

# CMS Proposed Rules Part 1: Access to Care and Transparency

May 23, 2023

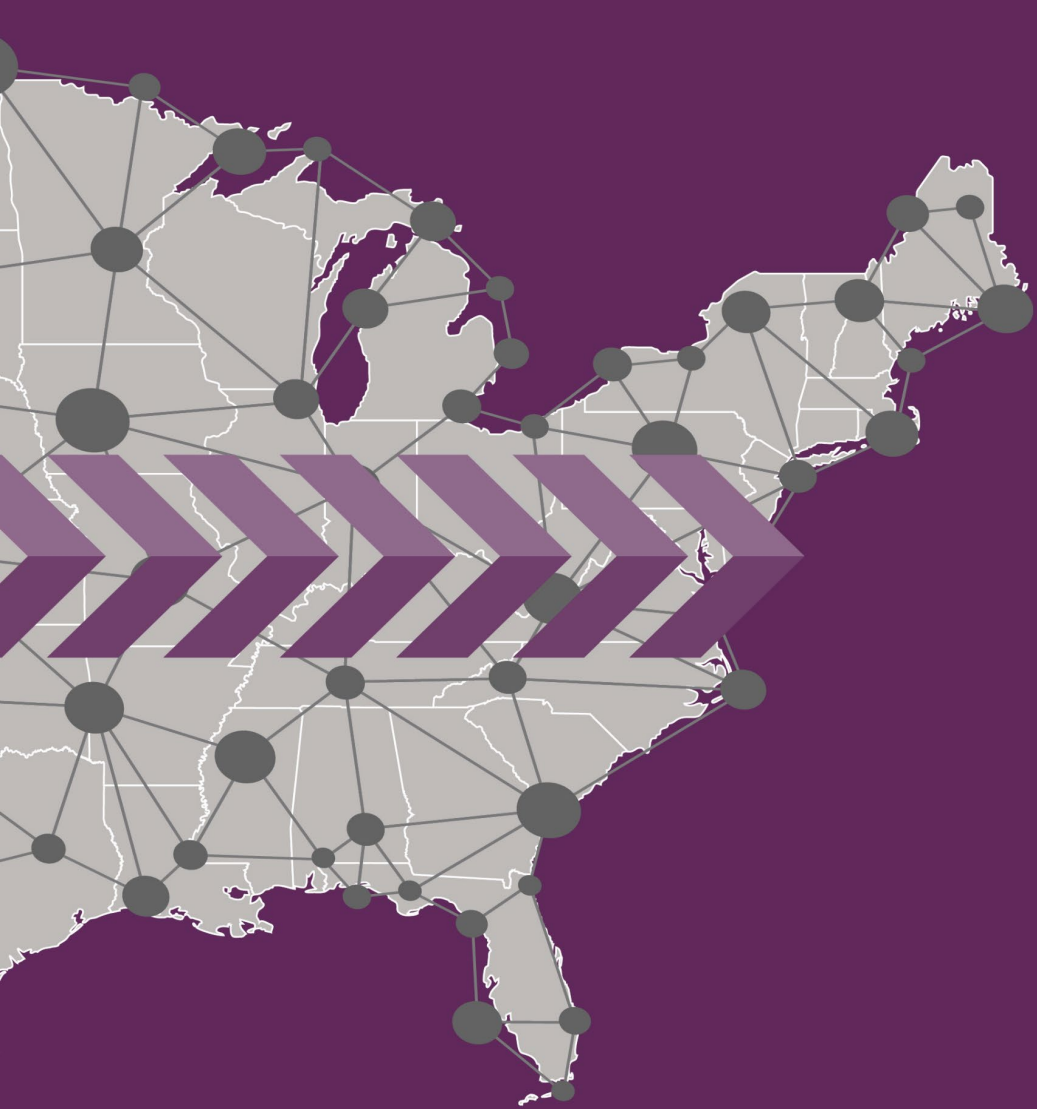
1:00 to 2:00 p.m. ET

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



# CMS Proposed Rules Part 1: Access to Care and Transparency

Manatt Health

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**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

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

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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](http://www.manatt.com/ManattHealth.aspx)

# Housekeeping Details

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- 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](http://www.shvs.org).

