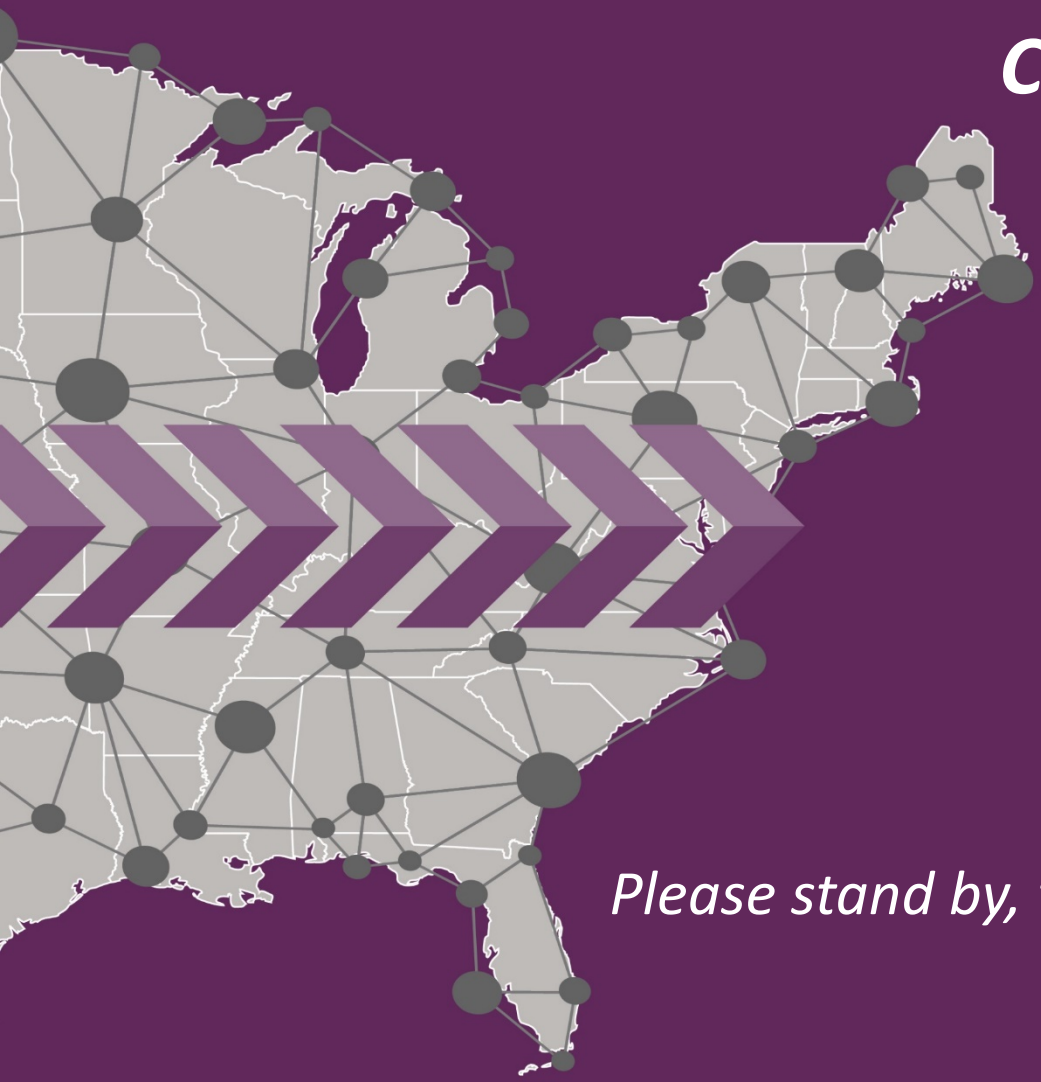

CMS Final Rules Part 1: Access, Enrollee Engagement, and Provider Payment Transparency

