

CMS Proposed Rules Part 2: Coverage, Financing, Payment, and Quality

May 26, 2023

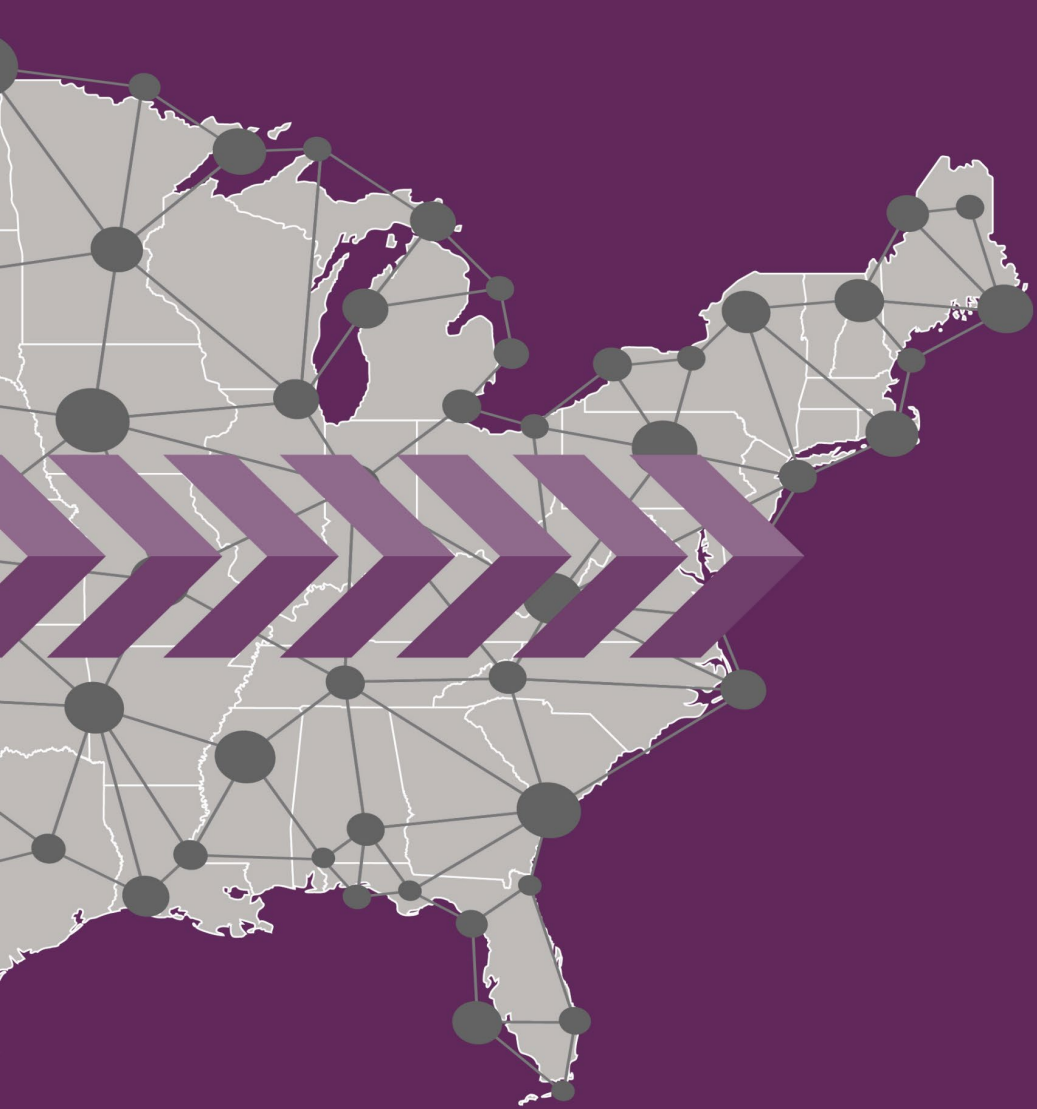
2:00 to 3:00 p.m. ET

Please stand by, this webinar will begin shortly

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CMS Proposed Rules Part 2: Coverage, Financing, Payment, and Quality

Manatt Health

May 26, 2023, 2:00 to 3:00 p.m. ET

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

*Support for this webinar was provided by the Robert Wood Johnson Foundation.
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About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.** The meeting facilitators will address questions and comments verbally in a manner that maintains the anonymity of the state.
- All participant lines are muted. Use the 'raise hand' feature in Zoom if you would like to speak during the discussion portion. The meeting facilitators will then unmute you.
- After the webinar, the slide deck and a recording will be available at www.shvs.org.