# Agenda


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

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- **Access to Care Provisions in Both Rules**
  - Access Monitoring
  - Enrollee Engagement
  - Payment Transparency
  - Home and Community-Based Services (HCBS)

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- **Discussion**




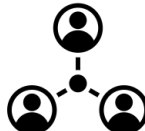



# Level-Setting

# 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><b>“Managed Care Access, Finance, and Quality” (or the “Managed Care Proposed Rule”)</b></p>	<p><b>“Ensuring Access to Medicaid Services” (or the “Access Proposed Rule”)</b></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...*

				
<p><b>Standards for Ensuring Access to Care</b></p>	<p><b>Engagement of People Enrolled in Medicaid</b></p>	<p><b>Transparency/ Oversight of Payment Rates</b></p>	<p><b>Quality Measurement</b></p>	<p><b>Program Accountability</b></p>

➤ 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 reflect CMS' 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).**

# Themes Across the Proposed Rules

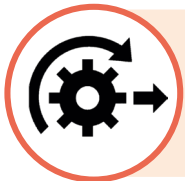
Several key themes emerge from the two proposed rules and CMS' preambles.



**Increased Transparency.** If finalized, these proposals would significantly increase transparency for Medicaid and CHIP program data related to provider payments and access to care.



**Commitment to Health Equity.** These rules show CMS' continued emphasis on addressing health disparities and advancing health equity.





**Program Alignment.** CMS seeks to align standards and approaches across federally regulated healthcare programs (often looking to the Marketplace and Medicare to inform Medicaid and CHIP standards).



**Rollout of Requirements.** The significant new requirements on states and managed care plans would require CMS guidance and technical support. CMS attempts to mitigate the administrative burden by focusing required analyses on a subset of key services or issues and implementing provisions over time.



# Timeline of Key Access to Care Proposals

CMS includes multiple proposals aimed at promoting access to care for Medicaid and CHIP enrollees and requiring greater transparency and standardization for program data.

Regulatory Proposal	Effective Date	Source
<b>Access Monitoring</b> 	Appointment Wait Time Standards: <i>establish maximum wait time standards and include standards in managed care contracts</i>	Managed Care Proposed Rule
	Secret Shopper Survey Requirements	
	Remedy Plans to Improve Access	
	Enhanced Reporting	
	Website Transparency	
<b>Enrollee Engagement</b> 	Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG)	Access Proposed Rule
	Enrollee Experience Surveys: <i>conduct Medicaid enrollee experience survey and use CHIP CAHPS* data to evaluate network adequacy</i>	Managed Care Proposed Rule

*Most access requirements in the Managed Care Proposed Rule would align across Medicaid and CHIP managed care. Standards would generally apply equally across managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), but most new standards do not apply to primary care case management (PCCM) entities.*

# Timeline of Key Access to Care Proposals (Cont'd)

Regulatory Proposal		Effective Date	Source
<b>Payment Transparency</b> 	Analysis of Managed Care Provider Payment Rates	For the first rating period at least 2 years after the effective date of the final rule	Managed Care Proposed Rule
	Analysis of FFS Provider Payment Rates	January 1, 2026 (using Medicaid payment rates in effect as of January 1, 2025)	Access Proposed Rule
	HCBS Payment Rate Disclosure		
	State Analysis for Rate Reduction/Restructuring	Upon the effective date of the final rule*	
<b>HCBS Access</b> 	Grievance Systems	2 years after the effective date of the final rule	Access Proposed Rule
	Person-Centered Service Plans	<u>FFS</u> : 3 years from the effective date of the final rule	
	Incident Management System	<u>Managed Care</u> : During the first rating period that begins at least 3 years after the effective date of the final rule	
	HCBS Access Reporting		
	HCBS Quality Measure Set		
	HCBS Payment Adequacy	<u>FFS</u> : 4 years following the effective date of the final rule <u>Managed Care</u> : During the first rating period that begins on or after 4 years after the effective date of the final rule	

*While all of the access requirements in the Access Proposed Rule would apply to the FFS delivery system, some (mainly the HCBS provisions) would extend to the managed care delivery system as well.*

**Citation:** CMS [Managed Care Access, Finance, and Quality](#) and [Ensuring Access to Medicaid Services](#). \*CMS noted they expect the effective date of the rule to be 60 days following publication of the final rule. There is no separate effective date proposed for this section (203(c)), so the changes would apply for all state plan amendments (SPAs) submitted after 60 days following the final rule's publication.



