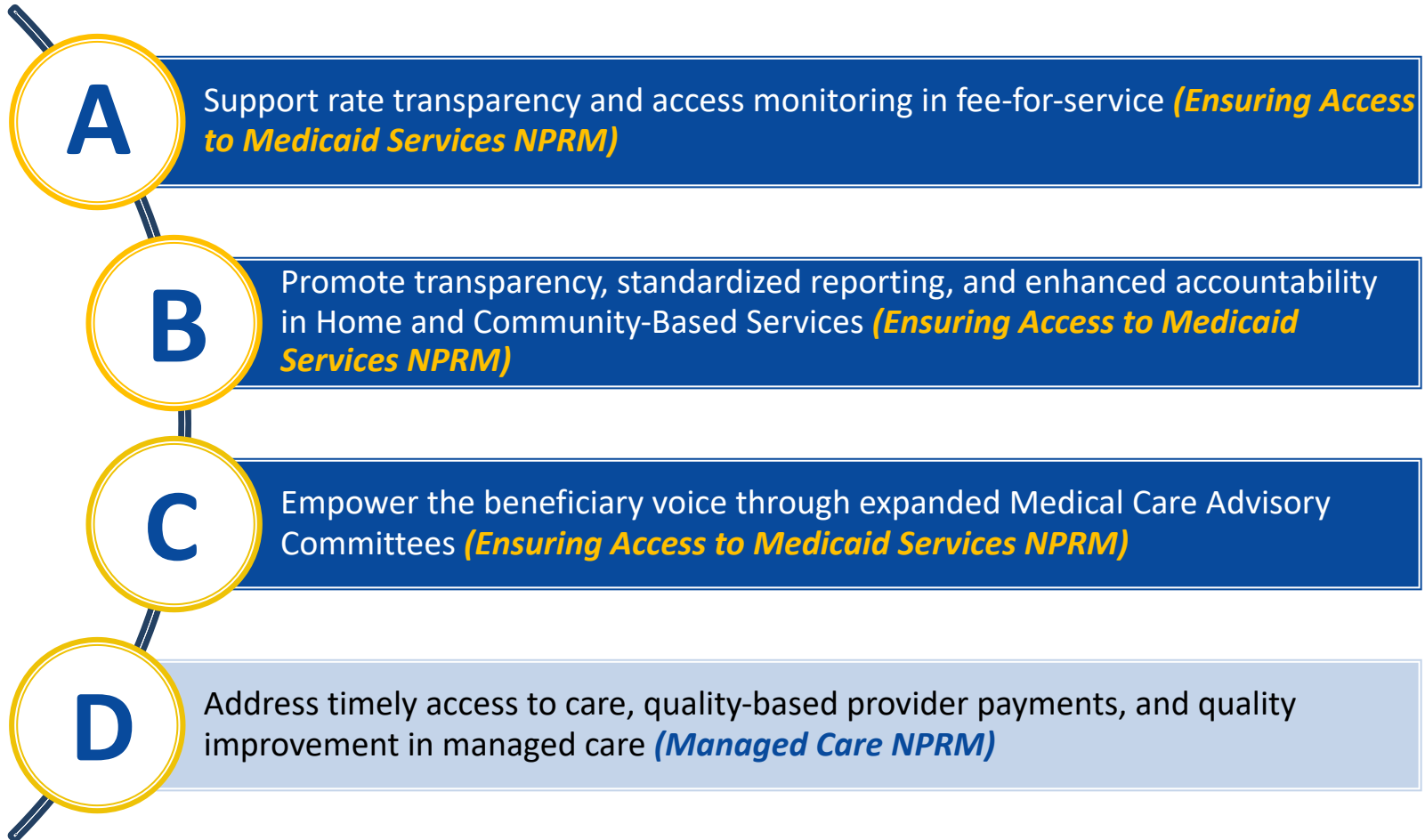
- Medicaid and CHIP provide essential health care coverage for 92 million people.
- Beneficiaries access their health care services using managed care and FFS delivery systems. Current regulations affecting access are not comprehensive nor consistent across payment systems and programs.
- Addressing these issues requires a thorough programmatic review and coordinated strategy with the following goals to improve and strengthen Medicaid and CHIP:
 - Remove barriers for eligible people when enrolling in and maintaining coverage
 - Ensure equitable access to Medicaid-covered health care services and supports
- CMS plans to achieve these goals through three rulemaking vehicles:

