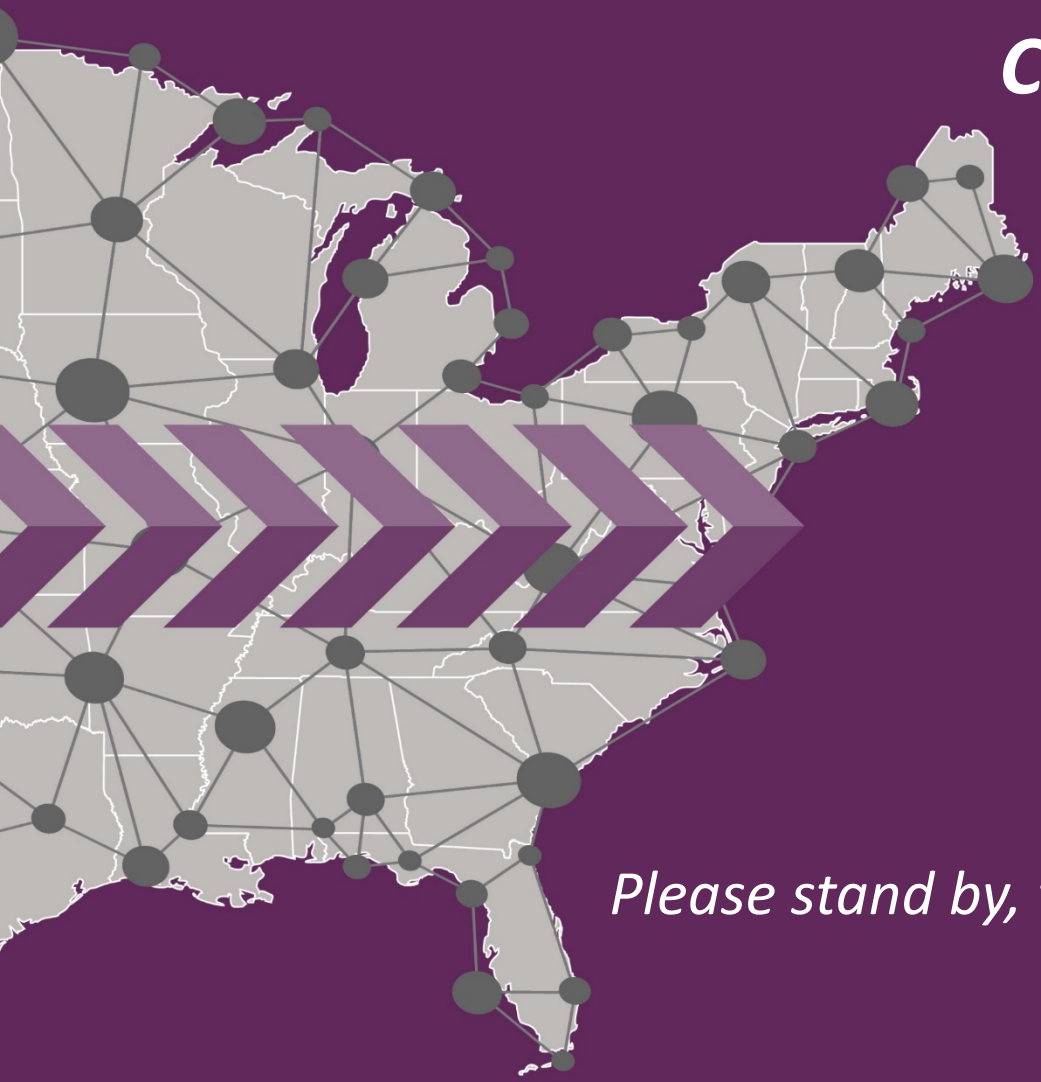

CMS Final Rules Part 2: Managed Care Payments, Quality, and Oversight

May 20, 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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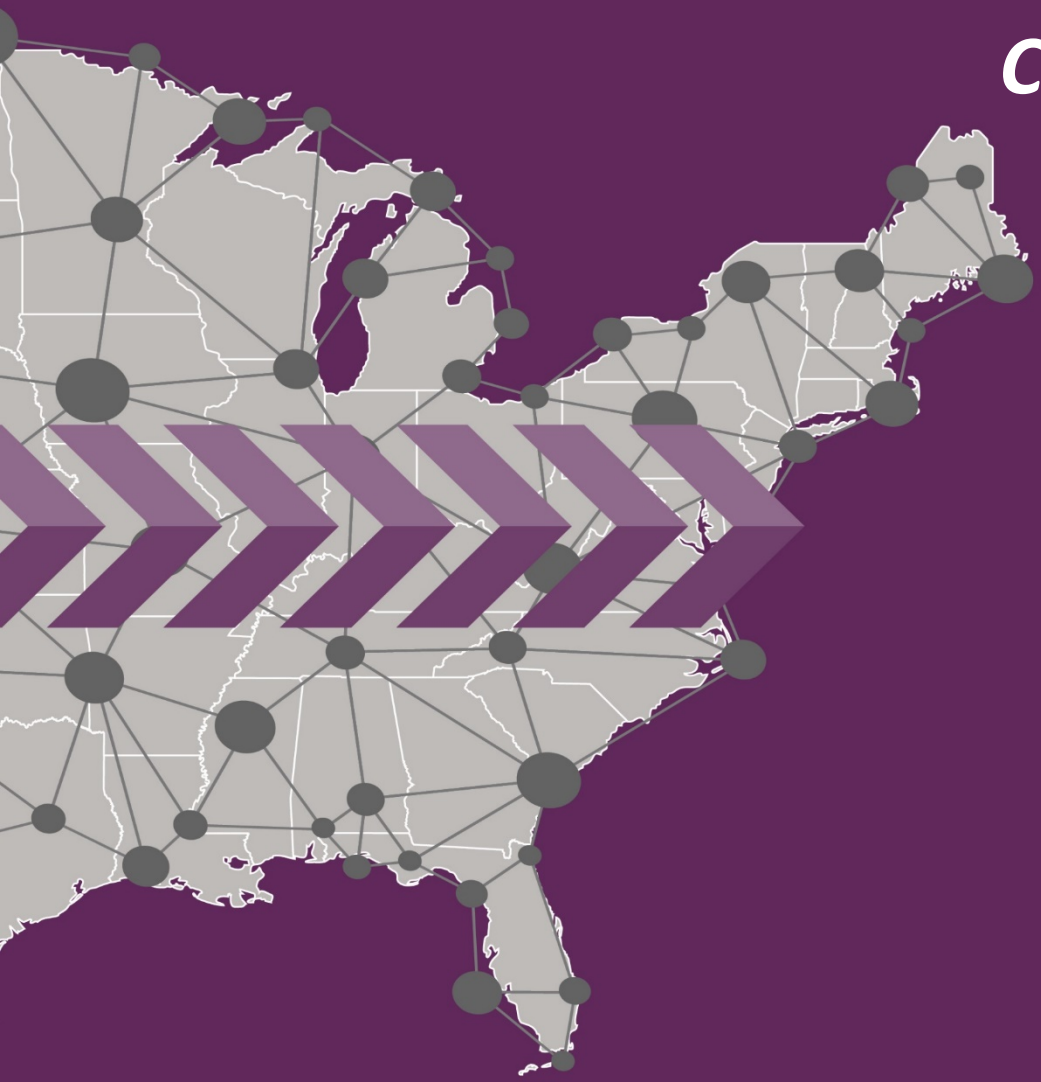

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About State Health and Value Strategies

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.
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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.**
- 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 final webinar 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

See this link

CMS Final Rules Part 2:

Managed Care Payments, Quality, and Oversight

Monday, May 20, 2024, 3:00 to 4:00 p.m. ET ***(Today)***

CMS Final Rules Part 3:

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**
- **Coverage, Financing, and Payment Provisions in the Managed Care Rule**
  - State Directed Payments (SDPs)
  - In Lieu of Services and Settings (ILOS)
  - Medical Loss Ratio (MLR) Standards
- **Quality Provisions in the Managed Care Rule**
  - Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Rating System (QRS)
  - State Quality Strategies and Quality Assessment and Performance Improvement (QAPI)
- **Discussion**
- **Looking Ahead**

Level-Setting: CMS Managed Care and Access Final Rules

= 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 fee-for-service (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 SDPs, including by prohibiting the use of separate payment terms.
- Codifies and builds on recent CMS policy changes related to ILOS.
- Modifies MLR methodologies and processes.
- Establishes new quality requirements, including a framework and enhanced requirements for managed care 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 home and community-based services (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.