# **Access Monitoring** ***(Managed Care Proposed Rule)***

# Appointment Wait Time Standards

The proposed rule would build upon existing network adequacy standards by establishing managed care national maximum appointment wait time standards for four types of “routine” appointments.

Appointment Type	Wait Time Must Not Exceed...
Outpatient mental health and substance use disorder (SUD)—adult and pediatric	10 business days from date of request
Primary care—adult and pediatric	15 business days from date of request
Obstetrics and gynecology (OB/GYN)	15 business days from date of request
An additional appointment type(s) selected by the state in an evidence-based manner	The state would establish its own standard(s)

*Note: CMS proposes to retain its ability to add additional appointment types to these standards after consulting with stakeholders and providing public notice/opportunity to comment.*

- States would then be responsible for establishing wait time standards and defining “routine” appointments for their Medicaid and CHIP managed care programs.
- States would have flexibility to: establish standards that are more stringent, but not more lenient, than the national standards; vary wait time standards for appointment types (e.g., adult vs. pediatric, telehealth vs. in-person, by geography); set standards for other appointments (e.g., urgent, emergent), and provide exceptions to appointment wait time maximums.

# Secret Shopper Surveys

To assess compliance with appointment wait time standards and validate provider networks, CMS would require states (through independent entities) to conduct annual secret shopper surveys to measure...



## Compliance With Wait Time Standards

- Plans would:
  - ✓ Be determined compliant by achieving a rate of appointment availability that meets the state-established standards at least 90% of the time.
  - ✓ Be held accountable for compliance with any additional appointment type(s) selected by the state as well as any appointment types that CMS adds at a later date.



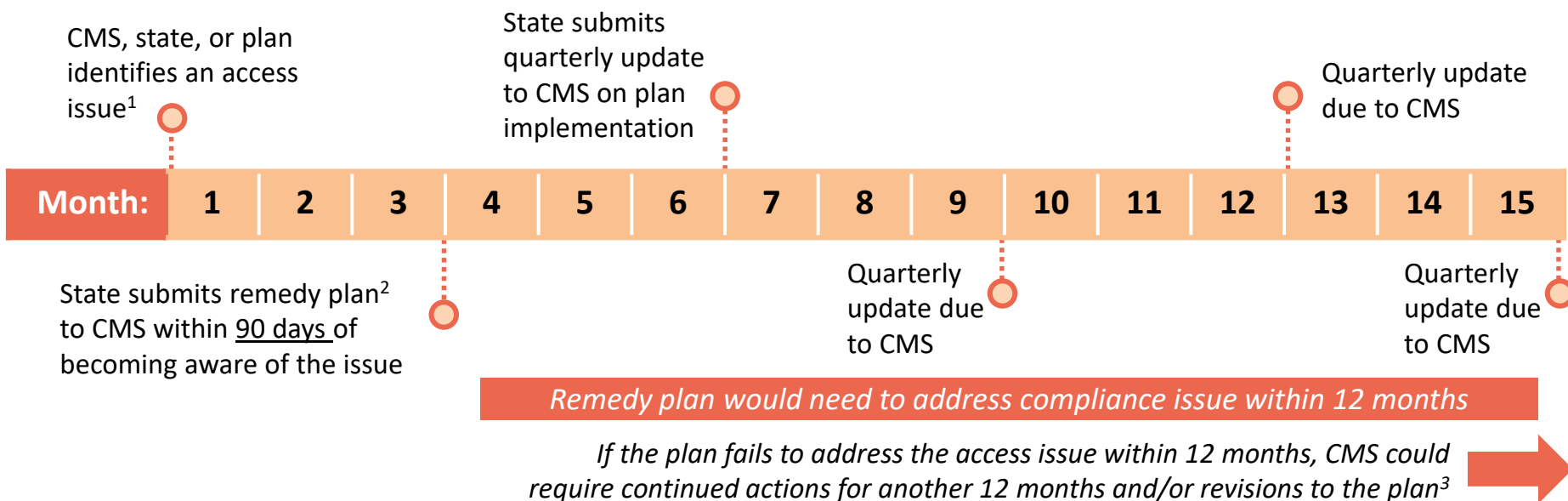
## Accuracy of Plans' Electronic Provider Directories