Agenda

- **Level-Setting: Centers for Medicare & Medicaid Services (CMS) Managed Care and Access Proposed Rules**

- **Managed Care Coverage, Financing, and Payment Provisions**
 - State Directed Payments (SDPs)
 - In Lieu of Services and Settings (ILOS)
 - Medical Loss Ratio (MLR) Standards

- **Managed Care Quality Provisions**
 - Medicaid and CHIP Managed Care Quality Rating System (QRS)
 - State Quality Strategies and Quality Assessment and Performance Improvement (QAPI)

- **Discussion**



Level-Setting

Overview of the Managed Care and Access Proposed Rules

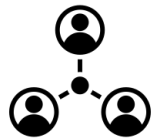
On April 27, 2023, CMS released two highly anticipated proposed rules that would reshape the federal regulatory landscape for Medicaid and the Children’s Health Insurance Program (CHIP).

<p>“Managed Care Access, Finance, and Quality” (or the “Managed Care Proposed Rule”)</p>	<p>“Ensuring Access to Medicaid Services” (or the “Access Proposed Rule”)</p>	
<p>Managed Care Delivery System Focus</p>	<p>Fee-for-Service (FFS) Delivery System Focus</p>	<p>Home and Community-Based Services (HCBS) Focus Across Delivery Systems</p>

Together, the rules would transform...



**Standards for
Ensuring Access to
Care**



**Engagement of
People Enrolled in
Medicaid**



**Transparency/
Oversight of
Payment Rates**



**Quality
Measurement**



**Program
Accountability**



These rules build upon CMS’ September 2022 proposed rule on Medicaid and CHIP eligibility, enrollment, and renewal, and make up CMS’ comprehensive strategy to improve access to coverage and care.

Citation: CMS [Managed Care Access, Finance, and Quality](#), [Ensuring Access to Medicaid Services](#), and [Streamlining Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes](#).

Summary of Provisions in the Proposed Rules

While the proposed rules have differences that extend beyond the delivery system of focus, provisions are complementary, overlap in some cases, and together create CMS' integrated access framework.

"Managed Care Access, Finance, and Quality" (or the "Managed Care Proposed Rule")

The proposed rule would, among other things...

- Strengthen access to care and monitoring through appointment wait time standards and secret shopper/enrollee surveys.
- Create new reimbursement transparency requirements.
- Codify and revise the federal regulations governing state directed payments (SDPs).
- Codify and build on recent CMS policy changes related to in lieu of services (ILOS).
- Modify medical loss ratio (MLR) methodologies and processes.
- Establish new quality requirements, including a framework and enhanced requirements for managed care quality rating systems (QRS).

"Ensuring Access to Medicaid Services" (or the "Access Proposed Rule")

The proposed rule would, among other things...

- Create new transparency and consultation requirements for FFS provider payment rates.
- Modify the procedures for requesting federal approval to reduce or restructure FFS rates.
- Strengthen program advisory groups.
- Update HCBS program standards and processes regarding care access, quality, and payment.

★ **Comments Due**
July 3, 2023

CMS seeks public input on all aspects of both proposed rules and invites comment on potential alternative or additional provisions (more on this in subsequent slides).



State Directed Payments (SDPs)
(Managed Care Proposed Rule)

Overview of Proposed Requirements for SDPs

In the proposed rule, CMS recognizes the important role of SDPs in promoting state access and quality goals, but also identifies concerns over the size of such payments and certain state approaches to financing the non-federal share of SDPs. The proposed rule would:



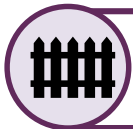
Codify the Average Commercial Rate (ACR) as the SDP payment ceiling for hospitals and other key providers, with new flexibility to calculate the ACR.



Grant new flexibilities, including permitting SDPs for non-network providers and exempting SDPs that match Medicare rates from the formal pre-approval process.



Mandate that states collect attestations from all providers receiving SDPs that they do not participate in “hold harmless” arrangements associated with provider taxes.



Place new guardrails on certain SDP methodologies, including the use of separate payment terms, that CMS believes are inconsistent with risk-based managed care.



Require new, provider-level reporting on SDPs to increase transparency and accountability, **limit formal evaluation reports to large SDPs** that exceed a certain expenditure level, and **heighten requirements for the evaluation reports to improve the link between SDPs and quality**.