Eligibility &
Enrollment
NPRM

Ensuring Access
to Medicaid
Services NPRM

Managed Care
NPRM

Regulatory Strategy: Enhancing Access to Medicaid Services



Ensuring Access to Medicaid Services

Notice of Proposed Rule Making

Topics covered:

- Fee-for-service
- Home and community-based services
- Medical care advisory committee

Fee-For-Service, Part 1 of 2

Background

- The Medicaid statute requires states to set rates that are sufficient to provide access to care consistent with care available to the general population in the same geographic areas
- CMS spends \$734B¹ on Medicaid, but has limited methods to effectively benchmark state Medicaid rates relative to any absolute standards. This makes it difficult to define or enforce what is a “sufficient” rate, and is the main motivating factor for this rulemaking provision
- CMS issued regulations in 2015 that required states to develop and update an access monitoring review plan that would rely on data and analysis to demonstrate and support the state’s conclusion that access to care is consistent with the statutory requirement
- States have raised concerns over the burden associated with the 2015 requirements and the usefulness of the data analysis, while providers and other stakeholders also voiced dissatisfaction with the requirements

1. 2021 National Health Expenditure Data <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet>

Fee-For-Service, Part 2 of 2

Proposed policies

- Rescind and replace the FFS access monitoring review plan (AMRP) requirements for states
- Require states to benchmark to and report on their state Medicaid base payment rates relative to Medicare rates for: primary care, obstetrical and gynecological, and outpatient behavioral health services (comparative payment analysis) and to publish average hourly payment rates for certain providers of HCBS (payment rate disclosure) every two years
- Require states to establish an advisory group to advise and consult on FFS rates paid for personal care, home health aide, and homemaker services
- Require states to publish and update all FFS Medicaid fee schedule rates publicly available and accessible on a state website
- Create new two-tiered state analysis process when a rate reduction or restructuring is proposed to ensure access is maintained. The level of analysis is dependent on how Medicaid payment rates compare to Medicare, the proposed decrease amount, and whether access concerns have been raised through public processes

Home and Community-Based Services (HCBS), Part 1 of 3

Background

- Workforce shortages are reducing access to services and are expected to worsen in the future
- Variation within and across states' incident management systems can result in a lack of oversight and intervention to prevent recurrence of negative outcomes
- Gaps in measurement and reporting hamper efforts of CMS and states in assessing and improving HCBS quality and outcomes and addressing racial and other disparities

Home and Community-Based Services (HCBS), Part 2 of 3

Proposed policies

- Establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for HCBS programs
- Strengthen person-centered service planning and incident management systems in HCBS
- Require states to establish grievance systems in FFS HCBS programs
- Require that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit)

Home and Community-Based Services (HCBS), Part 3 of 3

Proposed policies (cont.)

- Require states to report on waiting lists in section 1915(c) waiver programs, service delivery timeliness for personal care, homemaker and home health aide services, and a standardized set of HCBS quality measures
- Promote public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures.

Medical Care Advisory Committee, Part 1 of 2

Background

- The current regulations require states to establish Medical Care Advisory Committee (MCAC), but Committees are limited to medical topics and do not address how the beneficiary perspective and lived experience should be considered
 - Topics that impact the Medicaid program and their beneficiaries go beyond medical-related issues
 - Beneficiary perspectives need to be central to operating a high quality and equitable health coverage program
- There is wide variation across states in how Medical Care Advisory Committees are used
 - Opportunity to propose more robust requirements to ensure all states are leveraging these Committees optimally to realize a more equitable, effective, and efficient Medicaid program that is informed by the experiences of beneficiaries, their caretakers, providers, and other interested parties