May 9, 2024

3:00 – 4:00 p.m. ET

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES

Driving Innovation Across States

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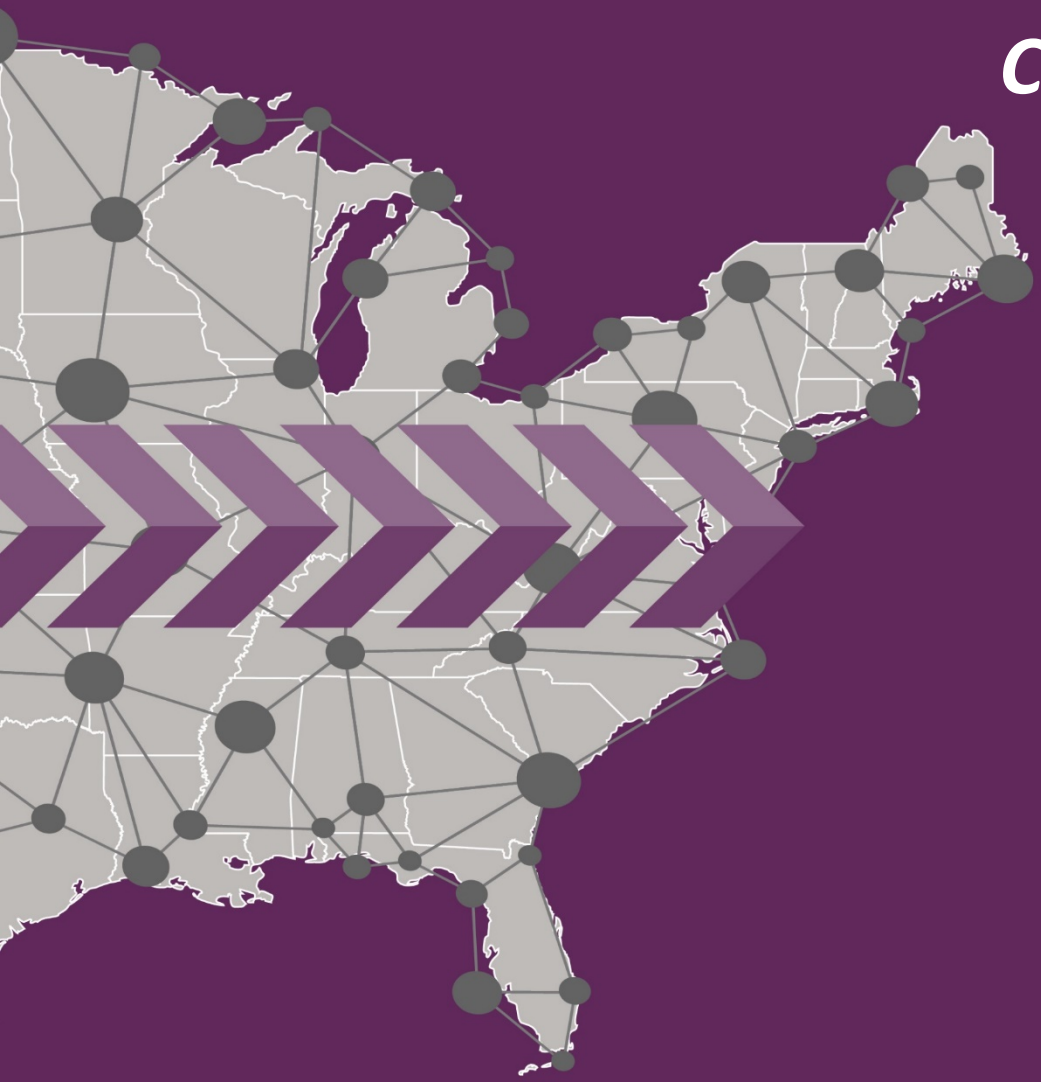

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About State Health and Value Strategies

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.
The views expressed here do not necessarily reflect the views of the Foundation.

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.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Webinar Series on CMS Final Rules

Remember to register for the next two webinars in our three-part series on the Medicaid access and managed care final rules.