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

Implementation Timeline

Regulatory Proposal		Effective Date*
Coverage, Financing, Payment 	**SDPs**	See below
	Payment Methodologies: 1) Non-network providers 2) Preprint submission requirements 3) Value-based payment (VBP) directed payments 4) Interim payments with reconciliation 5) Prohibition on separate payment terms	1) **July 9, 2024** 2) **July 9, 2024** 3) **Varies by provision** (between July 9, 2024 and July 9, 2026) 4) **July 9, 2027** (first rating period beginning on/after) 5) **July 9, 2027** (first rating period beginning on/after)
	Payment Levels: Codifying the Average Commercial Rate (ACR) as the maximum expenditure limit and ACR demonstration requirements	**July 9, 2024** (first rating period beginning on/after)
	Reporting Requirements: 1) Near-term reporting of actual aggregate directed payments 2) Longer- term provider-level reporting	1) **September 9, 2024**; thereafter, SDP data must be included in states' annual MLR reports 2) First rating period after CMS releases reporting instructions
	Non-Federal Share Financing: Provider attestation requirements	**January 1, 2028** (first rating period beginning on/after)
	Submission, Timelines and Appeals: 1) Appeals process 2) Preprint submission and contract requirements 3) Deadline to send contract amendments	1) **July 9, 2024** 2) **July 9, 2026** (first rating period beginning on/after) 3) **July 10, 2028** (first rating period beginning on/after)
	Evaluation Plan Standards and Report Requirement	**July 9, 2027** (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.

Implementation Timeline (Cont'd)

Regulatory Proposal		Effective Date*
Coverage, Financing, Payment 	**ILOS Requirements**	**September 9, 2024** (first rating period beginning on/after) (Although newly codified in regulations, many of these ILOS requirements have been in effect since January 2024 pursuant to 2023 CMS guidance.)
	MLR Standards	**September 9, 2024** (first rating period beginning on/after) for most policies
		July 9, 2025 (first rating period beginning on/after) for contract requirements for overpayments and standards for provider incentives
Quality 	**QRS That Meets National Standards** Note: States may request a one-year extension with respect to the phase 1 and/or phase 2 deadlines	**December 31, 2028** (phase 1 implementation deadline – all but certain requirements related to website display) **[TBD] No earlier than December 31, 2030** (phase 2 implementation deadline, to be announced by CMS)
	External Quality Review (EQR): 1) Exempting PCCMs from EQR 2) New optional EQR activities; 3) EQR results: reporting and publishing additional data	1) **July 9, 2024** 2) **July 9, 2024** 3) **Varies by provision** [from July 9, 2024 to December 31, 2025 (or later, depending on when CMS publishes an updated EQR protocol)]
	Managed Care State Quality Strategies	**July 9, 2025**
	QAPI Technical Changes	**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.

Coverage, Financing, and Payment Provisions: State Directed Payments (SDPs)

Overview of New Requirements for SDPs

In the final rule, CMS recognizes the important role of SDPs in promoting 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.

Key policies finalized as proposed (with relatively minor changes and/or effective date delays):

- **Codify the 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 formal pre-approval.
- Mandate that states collect attestations from providers receiving SDPs that they do not participate in **"hold harmless" arrangements** associated with provider taxes.
- Require **provider-level reporting** on SDPs, limit formal evaluation reports to large SDPs, and heighten SDP evaluation requirements to improve links to quality.

Policies that represent a departure from original proposals:

- **Prohibit the use of separate payment terms**, a mechanism by which states reimburse plans for SDPs separate from the capitation rates.
- Require states to **submit SDP preprints** to CMS before the SDP effective date.

Citation: §§ 438.6, 438.7, 430.3.

Payment Levels

In the final rule, CMS codifies the ACR as the upper limit of most SDPs.

Upper Limit on SDPs

Current Practice	Final Rule
▪ 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.	▪ **Codifies the "reasonable, appropriate, and attainable" standard.** ▪ **Establishes 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 has **not** set a formal SDP upper limit for other services, but notes that in practice it will use the ACR for assessing the "reasonable, appropriate, and attainable" standard for other services.

ACR Calculation

Current Practice	Final Rule
▪ 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.	▪ **Codifies the ACR Demonstration requirement**, with some significant departures from current practice, such as **not restricting the demonstration to the provider class**. Change benefits providers with a relatively high Medicaid payor mix that often receive lower commercial rates compared to providers with a larger share of commercial patients. ▪ States will need to **demonstrate the ACR** during the first year of the SDP, and then every 3 years thereafter while the arrangement remains in place. (Though increasing ACR for trend will require a new demonstration.)