Medical Care Advisory Committee, Part 2 of 2

Proposed policies

- Rename and expand the scope and use of states' Medical Care Advisory Committees. The renamed Medicaid Advisory Committees (MAC) would advise states on a range of issues including medical and non-medical services.
- Require states to establish a Beneficiary Advisory Group (BAG) with crossover membership with the MAC. The BAG would include Medicaid beneficiaries, their family members, and/or their caregivers.
- Establish minimum requirements for BAG representation on the MAC. At least 25 percent of the MAC membership would be reserved for BAG members.
- Promote transparency and accountability between the state and its stakeholders by making information on the MAC and beneficiary advisory group activities publicly available. States will publicly share information about the feedback they receive by posting materials like meeting schedules, meeting minutes, annual report, etc.

Managed Care Access, Finance, and Quality Notice of Proposed Rule Making

Topics covered:

- Access in managed care
- Addressing Health-Related Social Needs with In Lieu of Services and Settings
- State Directed Payments
- Medical Loss Ratio (MLR) and Program Integrity Provisions
- Quality Rating System
- Separate CHIP

Managed Care

Background

- 70-80% of Medicaid beneficiaries (83% for separate CHIP) are enrolled in managed care, which accounts for \$400B+ (60%) of total Medicaid spending. Oversight of managed care is a key priority focus for CMS.
- There is significant variation among Medicaid managed care programs both within and across states. This variation can result in measurable differences in access and quality of care, as well as fiscal sustainability and program integrity.
- Unlike in Medicare and the Marketplace, Medicaid and CHIP beneficiaries do not have a way to compare managed care plans based on quality. This rule also includes provisions to empower states and beneficiaries with plan quality and access information through the new Medicaid and CHIP quality rating system.
- To advance our ability to monitor the effectiveness of states' managed care programs and promote other Biden-Harris Administration priorities, we proposed a managed care rule that would strengthen CMS's oversight of Medicaid and CHIP programs.

Improving Access to Care in Managed Care, Part 1 of 2

Proposed policies

- Establish maximum standards. Require states to develop and enforce maximum appointment wait time standards (consistent with Marketplace) for:
 - Primary care services (adult and child) within 15 business days
 - Mental health and substance use disorder services (adult and child) within 10 business days;
 - Ob/Gyn services, within 15 business days; and
 - A state-selected service type within a state-established time frame.

Managed care plans must achieve 90% compliance with these standards.

- Require states to submit remedy plans to address any areas where managed care plans need to improve access. Remedy plans would include specific steps, timeframes, and responsible parties to achieve improvement within 12 months.

Improving Access to Care in Managed Care, Part 2 of 2

Proposed policies (cont.)

- Require annual independent secret shopper surveys to validate managed care plan performance with the appointment wait time standards and provider directory accuracy (e.g., real vs. ghost networks)
- Require states to conduct an annual enrollee experience survey that is posted on states' websites and reported to CMS as part of existing reporting vehicles
- Require states to submit an annual payment analysis comparing certain managed care provider rates to Medicare, or Medicaid FFS for personal care, homemaker, and home health aide services
- Require states to develop and implement remedy plans to address any access issues

Addressing Health-Related Social Needs with ILOSs, Part 1 of 3

Background

- In line with Biden-Harris Administration priorities, CMS has developed several opportunities for states to cover services that address the social determinants of health (SDOH), or more specifically, health-related social needs (HRSN), including nutrition and housing supports.
- An innovative opportunity to cover these services as “in lieu of services and settings” (ILOSs), which allow managed care plans to substitute state plan services or settings with innovative, cost-effective, medically appropriate alternatives.
 - For example, states can cover medically-tailored meals “in lieu of” nursing facility care or hospitalizations
- CMS approved this flexibility for California in December 2021 and published sub-regulatory guidance about ILOSs on January 4, 2023 for all states ([SMD 23-001](#)). CMS proposes to codify this updated ILOS policy to strengthen access to care while also maintaining appropriate enrollee protections, monitoring and oversight, and fiscal protections.
 - States interested in covering ILOSs must first submit their proposals to CMS for approval as part of the associated managed care plan contracts