- States would be required, for certain provider types, to determine accuracy of electronic provider directory information, including:
  - ✓ Active network status with the plan.
  - ✓ Provider street address and telephone number.
  - ✓ Whether the provider is accepting new patients.
- The independent entity would need to share data with the state/the plan for the plan to make necessary corrections within timeframes proposed by CMS.
- By July 1, 2025, states would need to make their provider directories searchable and inclusive of information on whether each provider offers telehealth services.

*States would (1) have significant flexibility related to secret shopper survey design, subject to certain methodological standards proposed by CMS; and (2) be required to post secret shopper survey results on their website and submit annual reports to CMS.*

# Remedy Plans to Improve Access

The proposed rule would require that states develop remedy plans when the state, CMS, or a plan identifies access issues—including compliance with appointment wait times or network adequacy.




1. Access issues include issues related to availability of services and network adequacy standards—extending to proposed appointment wait time standards, secret shopper surveys, and provider directory requirements.
2. Remedy plans must also: identify the responsible party that would take action; articulate the specific steps to be taken; and include a proposed implementation and completion timeline.
3. CMS also has authority to disallow federal financial participation (FFP) for managed care contract payments when an access issue has risen to the level of violating federal statutory standards.

**Citation:** § 438.207(f). \*Although the preamble does not specify whether new remedy plan provisions would apply to managed care plans covering separate CHIP programs, the existing regulatory structure suggests that it would. The new provisions on remedy plans would be codified in 42 CFR § 438.207.



# Website Transparency

CMS would require states to implement website changes making information more accessible to enrollees and improving the user experience.

 <b>Website Requirements</b>
Include required content (or links) on a single website.
Directly link to the specific information requested on a plan website.
Utilize clear and easy-to-understand labels on documents and links.
Explain the availability of assistance for accessing the information.



Required Content	Effective Date
Managed care plan contract	<i>Material is already posted to states' websites. However, states must implement the proposed transparency changes.</i>
Documentation demonstrating plan compliance with requirements for availability and accessibility of services	
Information on ownership and control of the plan, including names and titles of individuals	
Results of periodic audits of the accuracy, truthfulness and completeness of the encounter, and plan financial data	<i>Content must be added to the state's website by the first rating period beginning on or after 2 years following the final rule's effective date, although later effective dates apply to certain newly required analyses.</i>
Enrollee handbooks, provider directories, and formularies	
Information on rate ranges	
Managed care program annual reports	
State assurance of plan compliance with access/availability	
Network adequacy standards	
Secret shopper survey results	
SDP evaluation reports	
Information on and links to all required application programming interfaces	
Quality-related information	
Documentation of compliance with mental health/SUD parity	

States would also need to verify the website is up-to-date and working correctly at least quarterly.

Citation: §§ 438.10(c), 438.602(g), 457.1207, 457.1285.

# Access Monitoring: Request for Comment and Implications



## CMS Seeks Comment on...

- The proposed national maximum appointment wait time standards.
- How to define “urgent” and “emergent” appointment wait time standards (for potential consideration in future rulemaking).
- Whether to adopt standards regarding appointment wait time and secret shopper surveys to the FFS delivery system.
- The type of technical assistance that states would find most useful in implementing secret shopper surveys and best practices/lessons learned from using secret shopper surveys.



## Considerations for States...

- While CMS has proposed to phase-in the access monitoring requirements over time, states:
  - Will need to examine their current provider networks, identify access issues, and take steps to increase provider participation sooner rather than later.
  - Have acknowledged that the national maximum appointment wait time standards may be difficult to meet.
  - Will need to direct time and resources towards survey design and improving provider directories (especially those states that do not currently conduct secret shopper surveys).