CMS Final Rules Part 1:

Access, Enrollee Engagement, and Provider Payment Transparency

Thursday, May 9, 2024, 3:00 to 4:00 p.m. ET *(Today)*

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Home and Community-Based Services

Register here

Thursday, June 6, 2024, 2:30 to 3:30 p.m. ET

Agenda

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

- **Access to Care Provisions in Both Rules**
  - Access Monitoring
  - Enrollee Engagement
  - Provider Payment Transparency

- **Discussion**

- **Looking Ahead**

Level-Setting: CMS Managed Care and Access Final Rules

Medicaid's Federal Regulatory Landscape

On April 22, 2024, CMS finalized two rules that flow from a years-long process to develop a "comprehensive access strategy" in Medicaid and the Children's Health Insurance Program (CHIP).

2022

CMS Request for Information on issues related to access, payment, and eligibility and enrollment (E&E)*

7,000+ stakeholder comments

2023

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

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

>2,500 stakeholder comments (415 on Managed Care & >2100 on Access)

2024

Managed Care Final Rule

Access Final Rule

These rules will modernize how Medicaid and CHIP define, measure, and enforce the standards for access to care—the most significant change since CMS' 2016 managed care regulations.

***New E&E Rules.** In addition to rulemaking on access and managed care, CMS recently finalized two rules to streamline E&E for Medicaid and CHIP. These are the most significant E&E regulations since 2012 and 2013. See the SHVS webinar for more information, as well as this expert perspective specifically addressing Medicare Savings Programs.

Citation: CMS, Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment (September 2023); CMS, Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (April 2024); and CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Overview: Managed Care and Access Final Rules

The Managed Care and Access Final Rules generally align with the May 2023 proposed rules. Although the two rules focus on different delivery systems, they share common goals and themes.

Managed Care Final Rule	Access Final Rule	
Managed Care Delivery System Focus*	Fee-for-Service (FFS) Delivery System Focus	Home and Community-Based Services (HCBS) Focus Across Delivery Systems

Once implemented, these rules will transform:

Standards and Monitoring for Access to Care

Engagement of People Enrolled in Medicaid

Transparency and Oversight of Payment Rates

Quality Measurement

Program Accountability

**Most of the Managed Care Rule's requirements apply across Medicaid and CHIP managed care, and apply equally across managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), but not to PAHPs that exclusively provide non-emergency medical transportation (NEMT) or to primary care case management (PCCM) entities.*

Citation: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

= Today's Focus
★ = Significantly Modified from Proposed Rule

Summary of Provisions in the Final Rules

As in the proposed rules, the final rules describe complementary policies that often align across managed care and FFS delivery systems.

Managed Care Final Rule

- Strengthens access to care and monitoring through appointment wait time standards and secret shopper/enrollee surveys; and includes guidance on how telehealth can play a role.
- Creates new reimbursement transparency requirements.
- ★ Codifies and revises the federal regulations governing state directed payments, including by prohibiting the use of separate payment terms.
- Codifies and builds on recent CMS policy changes related to in lieu of services (ILOS).
- Modifies medical loss ratio (MLR) methodologies and processes.
- Establishes new quality requirements, including a framework and enhanced requirements for managed care quality rating systems (QRS).

Access Final Rule

- Creates new transparency and consultation requirements for FFS provider payment rates.
- Modifies the procedures for requesting federal approval to reduce or restructure FFS rates.
- Strengthens program advisory groups.
- ★ Establishes new payment standards for certain HCBS.
- Updates HCBS program standards and processes regarding care access and quality.

Implementation Timeframe
July 9, 2024 – 2030

Although the final rules formally take effect on July 9, 2024, CMS has defined implementation deadlines over the next six years, in addition to defining new exceptions and areas of state flexibility.

Citation: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Timeline of Key Access to Care Proposals

The final rules impose significant new requirements on states and managed care plans, which CMS seeks to mitigate with a staggered implementation timeline over a six-year period and other flexibilities.