Addressing Health-Related Social Needs with ILOSs, Part 2 of 3

Proposed policies

- Specify that ILOSs can be immediate or longer-term substitutes for covered state plan services or settings, or when the ILOSs can be expected to reduce or prevent the future need for such state plan services or settings
- Require ILOSs to be approvable services or settings under the state plan or a section 1915(c) waiver
- Limit total ILOS spending to no more than 5% of total managed care capitation payments, as certified by the state's actuary, for each applicable managed care program

Addressing Health-Related Social Needs with ILOSs, Part 3 of 3

Proposed policies (cont.)

- Codify contract requirements including documenting ILOS definitions, linking each ILOS with the services and settings for which they may substitute, identifying target populations, and specifying codes (such as CPT/HCPCS codes and modifiers) for identifying ILOSs in encounter data.
- Reinforce existing enrollee protections related to ILOSs, including that services must be optional for enrollees and do not absolve managed care plans from providing other medically necessary state plan services.
- Require a retrospective 5-year evaluation for states with ILOS spending above 1.5% of total capitation payments.

State Directed Payments, Part 1 of 2

Background

- State directed payments (SDPs) are contractual obligations where states direct Medicaid managed care plans' expenditures for services under the contract.
- SDPs have become a significant payment vehicle for states, accounting for more than \$25B annually across 37 states.
- SDPs allow states to take a more proactive role in directing managed care plans towards key policy and delivery system investments. However, some SDPs are correlated with financing challenges.

State Directed Payments, Part 2 of 2

Proposed policies

- Establish a payment rate ceiling at the average commercial rate for hospital services, nursing facility services, and professional services furnished at academic medical centers.
- Eliminate unnecessary regulatory limitations on value-based purchasing arrangements to enable states to more easily link SDP payments to quality metrics and other performance-based data.
- Ensure that existing requirements for allowable sources of non-federal share are explicitly applied to SDPs, and noting CMS may disapprove and take enforcement action on SDPs that do not comply with non-federal share financing requirements. Additionally, require states to ensure that providers attest that they do not participate in a hold harmless arrangement, as defined by statute and regulation.
- Require states to condition fee schedule based SDPs on actual utilization during the rating period and prohibit post-payment reconciliation process that initially condition payment on historical utilization outside the rating period.
- Strengthen evaluation requirements for SDPs and require states to submit evaluation results to CMS and post publicly.

Medical Loss Ratio (MLR) and Program Integrity Provisions, Part 1 of 2

Background

- MLR is a common financial metric used to report and benchmark the financial performance of a managed care plan.
- In Medicaid and CHIP managed care, the MLR represents the proportion of revenue used by the plan to fund claim expenses and quality improvement activities.
- The specifications for managed care plans' reporting to states were finalized in 42 CFR §§ 438.8 and 457.1203 in the 2016 final rule. State must submit summaries of these reports to CMS under 42 CFR § 438.74. The proposed modifications to these regulations are based on reviews of plan and state summary reports as well as alignment with recent MLR regulatory changes for Marketplace plans.

Medical Loss Ratio (MLR) and Program Integrity Provisions, Part 2 of 2

Proposed policies

- Requiring Medicaid managed care plans to include SDPs in their MLR reports to states, and states to submit these amounts as separate line items in their annual summary MLR reports to CMS.
- Technical revisions for provider incentive arrangements, quality improvement expenditures, and expense allocation reporting to align with Marketplace plan MLR calculations. These proposed changes would improve consistency in MLR reporting, allowing CMS to better compare MLRs across plans and states.
- Technical revisions for MLR resubmission criteria, state MLR summary report data requirements, and the publication of credibility adjustment factors.
- Requiring managed care plans' provider incentive arrangements to reflect sound contracting practices, and states' contracts must require managed care plans to report overpayments within 10 business days.