The proposed rule indicates CMS' preference to permit large SDPs as a key tool in support of state quality and access objectives, while enforcing federal rules related to non-federal share financing arrangements that CMS has long believed undermine the fiscal integrity of the Medicaid program.

SDPs: Payment Levels

In the proposed rule, CMS includes potential changes related to SDP payment levels.

	Current Practice	Proposed Rule
Upper Limit on SDPs	<ul style="list-style-type: none"> CMS evaluates SDPs to ensure provider rates are “reasonable, appropriate, and attainable,” aligned with the federal requirement for actuarially sound capitation. CMS has considered the ACR as the upper limit for SDPs. 	<ul style="list-style-type: none"> Would codify the “reasonable, appropriate, and attainable” standard. Would establish the ACR as the upper payment limit for SDPs made for: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. CMS would not set a formal SDP upper limit for other services.
ACR Calculation	<p>CMS requires states to demonstrate that any SDPs that exceed 100% of Medicare do not exceed the ACR for the class of services, but only for providers included in the SDP.</p>	<ul style="list-style-type: none"> Would codify the ACR Demonstration requirement, with some significant departures from current practice, such as not restricting the demonstration to the provider class. Change benefits for high Medicaid providers that often receive lower commercial rates compared to providers with a larger share of commercial patients. States would need to demonstrate the ACR during the first year of the SDP, and then every 3 years thereafter during which the arrangement remains in place.

CMS is considering alternatives to the ACR and other limitations to the SDPs, including setting an upper payment limit at Medicare rates, permitting payments at the ACR only for SDPs structured as value-based purchasing (VBP) initiatives, and/or implementing an aggregate expenditure cap.

SDPs: Non-Federal Share Financing

The proposed rule further reinforces CMS' hold harmless policy and would add new requirements to support compliance.

- CMS specifies that prohibited “indirect” hold harmless arrangements include those where Medicaid payments are redistributed among providers subject to the provider tax, **even if this redistribution happens without state involvement.**
- CMS notes that because hold harmless arrangements affect the validity of the tax and payments, **CMS would disapprove any SDPs where it identifies hold harmless arrangements are in place.**
- To promote compliance, the proposed rule would **require states to collect attestations from each participating provider eligible for the SDP that they do not participate in a hold harmless arrangement** (to be made available to CMS upon request). This requirement would apply to all directed payments, including those that do not require CMS prior approval.

SDPs: Payment Methodologies

The proposed rule would provide certain new flexibilities related to SDPs, but also place new restrictions on use of common payment arrangements. If finalized, the rule would...

Non-Network Providers	Preprint Submission Requirements	Interim Payments with Reconciliation	Separate Payment Terms	VBP Directed Payments
<p>Permit SDPs for network and non-network providers, allowing states to set minimum provider payment levels regardless of whether a provider is in network with a plan.</p>	<p>Exempt SDPs at Medicare rates from the preprint process.</p>	<p>Prohibit states from making interim lump sum payments to providers based on historical utilization from prior rate years, with reconciliation to actual utilization at the end of the rate year.</p>	<p>Continue permitting separate payment terms but add several new guardrails to align the practice with risk-based managed care.</p>	<p>Permit states to direct timing and amount of expenditures related to VBP directed payments, among other changes.</p>

Citation: §§ 438.6(c)(1)(iii), 438.6(c)(2)(vi), 438.6(c)(2)(vii), 438.6(c)(5), 438.7(c).

SDPs: Evaluation and Reporting Requirements

The proposed rule includes (1) requirements for evaluation of all SDPs as well as a subset of SDPs that exceed a specified expenditure threshold, and (2) near-term reporting of actual aggregate directed payments through updates to state MLR reporting and longer-term provider-level reporting via T-MSIS.*

Evaluation

- For all SDPs that require pre-approval, states must:
 - ✓ Include at least two measures in an **SDP evaluation plan**; one must be a performance measure, while the other can measure access.
 - ✓ Include specified baseline measures and performance targets.
 - ✓ Achieve stated goals and objectives in alignment with the state's evaluation plan.
- States would be required to submit an **evaluation report** to CMS if the size of the SDP exceeds 1.5% of the managed care program.

Evaluation reports would be required **every 3 years (rather than annually)** and would include 3 years of performance data. States would have **2 years after the end of the first three-year cycle** to submit the evaluation report.