# **Enrollee Engagement**

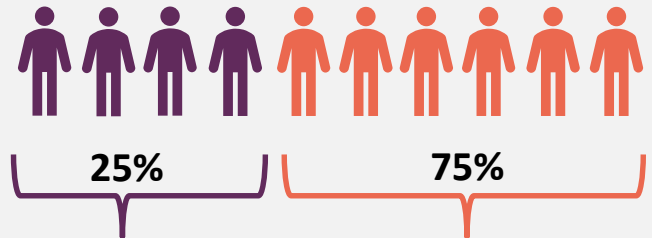
## ***(Managed Care and Access Proposed Rules)***

# Medicaid Advisory Committee and Beneficiary Advisory Group

The proposed rule would replace the existing Medical Care Advisory Committee (MCAC) with two new groups: a Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG).

- The MAC and BAG would be required to meet at least once per quarter, hold off-cycle meetings, and offer in-person and virtual attendance options.
  - MAC: At least 2 meetings per year would need to be open to the public.
  - BAG: Would be required to meet separately/in advance of MAC meetings.
- CMS would require the MAC to submit (and the state to post to its website) an annual report. The state would be required to post publicly the MAC and BAG bylaws, membership lists, meeting minutes, and process for member appointment and selection.
- CMS would require states to provide staffing, financial, and other administrative support. States would be able to claim FFP at the standard administrative match rate of 50%.

## MAC Membership



**From the BAG,** made up of current or past Medicaid enrollees or family members/caregivers of enrollees.

### At least one member from each category:

- Clinical providers or administrators.
- State, local, or community-based organizations.
- Participating plans/state associations.
- Other state agencies.

# Enrollee Experience Surveys

The proposed rule would require states to conduct a Medicaid enrollee experience survey of their choosing annually and use existing enrollee data in CHIP to evaluate network adequacy.



## Medicaid Enrollee Experience Survey

- CMS would require states to:
  - Conduct an annual enrollee experience survey of their choosing annually for each of their Medicaid managed care programs.
  - Evaluate the enrollee experience data as part of their Managed Care Program Annual Reports and post the report on their website 30 calendar days after submission to CMS.

**Reminder:** States may use external quality review organizations (EQROs) for the administration and validation of these surveys and receive a 75% enhanced federal match.



## CHIP Enrollee Experience Data

- CMS would require states to:
  - Use CHIP CAHPS survey data to evaluate network adequacy.
  - Annually post comparative summary results of CHIP CAHPS surveys by plan on their website.

# Enrollee Engagement: Request for Comment and Implications



## CMS Seeks Comment on...

- The minimum percentage of MAC members who should be current/past Medicaid enrollees or family members/caregivers of Medicaid enrollees.
- Whether an implementation date later than 60 days following publication of the final rule would be more appropriate for the requirement to leverage existing enrollee data in CHIP to evaluate network adequacy.
- Whether it should mandate the use of a specific enrollee experience survey and define the parameters of acceptable survey instruments that states must use; the cost and feasibility of implementing enrollee experience surveys for each plan; and states' experiences to date with enrollee experience surveys.



## Considerations for States...

- States have an opportunity to meaningfully engage Medicaid enrollees with the proposed MAC and BAG requirements, which would promote bi-directional feedback with the state; however, states would need to stand these groups up quickly (60 days after the effective date of the final rule, providing states with 1 year to implement per CMS).
- States would also need to make program changes involving their quality team to effectuate the enrollee experience survey/data requirements.



# **Payment Transparency**

## ***(Managed Care and Access Proposed Rules)***

# Analyses of Provider Payment Rates

CMS proposes to establish a new set of parallel processes for increasing payment rate transparency and monitoring the sufficiency of Medicaid FFS and managed care payment rates.

All states would be required to publish **all** approved Medicaid FFS payment rates on a website, with rates listed separately to the extent that they vary based on patient population (pediatric and adult), provider type, and/or geographic location. For a subset of services (detailed below), CMS proposes additional reporting for both FFS and managed care.