Increasing Transparency of Plan Quality and Access Information, Part 1 of 3

Background

- States are required to develop and maintain a managed care quality strategy, which includes performance measures and performance improvement projects implemented through managed care contracts as part of the state's quality assessment and performance improvement program.
- States are required to perform an external quality review (EQR) to validate each plan's quality programs on an annual basis, and review each plan's compliance with managed care standards every three years.
- Previous rulemaking established CMS's authority to require States to operate a Medicaid and CHIP managed care quality rating system (MAC QRS) using a CMS-developed framework or an alternative that is substantially comparable.

Increasing Transparency of Plan Quality and Access Information, Part 2 of 3

Proposed policies

- Several quality proposals modify existing quality strategy and external quality reporting requirements, aiming to make reporting more transparent and meaningful for driving quality improvement, and to reduce burden on certain external quality reporting requirements.
- For the MAC QRS, the proposals establish a framework aimed to empower beneficiary choice and ensure monitoring of plan performance, and include:
 - Establishing the MAC QRS website as a state’s “one-stop-shop” for beneficiaries to access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to beneficiary decision making, such as the plan’s drug formulary and provider network; and select a plan that meets their needs.
 - Establishing state requirements under the MAC QRS framework, including an initial set of mandatory measures, quality rating methodology and requirements for displaying information on a State’s MAC QRS website.
 - Broadening flexibility for states to implement an alternative QRS.

Increasing Transparency of Plan Quality and Access Information, Part 3 of 3

MAC QRS Website Display Prototype

Two MAC QRS website prototypes and video walk-throughs of each prototype are available at:

<https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-rating-system/index.html>

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Selected search criteria:
 Zip Code: 03278 | Child | Adult under 65 | I receive Medicare | Health Plan: Acme Health | Health Plan: Blue Ribbon | Health Plan: PrimeHealth

Quality Measures
 This page shows how the health plans performed on a wide range of quality measures. Select a domain and a view to show the quality measures of interest to you and your family.

Quality Measure Data:

Measure	Acme Health	Blue Ribbon	PrimeHealth
Controlling Diabetes Percentage of people whose diabetes was not controlled (HBA1c >9%) Ages: 18 - 75 Lower is better	66%	54%	This measure does not apply to the population covered by this plan.
Asthma Medication Percentage of people with asthma who had the right level of medication Ages: 19 - 64 Higher is better	64%	52%	This measure does not apply to the population covered by this plan.

Plan Information:
 Acme Health: acmehealth.com, (222) 312-9182
 Blue Ribbon: blueribbon.com, (644) 123-0456
 PrimeHealth: primehealth.com, (222) 867-5309

Separate CHIP Alignment with Medicaid, Part 1 of 3

Background

- **Alignment:** In previous rulemaking, CMS has mostly aligned separate CHIP with Medicaid managed care regulatory requirements with a few exceptions.
- For example, CMS did not adopt the Managed Care Program Annual Report (MCPAR) requirements at § 438.66 or the SDP regulations at § 438.6. In this NPRM, CMS proposes to largely continue this alignment.

Separate CHIP Alignment with Medicaid, Part 2 of 3

Proposed policies

- **Access Provisions:** Require alignment with Medicaid on nearly all provisions. However, for the proposed enrollee experience survey provision, states currently meet this requirement for CHIP through annual CAHPS surveys. Instead, require separate CHIPs to post summary comparative CAHPS results on the state's website and review CAHPS results in the state's annual analysis of network adequacy rather than through MCPAR.
- **Addressing Health-Related Social Needs:** Require alignment with Medicaid on nearly all ILOS provisions, except that actuarial certification requirements and reporting for SDPs do not apply.

Separate CHIP Alignment with Medicaid, Part 3 of 3

Proposed policies (cont.)

- **State Directed Payments:** Not require alignment with Medicaid.
- **Medical Loss Ratio (MLR) and Program Integrity Provisions:** Require alignment with Medicaid, however provisions related to SDPs and dually eligible reporting are not applicable.
- **Quality:** Require alignment with Medicaid, except provisions for dually eligible do not apply.

Questions?