Reporting

- **Minimum data requirements for the T-MSIS reporting would include detailed individual payment components** (including the negotiated rate, SDP payment, etc.) made to each provider.
- CMS considered, but did not propose, including the reporting in the Medicaid Budget and Expenditure System (MBES), where FFS supplemental payments are collected under reporting requirements enacted under the 2021 Consolidated Appropriations Act. As a result, **CMS will not have one location where all supplemental and directed payments are stored.**

SDPs: Request for Comment and Implications



CMS Seeks Comment on

- The appropriate payment level (i.e., ACR as proposed vs. one of the alternatives included in the preamble).
- The new parameters related to separate payment terms, among other proposals.



Considerations for States

- States may want to comment on the ACR payment level proposal and alternatives that CMS is considering to limit SDP payment levels.
- States may want to comment on new proposed flexibilities, including calculating the ACR at the service rather than provider class and exempting SDPs tied to Medicare rates from the preprint process.
- States may also want to comment on CMS' attempt to balance payment transparency and administrative burden, including proposed provider-level reporting requirements and approach to evaluation.



In Lieu of Services and Settings (ILOS) *(Managed Care Proposed Rule)*

ILOS: Overview of Requirements and Parameters

Maintaining the general requirements for ILOS established in 2016 regulation, the proposed rule broadens circumstances in which ILOS can be covered by managed care plans and establishes guardrails.

The proposed rule would...

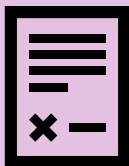
- **Clarify that ILOS may be used as an immediate or longer-term substitute for a covered service or setting under the state plan**, or when the ILOS can be expected to reduce or prevent the *future* need to utilize state plan covered services/settings.
- **Include new approval standards, financial, and reporting and evaluation requirements for ILOS guardrails.**
- **Generally not apply to the coverage of short-term stays in institutions for mental disease.**
- **Outline parameters for ILOS in managed care contracts:**
 - ✓ Would need to be a service or setting that would be approvable via a state plan amendment (SPA) or 1915(c) HCBS waiver.
 - ✓ Would limit amount of ILOS expenditures states can make.
 - “ILOS cost percentage” would not be permitted to exceed 5% of approved capitation payments.
 - ILOS documentation/reporting would be more streamlined for states with a projected cost percentage less than or equal to 1.5%.
 - ✓ Would require states to provide an annual report of the actual cost of delivering ILOS based on plans’ claims and encounter data.*

Reminder: ILOS Authority allows states to give Medicaid and CHIP managed care plans the option to pay for alternative services instead of standard Medicaid and CHIP benefits when it is medically appropriate and cost-effective to do so.

Citation: §§ 438.2, 438.3(e), 438.16, 457.1201(e); §§ 438.16(a)-(d), 457.1201(c), (e); and CMS, [SMD #: 23-001](#). *The ILOS cost report requirements would not apply to separate CHIP.

ILOS: Enrollee Rights and Protections

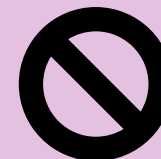
CMS proposes to further clarify enrollee rights and protections as they relate to ILOS, including by requiring states to adhere to and document in their managed care plan contracts and enrollee handbooks the following protections:



An enrollee who chooses not to use an ILOS **retains their right to receive the service or setting covered under the state plan**, with the same terms and requirements as if an ILOS was not an option.



ILOS may not be used to **reduce, discourage, or jeopardize an enrollee's access** to services and settings covered under the state plan.



Managed care plans **may not deny an enrollee access** to a service or setting covered under the state plan on the basis that an enrollee has been offered or used an ILOS in the past or is currently using an ILOS.

ILOS: Medically Appropriateness/Cost Effectiveness

To support medical appropriateness and cost-effectiveness determinations, the proposed rule would require states to document the following information for each ILOS in their managed care contracts:

- ✓ Name and definition of the ILOS.
- ✓ Identification of the state plan covered service for which the ILOS has been determined to be a medically appropriate and cost-effective substitute.
- ✓ A “clinically defined target population(s)” for which the ILOS has been determined to be a medically appropriate and cost-effective substitute.
- ✓ A process by which a licensed network or managed care plan staff provider would have to determine that an ILOS is medically appropriate for a specific enrollee.

Note: Determinations and a description of how the ILOS would address the individual’s needs would need to be documented within the enrollee’s records (e.g., plan of care or medical record).