Proposed Requirement	Frequency of Reporting
<p><b>Service Categories:</b> Primary Care, OB/GYN, Behavioral Health*</p> <p><b>FFS Rates</b> (§ 447.203(b)).</p> <ul style="list-style-type: none"> <li>▪ For each E/M code that CMS defines per category, <b>states</b> must compare the <b>FFS base payment</b> to the <b>non-facility rate in the Medicare Physician Fee Schedule</b> (Medicaid supplemental payments are excluded).</li> <li>▪ Separate reporting is required if rates vary based on provider type, adult vs. pediatric patient, or geographical location.</li> <li>▪ <b>States</b> must publish the analysis on their website.</li> </ul>	<p>States must publish a new analysis every other year.</p>
<p><b>Managed Care Payments</b> (§§ 438.207(b), 457.1230(b)).</p> <ul style="list-style-type: none"> <li>▪ For each E/M code that CMS defines per category, <b>plans</b> must calculate the <b>total amount paid under Medicaid and CHIP for each service category in the aggregate</b> and compare that amount against <b>the total amount Medicare FFS would have reimbursed for those same services</b> (reported as a percentage). <ul style="list-style-type: none"> <li>○ The aggregate analysis must account for rate variation based on provider type, geographical location, or site of service.</li> <li>○ With respect to patient age (adult vs. pediatric), separate percentages must be reported if the percentages vary.</li> </ul> </li> <li>▪ <b>States</b> must submit an “assurance and analysis” to CMS and publish it on their website, including reported percentages at the plan-level plus a weighted statewide average for each service category.</li> </ul>	<p>Reports are required for new managed care contracts (as part of readiness review), and thereafter, annually or whenever there has been a “significant change.”</p>

\*Behavioral health services are defined differently for FFS (“outpatient behavioral health services”) and managed care (“mental health and SUD services”).



# HCBS Payment Rate Disclosure

The proposed rule requires separate standardized rate disclosure and analysis for certain HCBS, including for direct care workers.

Proposed Requirement	Frequency of Reporting
<b>Service Categories: HCBS, Including Personal Care, Home Health, and Homemaker Services</b>	
<p><b>FFS Rate Analysis</b></p> <ul style="list-style-type: none"> <li>▪ States must publish their payment rates for these HCBS in the form of <b><i>an hourly payment rate</i></b> (regardless of whether the state pays for such services on an hourly, daily, or other basis).</li> <li>▪ Within each service category, separate reporting is required if rates vary based on:               <ul style="list-style-type: none"> <li>○ Whether the payment is made to an agency vs. directly to an individual provider.</li> <li>○ Provider type, adult vs. pediatric patient, or geographical location.</li> </ul> </li> </ul>	<p>States must publish a new analysis every other year.</p>

- The proposed rule would further require **states** to:
  - ✓ Disclose, for each service, the number of Medicaid-paid claims and the number of enrollees who receive one such service within a calendar year.
  - ✓ Establish an ***interested parties' advisory group*** to ***“advise and consult”*** on the state's FFS rates for HCBS services.
    - Include direct care workers, enrollees, enrollees' authorized representatives, other interested parties.
    - Meet every 2 years.

# HCBS Payment Adequacy

The proposed rule would set a minimum threshold of Medicaid payments in both FFS and managed care that must be spent on compensation for HCBS direct care workers who provide personal care, home health aide, and homemaker care services, and establish related reporting requirements.

- **Compensation for Direct Care Workers.** To address the shortage of HCBS direct care workers, the proposed rule would require that at least **80% of all Medicaid payments be spent on “compensation”** for direct care workers who provide home-based services, including personal care, home health aide, and homemaker care services. This compensation includes:
  - ✓ Salary.
  - ✓ Wages and other remuneration.
  - ✓ Benefits.
  - ✓ Employer share of payroll taxes.
- **Reporting Requirements.** The proposed rule would require states to report annually on the percentage of payments for home-based services that are spent on compensation for direct care workers.
  - States would be required to aggregate their reporting for each service across all of their HCBS programs, and report the percentage separately for each service.
  - Within each service category (personal care, home health aide, and homemaker care), states would be required to report separately on payments that are self-directed and those that are agency-directed.

# State Analysis for Rate Reduction/Restructuring

The proposed rule would establish a new process for CMS review of state plan amendments (SPAs) that propose to reduce rates.

## Threshold Access Analysis



### Aggregate Payments

Assess how payments for relevant benefit category would be affected as compared to Medicare FFS rates.



### Magnitude of Proposed Change

Cumulative effect of all rate reductions or restructurings.



### Public Comment

Comments from the public regarding the proposed change.

## Secondary Analysis Required if...

Rates for benefit category (including supplemental payments) would **fall below 80% of comparable Medicare rates.\***

State expects **more than a 4% reduction in aggregate Medicaid expenditures** for the benefit category during the state's fiscal year.