Key Provisions		Effective Date*	Source
Access Monitoring 	Appointment Wait Time Standards	**July 9, 2027** (first rating period beginning on/after)	Managed Care Rule
	Secret Shopper Surveys	**July 10, 2028** (first rating period beginning on/after)	
	Remedy Plans to Improve Access	**July 10, 2028** (first rating period beginning on/after)	
	Website Transparency	**July 9, 2026** (first rating period beginning on/after)	
Enrollee Engagement 	Medicaid Advisory Committee and Beneficiary Advisory Council	**July 9, 2025**	Access Rule
	HCBS Interested Parties Advisory Group	**July 9, 2026**	
	Enrollee Experience Surveys	**July 9, 2026** (for CHIP, first rating period beginning on/after)	Managed Care Rule
		July 9, 2027 (for Medicaid, first rating period beginning on/after)	

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.

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

Key Provisions		Effective Date*	Source
Provider Payment Transparency 	Analysis of Provider Payment Rates in Managed Care	**July 9, 2026** (first rating period beginning on/after)	Managed Care Rule
	Analysis of Provider Payment Rates in FFS	**July 1, 2026** (using Medicaid payment rates in effect as of July 1, 2025)	Access Rule
	HCBS Payment Rate Disclosure		
	HCBS Payment Adequacy	**July 10, 2028** (for managed care, first rating period beginning on/after): Annual reporting on direct care worker compensation percentage for home care (i.e., personal care, home health aide and homemaker) and habilitation services	
		July 9, 2030 (for managed care, first rating period beginning on/after): Compliance with 80% compensation standard for home care (but not habilitation)	
	State Analysis for Rate Reduction/Restructuring	**July 9, 2024**	

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.

Access Monitoring (Managed Care Final Rule)

Appointment Wait Time Standards

With only minor modification from the proposed rule, CMS builds upon existing network adequacy standards by establishing managed care national maximum appointment wait time standards for routine appointments for four types of services.

Routine Appointment Type	Wait Time Must Not Exceed…
Outpatient mental health and substance-use disorder (SUD) services—adult and pediatric	10 business days from date of request
Primary care services—adult and pediatric	15 business days from date of request
Obstetrical/gynecological (OB/GYN) services	15 business days from date of request
An additional service type(s) selected by the state in an evidence-based manner	State establishes its own standard(s)
Note: CMS retains its ability to add additional services to these standards after consulting with stakeholders and providing public notice/opportunity to comment.	

- CMS does not define "routine appointments"—but encourages states to include appointments for well-child visits, annual gynecological exams, and medication management at a minimum. CMS does not describe the "evidence-based" approach to choosing an additional service type; rather, CMS encourages states to consult with stakeholders and consider various sources (e.g., encounter data, provider complaints, grievances and appeals).
- States 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, by geography); and set standards for routine appointments for other additional services. (Any appointment standards for telehealth must not be a substitute for in-person services.)

Citation: §§ 438.68(e), 457.1218.8.5.

Secret Shopper Surveys

CMS finalized its proposal to requires states, through independent entities, to annually conduct secret shopper surveys in Medicaid and CHIP as a tool to enforce new appointment wait time standards and other aspects of provider network adequacy and access.

Compliance With Wait Time Standards

- Plans will be:
  - ✓ Determined compliant by achieving a rate of routine appointment availability that meets the state-established standards at least 90% of the time.
  - ✓ Held accountable for compliance with any additional service type(s) selected as well as any service types that CMS adds at a later date.
- Telehealth may count if the provider also offers in-person appointments, and telehealth visits are separately identified in survey results.