States with projected ILOS cost percentages above 1.5% of the capitation rate would be required to submit additional documentation on the process used to determine that each ILOS is medically appropriate and cost effective.

ILOS: Monitoring, Evaluation, and Oversight

The proposed rule would add ILOS-specific monitoring requirements, a risk-based approach to retrospective evaluation, and CMS and state actions for non-compliance with the new ILOS parameters.

Monitoring

- Review, validate, and report ILOS-related encounter data to CMS.
- Identify specific codes for managed care plans to use for each ILOS.

Evaluation

(For states with a final ILOS cost percentage exceeding 1.5%. Other states would be strongly encouraged to conduct an evaluation.)

- Complete a retrospective evaluation for each managed care program with one or more ILOS.
- Using the 5 most recent years of accurate and validated data, evaluate for each ILOS:

✓ Costs and utilization

✓ Access

✓ Grievances and appeals

✓ Quality of care

✓ Health equity

Oversight

If a state determines an ILOS is no longer medically appropriate or cost-effective or is not in compliance with requirements, a state would be required to:

- Notify CMS within 30 calendar days.
- Submit an ILOS transition plan to CMS within 15 days after the decision to terminate an ILOS.
- Notify enrollees of any changes to ILOS offerings.
- Develop a transition of care to other state plan services.
- Remove ILOS from the contract and submit a modified contract to CMS for review and approval.
- Evaluate if an adjustment to the capitation rate is necessary to ensure actuarial soundness.

Note: CMS may terminate the use of an ILOS deemed noncompliant.

ILOS: Implications



CMS Seeks Comment on

- The timeline for submitting the final ILOS cost percentage to CMS.
- The level at which the ILOS evaluation should be completed (e.g., for each managed care program, across all managed care programs, by managed care contract, etc.).
- Timing for the ILOS evaluation period and use of an independent evaluator.



Considerations for States

- States may consider leveraging ILOS authority to address non-medical needs of the Medicaid population, to the extent that they are not already doing so. States could review their state plan covered services or settings for potential ILOS use cases or review current ILOS to ensure alignment with CMS' principles and parameters.
- States will want to review current ILOS to ensure compliance with CMS expectations, including:
 - Assuring enrollee rights and protections, and corresponding documentation in enrollee handbooks and managed care contracts.
 - Defining additional ILOS details and documentation of details in managed care contracts.
- States may need to build in new ILOS specific requirements into their monitoring, oversight, and evaluation processes.



Medical Loss Ratio (MLR) Standards ***(Managed Care Proposed Rule)***

MLR: Methodology

$$\text{MLR} = \frac{\text{Incurred Claims} + \text{Quality Improvement Activities}}{\text{Revenue}}$$

CMS proposes to tighten what can be counted in both parts of the Medicaid and CHIP MLR numerator, due to concerns that current requirements allow plans to inflate MLRs without driving quality.

- **Standards for Provider Incentives.**

- CMS would require incentive payment arrangements (which are counted as incurred claims) between plans and providers to:

- ☑ Establish a **defined performance period** that can be tied to the applicable MLR reporting period(s).

- ☑ Establish **well-defined quality improvement or performance metrics** that the provider must meet to receive the payment.

- ☑ Identify a **specific dollar amount** that can be linked to the successful completion of these metrics, **including a payment date.**

- States would be required to identify the documentation that the plans must maintain to support these arrangements, which cannot include attestations.

- **Prohibited Costs in Quality Improvement Activities (QIA).** CMS would more closely align Medicaid and Marketplace rules with respect to QIA, such that certain administrative costs would be prohibited under the proposed rule, specifically indirect or overhead costs that do not directly improve quality.

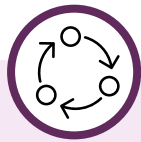
MLR: Reporting

CMS proposes to more closely align Medicaid and Marketplace rules regarding MLR reporting, including additional requirements to detail expense allocation and improve transparency and consistency.



Additional Requirements for Expense Allocation Methodology.

Plans would submit to the state a detailed description of the methods used to allocate expenses (incurred claims, QIA, taxes, and other non-claims costs).



Plan MLR Reporting Resubmission Requirements.

To reduce reporting burden, plans would only be required to resubmit MLR reports if the state changes the rate of payment or changes the terms of a state directed payment (not just enrollment reconciliations).



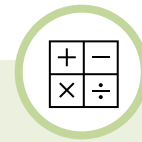
Level of MLR Data Aggregation.

