Policy Update

CMS Releases Proposed Rule: Medicaid and CHIP Managed Care Access, Finance, and Quality

Summary

On May 3, 2023, the Centers for Medicare & Medicaid Services (CMS) published the proposed rule, Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality.

The proposed rule would make transparency-related updates to state directed payments (SDPs). It would also require states to submit an annual payment analysis that compares managed care plans' payment rates for routine primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services as a proportion of Medicare's payment rates. The proposal would establish a framework for states to implement a Medicaid or Children's Health Insurance Program (CHIP) quality rating system to create a "one-stop-shop" for enrollees to compare Medicaid or CHIP managed care plans based on quality of care, access to providers, covered benefits and drugs, cost and other plan performance indicators. The rule would also require states to submit an annual payment analysis that compares managed care plans' payment rates for homemaker services, home health aide services and personal care services as a proportion of the state's Medicaid state plan payment rate.

The proposed rule is followed by a 60-day comment period. Comments must be submitted to the *Federal Register* no later than July 3, 2023.

This rule was released in coordination with the proposed rule Medicaid Program: Ensuring Access to Medicaid Services, which also has a 60-day comment period and requirements relating to Medicaid payment rate disclosures. Click here to read our analysis of that proposed rule.

Key Takeaways

CMS proposes several substantial updates to the Managed Care Rule, including the following:

- Making several process and transparency-related updates to SDPs to ensure integrity of payments and that SDPs meet the goals of the Medicaid program
- Creating new payment transparency for states by conducting a managed care provider payment rate analysis for certain services
- Establishing national maximum standards for certain appointment wait times for Medicaid or CHIP managed care enrollees for four specified service areas
- Requiring states to conduct independent secret shopper surveys of managed care plans to verify compliance with appointment wait time standards and to identify provider directory inaccuracies
- Requiring states to conduct annual enrollee experience surveys for each managed care program
- Requiring states to develop a remedy plan to address identified access issues with specific steps and timelines for implementation and completion, and responsible parties
- Creating new reporting and standard requirements for "in lieu of services"
- Increasing transparency and opportunity for meaningful ongoing public engagement around states' managed care quality strategies
- Establishing requirements for clinical or quality improvement standards for provider incentive arrangements and for expense allocation reporting, and prohibiting the inclusion of administrative costs in reporting quality improvement activities.

Medicaid State Directed Payments

Key Takeaway: The proposed rule includes several process and transparency-related changes to SDPs.

In 2016, CMS updated the regulations for Medicaid managed care and created a new option for states, allowing them to direct managed care organizations to pay providers according to specific rates or methods. Such payments are often referred to as SDPs. SDPs are commonly used "to establish minimum payment rates for certain types of providers or to require participation in value-based payment (VBP) arrangements." CMS notes that "as of December 2022, CMS has reviewed more than 1,100 SDP proposals and approved 993 proposals since the 2016 final rule was issued." Total federal and state spending for each SDP is almost $48 billion annually. This proposed rule would make several process and transparency-related updates to SDPs to ensure integrity of payments and that SDPs meet the goals of the Medicaid program.

SDP Process Proposals

The proposed rule would exempt certain SDPs from written prior approval by CMS if the SDP required the Medicaid managed care plan to use a minimum fee schedule that was equal to 100% of the total published Medicare payment rate. This exemption would be effective upon finalization of the rule. SDPs that propose provider payment rates that are either incomplete or above or below 100% of total published Medicare payment rates would remain subject to written prior approval by CMS.

The proposed rule would also require the managed care plan contract to include certain information about the Medicare fee schedule used in the SDP. The proposed rule would require a managed care contract to specify which Medicare fee schedule(s) the state directs the managed care plan to use, and any relevant and material adjustments due to geography (such as rural designations) or provider type (such as critical access hospital or sole community hospital designations). The managed care contract would also need to identify the time period for which the Medicare fee schedule was in effect.