Accuracy of Plans' Electronic Provider Directories

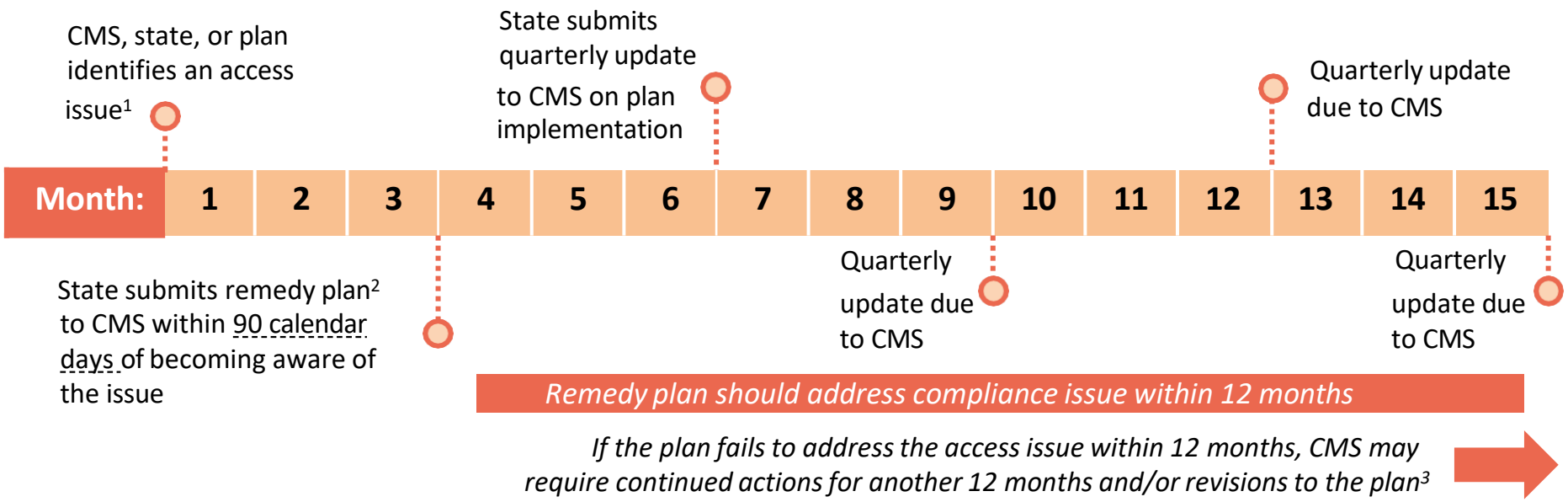
- For certain provider types, states must determine the accuracy of electronic provider directory information:
  - ✓ Active network status with the plan.
  - ✓ Provider street address and telephone number.
  - ✓ Whether the provider is accepting new patients.
- Plans must make necessary corrections within 30 calendar days of receiving updated provider information.
- By July 1, 2025, states must make their provider directories searchable and inclusive of information on whether each provider offers telehealth services.

States have significant flexibility related to survey design, subject to a minimum set of methodological standards established by CMS. States will be required to post secret shopper survey results on their website within 30 calendar days of submission to CMS and include secret shopper survey results in the Network Adequacy and Access Assurances Report.

Citation: §§ 438.68(f), 457.1207, 457.1218.

Remedy Plans to Improve Access

CMS finalized without modification the requirement that states develop remedy plans when the state, CMS, or a plan identifies access issues—including standards regarding availability of services, network adequacy, appointment wait time, secret shopper, and provider directory.



1. An access issue refers to an area in which the plan's performance "under the access standards … could be improved…"
2. Remedy plans need to: identify the responsible party that will be required to take action; articulate the specific steps to be taken; and include a proposed implementation and completion timeline.
3. CMS has existing 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). *The new provisions on remedy plans are codified in 42 CFR § 438.207, which applies (with limited exceptions) to separate CHIP programs, per 42 CFR § 457.1230.

Website Transparency

CMS finalized its proposal to implement website changes that will make information more accessible to enrollees and improve the user experience.

Website Requirements

- Include required content (or links to content) 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.

At least quarterly, states must verify that the website is working as intended and that information is up to date.