CMS would explicitly require states to provide MLR information *for each plan* in their annual summary reports to CMS, as CMS intended in the 2016 managed care rule.



Contract Requirements for Overpayments.

In response to concern that plans may not be promptly reporting all overpayments to the state, the proposed rule would require plans report both identified and recovered overpayments within 10 business days.



Reporting of SDPs in the MLR.

In annual MLR reports to states, Medicaid plans would be required to include SDP payments to providers in the numerator and associated revenue in the denominator.

Citation: §§ 438.8(k)(1)(vii), 457.1203(f); §§ 438.8(m), 457.1203(f); §§ 438.74, 457.1203(e); §§ 438.608(a)(2), (d)(3), 457.1285; and §§ 438.8(e)(2)(iii), (f)(2), 438.74, 457.1203(e), (f).

*Reporting of SDPs in the MLR do not apply to CHIP.

MLR: Request for Comment and Implications



CMS Seeks Comment on

- The definition of “prompt” reporting for plans to report overpayments to CMS—specifically, CMS seeks comment on the proposed timeframe for reporting overpayments (10 business days) and whether reporting should be from the date of identification or recovery, or instead on a routine basis (e.g., monthly).



Considerations for States

- The MLR in Medicaid and CHIP serves as an important tool for states to evaluate how funds are being spent by plans; more consistency across commercial, Marketplace, Medicaid, and CHIP MLR requirements may lead to better comparisons for state policymaking.
- While most of the reporting requirements apply to plan submissions to states, states should note the effective dates for new reporting requirements to CMS (e.g., level of data aggregation) and whether the changes will impact current practices.
- States can leverage MLR requirements to drive managed care plan investments in high quality provider networks.



Quality Proposals

(Managed Care Proposed Rule)

QRS: Measure Set and Methodology

CMS would establish minimum federal Medicaid and CHIP Managed Care Quality Rating System (MAC QRS) standards, including a national framework and quality measure set, as well as a rating methodology.

- A state's QRS must include a mandatory minimum measure set of 18 mandatory measures, upon which states can expand. CMS outlines the **methodology by which states would establish quality ratings** for plans:



Collect Data: from plans with 500 or more enrollees, including Medicaid managed care, FFS, and Medicare Advantage (MA) plans (when appropriate).

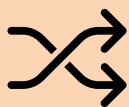


Validate Data: review extent to which data are unbiased, accurate, and complete; the same definition currently applied by states for quality reviews (and aligns with MA and Marketplace).



Calculate Performance Rates: each plan would receive multiple quality ratings, one for each mandatory measure that applies to the plan's covered populations and services.

- States would further be required to ensure that quality ratings: (1) include data for all enrollees receiving coverage from the managed care plan, **including enrollees who are dually eligible** and receive services through the Medicaid managed care plan; and (2) are calculated for each measure at the plan level by program.



States can request to implement an alternative QRS system.

- CMS would narrow the information states need to submit in their request to implement an alternative.
- CMS would also remove the requirement for approval to include measures beyond the mandatory set.

QRS: Website Display and Reporting

CMS also proposes to update regulations that already require states to prominently display the quality rating of each managed care plan online, and submit information on their QRS, upon request.

States must have a MAC QRS website that includes:

- Clear information** that is understandable and usable for navigating a MAC QRS website, **including how to access the beneficiary support system** to respond to questions related to the MAC QRS.
- Interactive features that allow users to tailor specific information**, such as formulary, provider directory, and quality ratings based on demographic data such as user's age, geographic locations, and dual eligibility status.
- Standardized information that facilitates user comparisons** of managed care programs and plans, including certain metrics of plan performance (e.g., the results of the secret shopper surveys).
- Information that promotes enrollee understanding of and trust** in the displayed quality ratings, such as data collection timeframes and validation confirmation.
- Access to Medicaid and CHIP enrollment and eligibility information**, either directly on the website or through external resources.



States must submit to CMS (at request) information on their QRS ratings, documentation, a link to the website, etc., no more than annually.

State Quality Strategies and QAPI

CMS proposes technical changes to existing regulations to increase the transparency of a state's managed care quality strategy, and to reduce quality program duplication for plans that serve the dually eligible.