Public comments yield **significant concerns about access to care** and the state is unable to respond or mitigate those concerns.

## Requirements of Secondary Analysis

### Proposed Payment Change

Analysis of cumulative effect of all reductions or restructurings on aggregate FFS Medicaid expenditures for each benefit category.

### Overview of Payment Rates

Analysis and comparison of before and after proposed reduction (including base and supplemental payments).

### Additional Data

- ✓ Actively participating providers.
- ✓ Number of Medicaid enrollees receiving FFS services.
- ✓ Number of services furnished through FFS delivery system.

### State Mitigation Plan

Responses to access to care concerns.

CMS may disapprove a SPA if a state fails to submit all required information under one or both tiers of the analysis.

# Payment Transparency: Request for Comment and Implications



## CMS Seeks Comment on...

- Whether additional access standards for states with fully FFS delivery systems would be appropriate.
- Broader application of timeliness standards proposed in managed care regulation.
- If the appropriate service categories (primary care, OB/GYN, behavioral health\*) were captured in the provider payment rate analysis.
- Related to payment adequacy for direct care workers: minimum percentage of payments that must be spent on compensation to direct care workers; whether facility or other indirect costs should factor into payment adequacy assessments; and additional information that should be reported.
- For rate reduction/restructuring—whether states should be permitted to bypass the first tier of analysis in instances where:
  1. Proposed rate reductions are necessary to implement federal Medicaid payment requirements.
  2. Rates would be at or above Medicare and/or average commercial rates (even after proposed rate reductions).
  3. State payment methodology adheres to Medicare methodology.



## Considerations for States...






- Though phased-in over time, the proposed rules would require states to make publicly available and maintain a public repository of payment rate information. States may want to consider commenting on CMS' proposed balance between rate transparency and administrative burden.

\*Behavioral health services are defined differently for FFS (“outpatient behavioral health services”) and managed care (“mental health and SUD services”).



# **Home and Community-Based Services (HCBS)** ***(Access Proposed Rule)***

# Additional HCBS Access Provisions

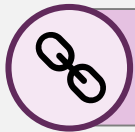
The proposed rule would:	Applicable to:		
 Revise <b>state reporting requirements</b> related to their completion of <b>person-centered service plans</b> .	Medicaid Managed Care	CHIP Managed Care	Medicaid FFS
 Require states to <b>establish a grievance system</b> for individuals receiving HCBS services through an FFS delivery system. (This system is modeled on the existing requirements for managed care plans' grievance systems.)	Medicaid Managed Care	CHIP Managed Care	Medicaid FFS
 Require states to <b>operate an electronic incident management system</b> , collect a range of data to identify critical incidents, and meet new reporting requirements.	Medicaid Managed Care	CHIP Managed Care	Medicaid FFS
 Create several new <b>annual reporting requirements</b> for states related to HCBS waiting lists, timely access to HCBS, and HCBS utilization.	Medicaid Managed Care	CHIP Managed Care	Medicaid FFS
 Require <i>CMS</i> to <b>identify measures</b> included in the 2022 HCBS Quality Measure Set and require <i>states</i> to meet certain reporting requirements.	Medicaid Managed Care	CHIP Managed Care	Medicaid FFS

**Citation:** §§ 42 CFR 441.301(c), 441.450(c), 441.540(c), 441.725(c); §§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), 441.745(a)(1)(iii); §§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v); §§ 441.303(f)(6), 441.311(d), 441.474(c), 441.580(i), 441.745(a)(1)(vii); and §§ 441.311(c), 441.312, 441.585(d), 441.745(b)(1)(v).

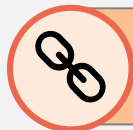
# Discussion

The slides and a recording of the webinar are available at [www.shvs.org](http://www.shvs.org).

**Reminder:** CMS seeks public input on all aspects of both proposed rules and invites comment on potential alternative or additional provisions **by July 3, 2023**.



The “Managed Care Access, Finance, and Quality” (or the “Managed Care Proposed Rule”) is available [here](#).



The “Ensuring Access to Medicaid Services” (or the “Access Proposed Rule”) is available [here](#).

# Thank You

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