Required Content	Effective Date
Managed care plan contract	*Material is already posted to states' websites. However, states must implement new transparency changes.*
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	
Enrollee handbooks, provider directories, and formularies	*Content must be added to the state's website by the first rating period on/after July 9, 2026 (although later effective dates apply to certain newly required analyses).*
Information on rate ranges	
Managed care program annual reports	
State assurance of plan compliance with access/availability	
Network adequacy standards	
Secret shopper survey results	
State directed payments evaluation reports	
Information on and links to all required application programming interfaces	
Quality-related information	
Documentation of compliance with mental health/SUD parity	

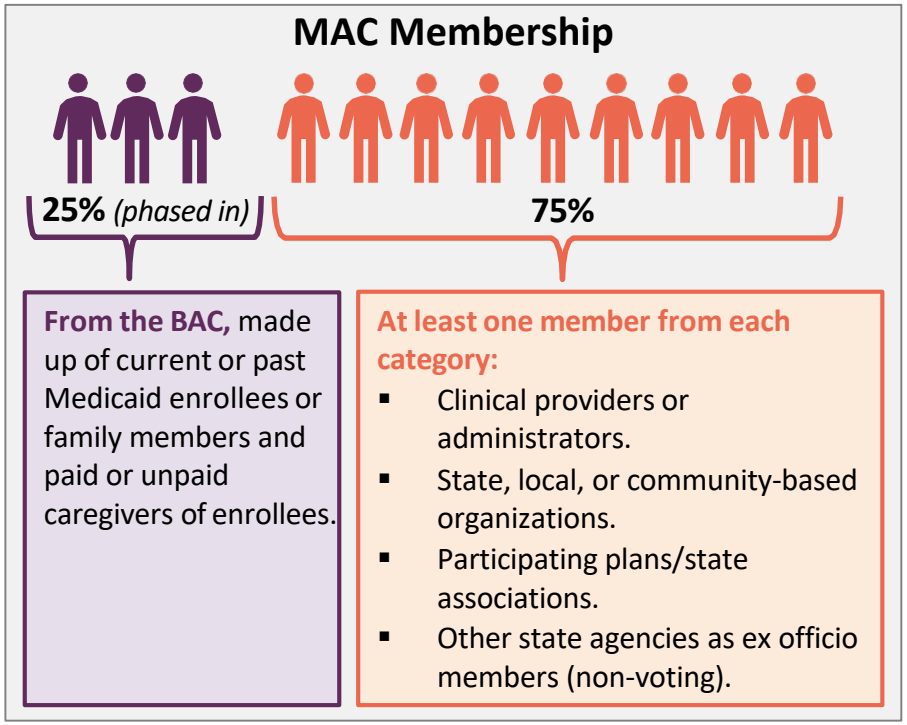
Citation: §§ 438.10(c), 438.602(g), 457.1207, 457.1285.

Enrollee Engagement (Managed Care and Access Final Rules)

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

CMS finalized, with few changes, its proposal to replace the Medical Care Advisory Committee with two new groups: a MAC and a BAC.

- The MAC and BAC are required to meet at least once per quarter.
  - ✓ At least 2 MAC meetings per year must be open to the public, with dedicated time for public comment.
  - ✓ The BAC must meet separately and in advance of MAC meetings.
- States must offer a rotating variety of meeting attendance options (in-person, virtual, hybrid) and always offer a telephone dial-in option.
- States must post publicly the MAC/BAC annual report (including state responses to recommendations), along with bylaws, membership lists, meeting minutes, and the member recruitment and selection process.
- CMS requires states to provide staffing, financial, and other administrative support. States may claim FFP at the standard administrative match rate of 50%.



CMS plans to issue a toolkit with "guidance on model practices, recruitment strategies, and ways to facilitate beneficiary participation."

Citation: § 431.12.

HCBS Interested Parties' Advisory Group

States must also establish an advisory group to "advise and consult" on payment rates and access metrics for home care and—newly added in the final rule—habilitation services.*

Advisory group membership must include, at a minimum:

- Direct care workers (DCWs).
- Medicaid enrollees.
- Authorized representatives of Medicaid enrollees.
- "Other interested parties impacted by the services rates in question, as determined by the State" *(e.g., family members, HCBS provider agencies, unions, or advocacy organizations).*

States are permitted, but not required, to have the MAC perform the functions of the home care advisory group, as long as the MAC satisfies all relevant requirements.