	Current Regulations Require ...	CMS Proposes ...
Quality Strategies	<ul style="list-style-type: none"> States to draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by plans; and evaluate and update their quality strategy at least every 3 years or when there are significant changes to the strategy or the Medicaid program. 	<ul style="list-style-type: none"> To require states to allow public comment and submit the quality strategy to CMS every 3 years, regardless of whether any changes are made; and to require states post the results of the 3-year evaluation on the state's website.
QAPI	<ul style="list-style-type: none"> States to require plans to establish a QAPI program, including conducting performance improvement projects. 	<ul style="list-style-type: none"> Technical changes to the QAPI program to streamline requirements and increase consistency with MA programs that also serve dually eligible members (e.g., states can allow a plan to use a Chronic Care improvement Program as their quality improvement project).



CMS also proposes updates to External Quality Review regulations, including adding an option to assist in new evaluation requirements and changing the content/timing of the External Quality Review technical report.

QRS, State Quality Strategies, and QAPI: Request for Comment and Implications



CMS Seeks Comment on

- The process and documentation for assessing whether a proposed alternative QRS framework is substantially comparable.
- The type of technical assistance that would be helpful to states in obtaining and using quality data across payment systems. (CMS acknowledges that a gradual implementation of contract or system changes to collect data may be necessary.)
- Additional quality ratings requirements not reflected in the proposed rule: (1) requiring states to calculate and display a performance rating that reflects a national baseline for each mandatory measure in addition to each plan's measure-specific scores, and (2) requiring states to calculate and display performance ratings at the domain level.
- The posted prototypes for review and comment of MAC QRS websites.
- How to best support states via future guidance.



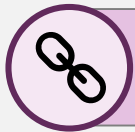
Considerations for States

- Proposals add significant data reporting and systems changes with 4 years to implement.
- States will need to weigh the benefits of proposing alternative versus a standardized approach to QRS.
- CMS notes states can leverage an EQRO to conduct validation of QRS data and reduce burden. States could also adapt an expanded role for EQROs through optional activities related to SDPs and ILOS, to increase efficiency and reduce burden on state workforce.

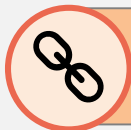
Discussion

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Thank You

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Appendix

Timeline of Key Managed Care Proposals

Regulatory Proposal		Effective Date
Coverage, Financing, Payment 	SDPs	<i>See below</i>
	Payment Methodologies: (1) <i>non-network providers</i> ; (2) <i>preprint submission requirements</i> ; (3) <i>value-based payment (VBP) directed payments</i> ; (4) <i>interim payments with reconciliation</i> ; (5) <i>separate payment terms</i>	(1-2) Upon the effective date of the final rule (3) Upon the effective date of the final rule, with the exception of population- or condition-based VBP payments—applicable no later than the first rating period beginning on or after the effective date of the final rule (4) No later than the first rating period beginning on or after 2 years after the effective date of the final rule (5) No later than the first rating period beginning on or after 4 years after the effective date of the final rule
	Payment Levels: <i>codifying the ACR as the maximum expenditure limit and ACR demonstration requirements</i>	No later than the first rating period beginning on or after the effective date of the final rule
	Reporting Requirements: (1) <i>near-term reporting of actual aggregate directed payments</i> ; and (2) <i>longer-term provider-level reporting</i>	(1) Beginning on or after 60 days following the effective date of the final rule (2) Following the first rating period after the release of reporting instructions by CMS
	Non-Federal Share Financing: <i>provider attestation requirements</i>	No later than the first rating period beginning on or after 2 years after the effective date of the final rule
	Submission, Timelines and Appeals: (1) <i>appeals process</i> ; (2) <i>preprint submission and contract requirements</i> ; and (3) <i>deadline to send contract amendments</i>	(1) Upon the effective date of the final rule (2) No later than the first rating period beginning on or after 2 years after the effective date of the final rule (3) No later than the first rating period beginning on or after 4 years after the effective date of the final rule
	Evaluations Plan Standards and Report Requirement	No later than the first rating period beginning on or after 3 years after the effective date of the final rule

Timeline of Key Managed Care Proposals (Cont'd)

Regulatory Proposal		Effective Date
Coverage, Financing, Payment 	ILOS Requirements	During the first rating period beginning on or after 60 days following the effective date of the final rule
	MLR Standards	Generally 60 days after the effective date of the final rule, for both Medicaid and CHIP
Quality 	EQR: (1) <i>optional</i> EQR activity; (2) EQR results	(1) Upon the effective date of the final rule (2) No later than 1 year from the release of further guidance
	Managed Care State Quality Strategies	No later than 1 year from the effective date of the final rule
	QAPI Technical Changes	No later than the rating period beginning after the effective date of the final rule
	QRS that Meets National Standards	By the end of the fourth calendar year following the effective date of the final rule

Citation: CMS [Managed Care Access, Finance, and Quality](#).