Citation: § 438.6(c)(2)(iii).

Non-Federal Share Financing

The final rule reinforces CMS' hold harmless policy but delays the effective date of a key provision until 2028.

Hold Harmless Requirements

- CMS reinforces (as in other guidance) 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 direct state involvement.**
- CMS notes that because hold harmless arrangements affect the validity of the tax and payments, **CMS will disapprove any SDPs where it identifies hold harmless arrangements are in place**.

Provider Attestations

- To promote compliance, the final rule **requires 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 applies to all SDPs, including those that do not require CMS prior approval.
- CMS will **allow states to provide an explanation as to why specific providers are unable or unwilling to make attestations** in response to concerns that individual providers could prevent states from implementing SDPs by not complying with attestation requirements.

New compared to CMS' original proposal

- **Provider attestation requirements are effective January 1, 2028** (a two-year delay compared to CMS' original proposal to allow states to establish attestation collection processes and restructure any noncompliant SDPs).
- **CMS indicated it will not enforce the prohibition on hold harmless arrangements related to redistribution of provider payments until January 1, 2028,** in an Informational Bulletin. However, CMS noted that new healthcare-related taxes that involve the redistribution of provider payments may result in CMS disapproval.

Citation: § 438.6(c)(2)(ii)(H)).

Payment Methodologies

The final rule provides new flexibilities related to SDPs, but also places new restrictions on the use of common payment arrangements and methodologies.

New Flexibilities

Non-Network Providers

Permits 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.

Effective July 9, 2024

Preprints: Medicare Rates

Exempts SDPs at Medicare rates from the preprint process.

Effective July 9, 2024

VBP Directed Payments

Permits states to direct timing and amount of expenditures related to VBP directed payments, among other changes.

Effective dates vary

New Limitations

Interim Payments with Reconciliation

Prohibits 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.

Effective July 9, 2027

Separate Payment Terms

Prohibits the use of separate payment terms (a departure from CMS' original proposal). *(See next slide.)*

Effective July 9, 2027

Citation: §§ 438.6(c)(1)(iii), 438.6(c)(2)(vi), 438.6(c)(2)(vii), 438.6(c)(5), 438.6(c)(6), 438.7(c).

Separate Payment Terms

In a departure from the proposed rule, the final rule prohibits the use of separate payment terms—a mechanism by which states reimburse plans for SDPs separate from capitation rates.

Current State

States currently have two options to account for SDPs in the managed care rate certification:

Option 1: Adjustments to the **base capitation rate**, incorporating the SDP. Under this option, plans are at financial risk for SDPs.

Option 2: A **separate payment term**, where an aggregate pool of funding is reserved for the SDP, separate from the base capitation rate. Under this option, plans are *not* at financial risk for SDPs.

Final Rule
(Effective July 9 , 2027)

✓ → States must incorporate SDPs into capitation

X → Separate payment terms are prohibited

Over half of SDPs (55% in 2021) are structured as separate payment terms. States and providers often prefer this approach because it:

- Removes the incentive for plans to steer utilization to providers not eligible for the SDP.
- Simplifies nonfederal share financing calculations.

The phaseout of separate payment terms will have **significant implications** for states and providers.

Provider taxes and **intergovernmental transfers** used to finance the non-federal share of separate payment term SDPs will likely need to be restructured.

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

Submission Requirements, Timelines, and Appeals

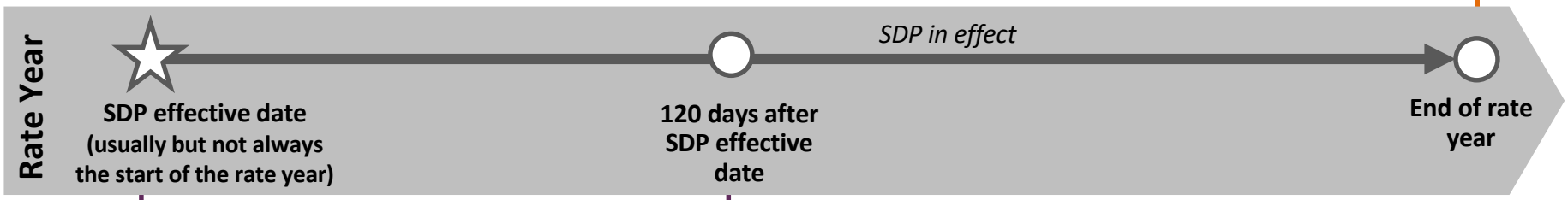
CMS has established new requirements for submission timelines related to SDPs and a new appeals process.