The proposed rule would require SDPs that need written prior approval from CMS to be submitted no later than 90 days in advance of the end of the rating period to which the SDP applies. CMS currently encourages a 90-day threshold but does not require it. If the state failed to meet this deadline, the SDP would not be included in the Medicaid managed care contracts and rate certifications for that rating period (with exceptions for public health emergencies and natural disasters). States would be required to comply with these new submission timeframes beginning with the first rating period that starts two years after the effective date of the final rule. In the interim, CMS plans to continue its current policy of not accepting submissions for SDPs after the rating period has ended.

SDP Transparency and Payments Proposals

The proposed rule also includes updates to the transparency of funding in SDPs, and would create limitations on funding through SDPs. For example, the proposed rule would require that upon request from CMS, the state must provide documentation demonstrating the total payment rate for each service and provider class.

Under the proposed rule, the total SDP amount for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center could not exceed the average commercial rate (ACR). This payment ceiling would not apply to any other services. Any SDP that directed plan funding such that the total payment rate was above the ACR for any of these four types of services would not be approved. These changes would be effective beginning the first rating period after the rule's effective date. CMS is considering establishing the total payment rate limit at the Medicare rate and accordingly seeks comments on the limits to the total payment rate.

CMS is also examining the state share financing of SDP. State share of Medicaid financing is typically derived from state general funds, revenue from healthcare-related taxes, provider-related donations and

intergovernmental transfers. CMS has expressed concerns that state share financing may not comply with federal law, in particular as it relates to hold harmless agreements. In a hold harmless agreement, for example, providers could agree to make a donation to the state. In return the provider would support (or not oppose) a tax on its activities or revenues. Ultimately, these donations or taxes could generate funds that could then be used to raise Medicaid payment rates to the providers. Federal rules govern the limitations of provider donations and healthcare taxes, and disallowances on hold harmless agreements. CMS has concerns that state share financing in SDPs is not complying with the federal requirements, and that SDP funding is being directed to providers serving a low number of Medicaid beneficiaries. Under the proposed rule, states would be required to ensure that each participating provider in an SDP arrangement attests that it does not participate in any hold harmless arrangement. States would also be required to obtain attestations from the providers. Under the proposed rule, CMS may deny written prior approval of an SDP if it does not comply with any of the federal rules regarding state share of Medicaid financing.

Under current regulations, states are required to demonstrate that SDPs are based on the utilization and delivery of services to Medicaid enrollees covered under the managed care plan contract. The proposed rule would codify guidance from a State Medicaid Director Letter that outlines that SDPs are conditioned on the utilization and delivery of services under the managed care plan contract for the applicable rating period only. This would preclude states from making any SDP on a historical basis or any other basis that was not tied to the delivery of services in the current rating period. Reconciling payment during previous rating periods would be prohibited. This proposal would be effective by the first rating period beginning two years after the effective date of the final rule.

CMS also proposes to enhance reporting on SDPs. For SDPs that require prior approval, states would be required to submit an evaluation plan. The evaluation plan must identify at least two metrics that would be used to measure the effectiveness of the payment arrangement in advancing the identified goals and objectives of the state's managed care quality strategy on an annual basis. States would also be required to submit SDP evaluations every three years if SDP costs (as a percentage of total capitation payments) exceeded 1.5%. States would not be required to submit evaluation results for SDP arrangements that did not exceed the threshold.

The proposed rule would also require managed care plans to include SDPs and associated revenue as separate lines in their medical loss ratio (MLR) reports to states. Plans would have to report the amount of payments to providers made under SDPs and the payments from the state to the managed care plans for expenditures related to these SDPs. States would be required to submit these data annually no later than 180 days after each rating period to Transformed Medicaid Statistical Information System (T-MSIS). Minimum data fields for this reporting include provider identifiers; enrollee identifiers; managed care plan identifiers; procedure and diagnosis codes; and allowed, billed and paid amounts.

Provider Payment Transparency

Key Takeaway: The proposed rule would create new payment transparency for states by conducting a managed care provider payment rate analysis for certain services.

The proposed rule would require plans to submit to the state a payment analysis and annual documentation that demonstrates their level of payment for certain services as compared to Medicare rates. The analysis would use paid claims data from the immediate prior rating period to determine the total amount paid for evaluation and management current procedural terminology codes for primary care, obstetrical and gynecological services, and mental health and substance use disorder services, including separate total amounts paid and separate comparison percentages to Medicare for these same services. In short, the analysis would compare Medicaid managed care payment of these services to Medicare payment for these services.