SDP Context

Under current managed care rules, states are permitted to direct managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, to use particular provider payment methodologies that promote access, quality, and delivery system reform.

- States can mandate **two broad types of SDPs**:



Minimum, maximum, or uniform payment increases that plans must pay providers (“state-directed fee schedules”).

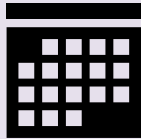


State-specified value-based purchasing and delivery system reform methodologies (“VBP directed payments”).

- SDPs must be **tied to utilization and distributed to a defined class of providers**, but states have flexibility to define the class.
- To obtain approval for SDPs, states must **document arrangements in the contract with plans and the managed care rate certification**.
- In most cases, under current rules, states must also **submit a preprinted form** to CMS requesting pre-approval for the arrangement.

SDPs: Submission Requirements, Timelines, and Appeals

CMS proposes new requirements related to SDP submission, timelines and appeals.



CMS would require that states submit SDP preprints **no later than 90 days before the end of the rate year**. (CMS will not consider SDPs submitted after the rate year ends.)

CMS would require states to include more specific language related to SDPs in managed care contracts, with varying requirements based on the type of directed payment. **States would have until 120 days from (1) the start date of the SDP or (2) the CMS approval date, whichever is later, to submit contract amendments.**



The proposed rule would **establish a formal appeals process** in instances where CMS denies state preprint requests. Under the proposal, states could appeal to the U.S. Health and Human Services (HHS) Department Appeals Board.

QRS: Measure Set and Methodology (Cont'd)

A state's QRS must include a mandatory minimum measure set of 18 mandatory measures, upon which states can expand.

- CMS proposes a **sub-regulatory process** to update the mandatory measure set, which would include engagement with states and other stakeholders, plus public notice.
- Updates would be communicated through an annual technical resource manual** for states; states would have 2 calendar years from the start of the measurement year immediately following the update to display the updated measurement results and ratings.

CBE#	Measure Steward	Measure Name
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
0004	NCQA	Initiation and Engagement of Substance Use Disorder (SUD) Treatment
0418	CMS	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF)
3489	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30)
1516	NCQA	Child and Adolescent Well-Care Visits (WCV)
2372	NCQA	Breast Cancer Screening (BCS)
0032	NCQA	Cervical Cancer Screening (CCS)
0034	NCQA	Colorectal Cancer Screening (COL)
2517	DQA	Oral Evaluation, Dental Services (OEV)
2902	OPA	Contraceptive Care - Postpartum Women (CCP)
1517	NCQA	Prenatal and Postpartum Care (PPC)
0575/0059	NCQA	Hemoglobin A1c Control for Patients with Diabetes (HBD)
1800	NCQA	Asthma Medication Ratio (AMR)
0018	NCQA	Controlling High Blood Pressure (CBP)
0006	AHRQ	CAHPS – How people rated their health plan
0006	AHRQ	CAHPS – Getting care quickly
0006	AHRQ	CAHPS – Getting needed care
0006	AHRQ	CAHPS – How well doctors communicate
0006	AHRQ	CAHPS – Health plan customer service
Not endorsed	CMS	MLTSS-1 LTSS Comprehensive Assessment and Update
3547	CMS	MLTSS-7: LTSS Minimizing Institutional Length of Stay

External Quality Review

CMS proposes several updates to External Quality Review regulations, including adding an optional activity and changing the content/timing of the External Quality Review technical report.



External Quality Review Activities. Federal regulations currently define a minimum set of mandatory External Quality Review activities, as well as a set of additional *optional* activities, to assess the quality, timeliness, and access to health services that a managed care plan furnishes.

- **Optional Activity:** CMS proposes that External Quality Review Organizations (EQROs) can assist in the new evaluation requirements under the proposed rule, including related to state directed payments and ILOS.



EQR Results. EQROs are currently required to produce an annual technical report for states summarizing the results of their mandatory and optional review activities.

- CMS proposes a number of technical changes with the aim of emphasizing outcomes and promoting equity, by expanding the data included in the External Quality Review reports to:
 - (1) Require reports include any outcomes data and results from quantitative assessments; and
 - (2) Require similar data from the mandatory network adequacy validation activity.