Current State

Preprint Submission Deadline
CMS has encouraged states to submit their preprints 90 days in advance of the start of the applicable rating period; in practice, CMS has considered preprints submitted before the end of the rate year, retroactive to the start of the year.

Managed Care Contracts + Rate Certification
CMS has allowed states to submit managed care contract amendments and rate certification documentation after preprint approval (which can occur after the applicable rate year ends).

Rate Year



Final Rule

Preprint Submission Deadline
States must submit SDP preprints **before the start date of the payment arrangement.** (Amendments must also be submitted before the amendment start date.)

Effective July 9, 2026

Managed Care Contracts + Rate Certification
States have until 120 days from the start date of the SDP to submit **contract amendments, rate certification documentation,** and any **retroactive rate adjustments**.

Effective July 10, 2028

Appeals: The final rule **establishes a formal appeals process** in instances where CMS denies state preprint requests. States may appeal to the U.S. Health and Human Services Department Appeals Board.

Citation: §§ 438.6(c)(2)(viii), 438.6(c)(5), 438.7(c)(6), 430.3(e).

Evaluation and Reporting Requirements

The final 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, the other can measure access.
  - ✓ Include baseline measures and performance targets.
  - ✓ Achieve stated goals and objectives in alignment with the state's evaluation plan.
- States are required to submit an **evaluation report** to CMS if the size of the SDP exceeds 1.5% of the managed care program. **CMS will not approve the renewal of any SDP requiring pre-approval for which performance targets are not met for two successive evaluation reports.**

Evaluation reports are required **every 3 years (rather than annually)** and must include 3 years of performance data. States 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.
- Because CMS did not include 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, **CMS will not have one location where all supplemental and directed payments are stored.**

Citation: §§ 438.6(c)(2)(iv), 438.6(c)(2)(v), 438.6(c)(7), § 438.6(c)(4). *T-MSIS = Transformed Medicaid Statistical Information System.

Coverage, Financing, and Payment Provisions: In Lieu of Services and Settings (ILOS)

Overview of Requirements and Parameters

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

The final rule :

- **Clarifies 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.
- **Includes new approval standards, financial, and reporting and evaluation requirements for ILOS guardrails.**
- **Generally does not apply to the coverage of short-term stays in institutions for mental disease**.
- **Outlines parameters for ILOS in managed care contracts**:

✓ Must be a service or setting that would be approvable via a state plan amendment or 1915(c) HCBS waiver.

✓ Limits the 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%.

✓ Requires 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.*

For additional information on the final rule's requirements related to ILOS, see slides in the appendix.

Citation: §§ 438.2, 438.3(e), 438.16, 457.10, 457.1201(c), 457.1201(e); and CMS, SMD #: 23-001. *The ILOS cost report requirements would not apply to separate CHIP.

Coverage, Financing, and Payment Provisions: Medical Loss Ratio (MLR) Standards

MLR Methodology

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

CMS finalized its proposals to tighten what can be counted in the Medicaid and CHIP MLR numerator due to concerns that, under existing policy, plans can inflate MLRs without advancing quality.

- **Prohibited Costs in Quality Improvement Activities (QIA).** CMS will more closely align Medicaid and Marketplace rules relating to QIA, so that certain administrative costs—such as indirect or overhead costs that do not *directly* improve quality—will be prohibited in calculations of the numerator.

- **Standards for Provider Incentives.**
  - CMS will require incentive payment arrangements between plans and providers (which are counted as incurred claims in the numerator) to:

☑ **Establish a defined performance period** that can be tied to the applicable MLR reporting period(s); agreements must be signed by both parties *before* this period.

☑ **Establish clearly-defined, objectively measured, and well-documented clinical or quality improvement standards** that the provider must meet to receive payment.

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

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

Citation: §§ 438.3(i), 438.8(e)(2), (3), 457.1201, 457.1203.