- The advisory group must meet at least every other year to issue "recommendations to the Medicaid agency on the sufficiency of … direct care worker payment rates" under all applicable HCBS authorities.
- The state must provide the advisory group with relevant data on home care and habilitation payment rates and Medicaid enrollees' access to care.
- Although the state is not required to adopt the advisory group's recommendations, the state must publish these recommendations along with a biennial report on FFS home care rate transparency (discussed in the next section of this deck).

** "Home care services" refers to personal care, home health aide, and homemaker services. Habilitation services include residential, day, and home-based habilitation services.*

Citation: § 447.203(b)(6).

Enrollee Experience Surveys

CMS finalized its proposal requiring states to (1) conduct an annual Medicaid enrollee experience survey, and (2) use existing enrollee data in CHIP to evaluate network adequacy.

Medicaid Enrollee Experience Survey

- States are newly required to:
  - Conduct an annual enrollee experience survey of their choosing for each of their Medicaid managed care programs (except for those exclusively serving Medicare Advantage dual eligible special needs plan enrollees).
  - Evaluate the enrollee experience data as part of their Managed Care Program Annual Report 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

- States are also required to:
  - Use CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data (which states already collect) to evaluate network adequacy.
  - Annually post comparative summary results of CHIP CAHPS surveys by plan on their website.

Citation: §§ 438.66(b), (c), 457.1230(b), 457.1207.

Provider Payment Transparency (Managed Care and Access Final Rules)

Medicaid Managed Care	CHIP Managed Care	Medicaid FFS

Analyses of Provider Payment Rates

CMS is establishing 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 will be required to publish **all** approved Medicaid FFS fee schedule payment rates on a website, with rates listed separately to the extent that they vary based on patient population, provider type, and/or geographic location. For certain bundled payments, states will be required to disaggregate the bundle into its constituent services.* Also, for a subset of services, CMS proposes additional reporting for both FFS and managed care.*

Final Rule Requirements	Frequency of Reporting
Service Categories: Primary Care, OB/GYN, Outpatient Mental Health and SUD	
FFS Rates (§ 447.203(b)). ▪ For each evaluation/management (E/M) code that CMS defines per category, **states** must compare the ***Medicaid FFS fee schedule payment rate*** to the ***non-facility rate in the Medicare Physician Fee Schedule*** (supp. payments are excluded). ▪ Separate reporting is required if rates vary based on provider type, adult vs. pediatric patient, or geographical location. ▪ **States** must publish the analysis on a publicly accessible website.	States must publish a new analysis every other year.
Managed Care Payments (§§ 438.207(b), 457.1230(b)). ▪ For each E/M code that CMS defines per category, **plans** must calculate the ***total amount paid under Medicaid and CHIP for each service category in the aggregate*** and compare that amount against ***the total amount Medicare FFS would have reimbursed for those same services*** (reported as a percentage). ○ The aggregate analysis must account for rate variation based on provider type, geographical location, or site of service. ○ With respect to patient age (adult vs. pediatric), separate percentages must be reported if the percentages vary. ▪ **States** 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.	Reports are required for new managed care contracts (as part of readiness review), and thereafter, annually or whenever there has been a "significant change."

*CMS initially proposed to require states to "break down" all Medicaid bundled payment rates. However, in the final rule, CMS narrowed this requirement to apply only to bundled payments that are based on fee schedule payment rates for each constituent service.

HCBS Payment Rate Disclosure

The final rule requires a separate standardized rate disclosure and analysis for certain home care and habilitation services.

Provision Requirement	Frequency of Reporting
Service Categories: Personal Care, Home Health Aide, and Homemaker Services, and–newly added in the final rule—Habilitation Services (including residential, day, and home-based habilitation services)	
FFS Rate Analysis (§ 447.203(b)). ▪ States must publish their payment rates for these HCBS in the form of ***an hourly payment rate*** (regardless of whether the state pays for such services on an hourly, daily, or other basis). ▪ Within each service category, ***separate reporting*** is required if rates vary based on: ○ Whether the payment is made to an agency vs. directly to an individual provider. ○ Provider type, adult vs. pediatric patient, or geographical location. ○ Whether the payment rate includes facility-related costs (re: habilitation services). ▪ **States** must publish the analysis on their website.	States must publish a new analysis every other year, along with the recommendations from the HCBS Interested Parties' Advisory Group.