MLR Reporting

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

Additional Requirements for Expense Allocation Methodology Reporting

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

Level of MLR Data Analysis and Aggregation

States must provide MLR information *for each plan* in their annual summary reports to CMS, as CMS intended in the 2016 managed care rule but not all states did.

Contract Requirements for Overpayments

State contracts with plans must require *prompt* reporting to the state of *any* overpayment, whether identified or recovered (i.e., within no more than 30 calendar days).

Reporting of State Directed Payments (SDPs) in the MLR

In annual MLR reports to states, plans must include all SDP payments made to providers in the numerator and associated revenue in the denominator.

Citation: §§ 438.8(e)(2)(iii), (f)(2), (k)(1)(vii), (m), 438.74, 438.608(a)(2), (d)(3), 457.1203(e), (f), 457.1285.*Reporting of SDPs in the MLR do not apply to CHIP.

Quality Provisions

QRS: Methodology

CMS finalized, with minimal changes, a new regulatory framework for a Medicaid and CHIP Managed Care Quality Rating System (MAC QRS).

Each state's QRS must assess plan performance against, at minimum, the performance measures included in CMS' mandatory measure set. 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/ Medicare Advantage (MA) plans (to the extent feasible without undue burden).

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 and Issue Performance Rates: states must calculate quality ratings for each measure, for each plan, for each program.

States may delegate each of these functions to their managed care plans or their external quality review organization (EQRO) with the following exceptions: (1) data validation may not be delegated to an entity with a conflict of interest; and (2) states may not delegate calculation of quality ratings.

With CMS permission, states may implement an alternative QRS methodology that is "substantially comparable"—but the final rule clarifies that this flexibility pertains to the methodology only and does not allow states to modify the list of mandatory measures or baseline requirements for the QRS website.

Citation: §§ 438.515, 457.1240(d).

QRS: Measure Set and Technical Resource Manual

A state's QRS must include a mandatory minimum measure set of 16 measures (down from 18 in the proposed rule), upon which states can expand without CMS' permission.

CMS finalized, largely as proposed:

- **The standards by which it will select measures** for inclusion in the mandatory measure set.
- **The list of specific measures in the initial mandatory set.** *(CMS did not finalize two Medicaid long-term services and supports measures that were listed in the proposed rule, citing commenters' concern regarding administrative burden.)*
- **The sub-regulatory process for updating the measure set over time**, including requirements for public notice and comment. Updates will be communicated through an annual technical resource manual for states.

CMIT#	Measure Steward	Measure Name	Data Collection Method
743	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Administrative
394	NCQA	Initiation and Engagement of SUD Treatment (IET)	Administrative or electronic health record (EHR)
672	CMS	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF)	Administrative or EHR
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)	Administrative
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30)	Administrative
123	NCQA	Child and Adolescent Well-Care Visits (WCV)	Administrative
93	NCQA	Breast Cancer Screening (BCS-E)	Electronic Clinical Data System (ECDS)
118	NCQA	Cervical Cancer Screening (CCS, CCS-E)	Administrative, hybrid, EHR, or ECDS
139	NCQA	Colorectal Cancer Screening (COL-E)	ECDS
897	Dental Quality Alliance	Oral Evaluation, Dental Services (OEV)	Administrative
166	Office of Population Affairs	Contraceptive Care - Postpartum Women (CCP)	Administrative
581	NCQA	Prenatal and Postpartum Care (PPC)	Administrative or hybrid
148	NCQA	Glycemic Status Assessment for Patients with Diabetes (GSD)	Administrative or hybrid
80	NCQA	Asthma Medication Ratio (AMR)	Administrative
167	NCQA	Controlling High Blood Pressure (CBP)	Administrative, Hybrid, or EHR
151/152	AHRQ	CAHPS – How people rated their health plan	Consumer survey
151/152	AHRQ	CAHPS – Getting care quickly	Consumer survey
151/152	AHRQ	CAHPS – Getting needed care	Consumer survey
151/152	AHRQ	CAHPS – How well doctors communicate	Consumer survey
151/152	AHRQ	CAHPS – Health plan customer service	Consumer survey

Citation: §§ 438.510, 438.530, 457.1240(d).

QRS: Website Display and Reporting

CMS finalized with minimal modifications the proposed requirement for states to publicly 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:

- **An overview of the MAC QRS**, including instructions for using the website and information on how to contact the managed care enrollee support system with questions about the QRS.
- **Standardized information that facilitates user comparisons of managed care programs and plans**, including information on Medicare as relevant for dual-eligibles (requirements to be phased-in). This includes each plan's quality ratings, as well as information on member eligibility and enrollment, provider networks, prior authorization requirements, and drug formularies.
- **Interactive features** that allow users to tailor information (requirements to be phased-in).

Note: States may provide additional data or features to their QRS website beyond this federal baseline and do not need to seek CMS permission before doing so.

CMS finalized as proposed the requirement that states submit, upon request, information on their MAC QRS. CMS will request QRS reports no more than once a year and will provide at least 90 days' advance notice.

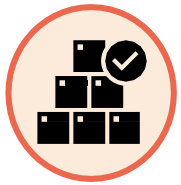
Citation: §§ 438.515, 438.535, 457.1240(d).

External Quality Review

CMS finalized several updates to EQR regulations, including adding an optional activity and changing the content/timing of the EQR technical report.

EQR Activities. Federal regulations currently define a minimum set of mandatory EQR 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.

- ***New Optional Activity:*** CMS finalized that EQROs can assist in the new evaluation requirements under the final rule, including related to SDPs and ILOS.
- ***New Exemption:*** CMS will now exempt primary care case management (PCCM) entities from mandatory EQRO review.



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 finalized technical changes with the aim of emphasizing outcomes and promoting equity, by expanding the data included in the EQR 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.

Citation: §§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250.

State Quality Strategies and QAPI

CMS finalized technical changes to existing regulations to increase transparency of the state managed care quality strategy and reduce quality program duplication for plans serving dually eligible individuals.

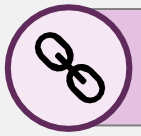
	Current Regulations Require …	The Final Rule…
Quality Strategies	❑ States to draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by plans; and **evaluate and update their quality strategy at least every 3 years** or when there are significant changes to the strategy or the Medicaid program.	❑ Will require states to **allow public comment and submit the quality strategy to CMS every 3 years, regardless of whether any changes are made**; and require states to post the results of the 3-year evaluation on the state's website.
QAPI	❑ States to require plans to **establish a QAPI program**, including conducting performance improvement projects.	❑ Makes technical changes to the QAPI program to **streamline requirements and increase consistency with MA programs** that also serve dually eligible individuals (e.g., states can allow a plan that exclusively serves duals to use a Chronic Care improvement Program as their quality improvement project).

CMS finalized updates to EQR regulations, including adding an option to assist in new evaluation requirements and changing the content/timing of the EQR technical report.

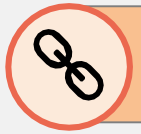
Citation: §§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250.

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

Remember to register for the final webinar 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

See this link

CMS Final Rules Part 2:

Managed Care Payments, Quality, and Oversight

Monday, May 20, 2024, 3:00 to 4:00 p.m. ET

CMS Final Rules Part 3:

Home and Community-Based Services

Register here

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

Thank You

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Appendix

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 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.

Source: 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

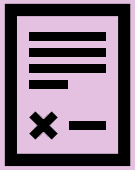
Program Accountability

**Most of the Managed Care Rule's requirements apply across Medicaid and CHIP managed care, and apply equally across managed care organizations, prepaid inpatient health plans, 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.*

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

Enrollee Rights and Protections

CMS further clarifies 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.

Citation: §§ 438.3(e), 438.10(g), 457.1201(e), 457.1207.

Medically Appropriateness / Cost Effectiveness

To support medical appropriateness and cost-effectiveness determinations, the final rule requires 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. The preamble of the final rule indicates that it is not sufficient to define the target population as any individual "at risk for any chronic condition"; rather the contract must identify a specific, documented clinical condition that would be improved by the ILOS.
- ✓ A process by which a licensed network or managed care plan staff provider determines 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 must 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 are required to submit additional documentation on the process used to determine that each ILOS is medically appropriate and cost-effective.

Citation: §§ 438.16(d), 457.1201(e).

Monitoring, Evaluation, and Oversight

The final rule adds 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 are 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 is required to:** ▪ Notify CMS within 30 calendar days. ▪ Submit an ILOS transition plan to CMS within 30 days after the decision to terminate an ILOS. ▪ Notify enrollees of any changes to ILOS offerings (updated from 15 days in the proposed rule). ▪ 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.

Citation: §§ 438.16(d), (e), 438.66(e), 457.1201(c), (e).