In addition, states must disclose, for each service, the number of Medicaid-paid claims and the number of enrollees who receive one such service within a calendar year. Within each service, this information must be reported separately for agency providers vs. individual providers.

Note: This rate disclosure requirement applies only to HCBS authorized under 1915 or 1115 authorities, not to 1905(a) state plan services.

HCBS Payment Adequacy

For home care services authorized under 1915 or 1115, states must ensure that 80% of Medicaid payments go to "compensation" for DCWs, at both the state and provider level. Related reporting requirements apply to both home care and habilitation services* (new in final rule).

Calculating the Compensation %

- **Eligible DCWs** include licensed and unlicensed workers performing eligible services, including nursing staff who provide nursing services to HCBS recipients or (new in final rule) clinical supervision for workers.
- **Eligible "compensation"** includes salary/wages, benefits, and the employer share of payroll taxes.

Automatic Exclusions from the 80% Requirement (new in final rule)

- **Excluded costs.** Before calculating the DCW compensation percentage, **exclude costs** for: (1) required trainings, (2) worker travel, and (3) personal protective equipment.
- **Excluded providers** not subject to the 80% standard: (1) workers under a self-directed model with enrollee-determined rates ("budget authority"); and (2) Indian Health Service and Tribal health programs.

Optional State-Defined Exemptions (new in final rule)

- For **small providers,** the state may establish a compensation threshold below 80%.
- States may temporarily exempt providers that face **"extraordinary circumstances"** from the 80% standard.

***Note:** Additional reporting requirements apply if more than 10% of providers receive an exemption.*

Reporting Requirements. States must report annually on the DCW compensation % for home care and habilitation services (although habilitation is not subject to the 80% standard). Separate reporting is required for each type of service, and within each, for services that are (1) self-directed, and (2) delivered at a provider site with facility costs built into the payment rate.

Citation: §§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi). *Note: "Home care services" refers to personal care, home health aide, and homemaker services. Habilitation services include residential, day, and home-based habilitation services.

State Analysis for Rate Reduction/Restructuring

The final rule establishes 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
- ✓ Number of participating providers.
- ✓ Number of Medicaid enrollees receiving FFS services.
- ✓ Number of services furnished through FFS delivery system.

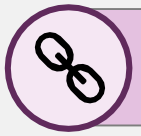
State Mitigation Plan
Responses to access to care concerns.

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

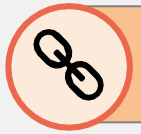
Citation: § 447.203(c). **Although this approach is not entirely clear from the regulatory text, CMS' preamble confirms its intent that states examine the average Medicaid-to-Medicare percentage across the entire benefit affected by the rate reduction or restructuring.*

Discussion

The slides and a recording of the webinar are available at www.shvs.org.



The Managed Care Final Rule is available here.



The Access Final Rule is available here.

Looking Ahead

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Thank You

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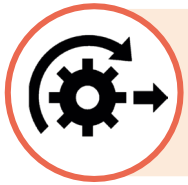
Appendix

Themes Across the Rules

The final rules reflect CMS' overarching priorities regarding:

Increased Transparency. These rules will significantly increase transparency for Medicaid and CHIP program data related to provider payments and access to care, including public disclosure of standardized quantitative data.

Commitment to Health Equity. These rules show CMS' continued emphasis on promoting health equity by identifying and addressing health disparities (e.g., by stratifying enrollee data based on race and ethnicity).



Program Alignment. CMS seeks to align standards and approaches across federally regulated healthcare programs, including using Medicare rates as a benchmark for payment adequacy, as well as aligning managed care standards with Medicare Advantage and the Marketplace.

Rollout of Requirements. Implementing these new rules—and the new E&E rules—may require substantial investments for many states and managed care plans. In addition to pledging additional guidance and technical assistance, CMS attempts to mitigate these burdens by phasing in requirements over time and focusing certain analyses on a subset of key services.

Citation: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).