The rule would also require another payment analysis for the total amount paid for homemaker services, home health aide services and personal care services. The state would be required to compare the managed care

payment rates for these services to the Medicaid fee-for-service rates for these services. CMS seeks comments on whether in-home habilitation provided to individuals with developmental disabilities should be added to this analysis. The analysis would be performed using claims for which the plan is the primary payer by identifying paid claims in the prior rating period for each required service type, identifying the appropriate codes and aggregating the payment amounts for the required service types, and calculating the total amount that would be paid for the same codes on the claims at 100% of the appropriate published Medicare rate or Medicaid fee-for-service rate.

States would have to comply with these requirements no later than the first rating period that begins two years after the effective date of the final rule.

Access Proposals

Wait Time Standards

Key Takeaway: CMS proposes to establish national maximum standards for certain appointment wait times for Medicaid or CHIP managed care enrollees for four specified service areas.

The proposed rule would require that states develop and enforce wait time standards for routine appointments for four types of services:

- Outpatient mental health and substance use disorder (no longer than 10 business days)
- Primary care (no longer than 15 business days)
- Obstetrics and gynecology (no longer than 15 business days)
- An additional type of service to be determined by the state.

CMS proposes to require 90% compliance with the 10- and 15-business-day maximum appointment wait time standards, which would be consistent with standards set for Marketplace plans for plan year 2024. These wait time standards would only apply to routine services, not complex conditions or patient-specific protocols for urgent or emergency care. These requirements would be in effect by the first rating period beginning three years after the effective date of the final rule.

Secret Shopper Surveys

Key Takeaway: CMS would require states to conduct independent secret shopper surveys of Medicaid or CHIP managed care plans to verify compliance with appointment wait time standards and identify provider directory inaccuracies.

The proposed rule includes a requirement that states use independent entities (independent of the Medicaid or CHIP agencies) to conduct annual secret shopper surveys of managed care plan compliance with appointment wait time standards and the accuracy of certain data in all plans' electronic provider directories. The secret shopper surveys would include verification of certain providers' active network status, street address, telephone number and whether the provider is accepting new enrollees. CMS outlines a small number of standards for conducting the secret shopper survey, but offers significant flexibility to states when designing the survey. The proposal would also require surveys of electronic provider directory data for primary care providers, obstetrics and gynecology providers, and outpatient mental health and substance use disorder providers. States might have to select multiple provider types to account for all of their managed care programs. CMS highlights that additional provider types may be added to secret shopper surveys of appointment wait time standards in the final rule.

Appointments offered via telehealth would only be counted toward compliance with appointment wait time standards if the provider also offers in-person appointments. The proposed rule stipulates that telehealth visits offered during the secret shopper survey must be separately identified in the survey results.

States would be required to receive information on all provider directory data errors identified in secret shopper surveys no later than three business days from identification, and must then send that data to the

applicable managed care plan within three business days of receipt. Updating provider directory data after it was counted as an error in secret shopper survey results would not change a managed care plan's compliance rate.

The results of these surveys would be reported to CMS and posted on the state's website. States would have to comply with the requirement no later than the first rating period four years after the effective date of the final rule.

As required by the Consolidated Appropriations Act of 2023, CMS also would require that managed care plan electronic provider directories be searchable. This requirement would need to be in place by July 1, 2025.

CMS requests comments on the type of technical assistance that would be most useful for states as well as states' best practices and lessons learned from using secret shopper surveys.

Enrollee Experience Surveys

Key Takeaway: CMS would require states to conduct annual enrollee experience surveys.

The proposed rule would require states to conduct an annual enrollee experience survey for each managed care program in the state. Experience surveys may ask patients to describe whether or how often they accessed healthcare, barriers they encountered in accessing healthcare and their overall experience, including communication with their doctors, understanding their medication instructions and the coordination of their healthcare needs.

Results from enrollee experience surveys must be included in the Managed Care Program Annual Report, and states would be required to post the report on their website within 30 calendar days of submitting it to CMS. States already collect CAHPS® data for CHIP enrollees, and the proposed rule would require states to post comparative summary results of CAHPS® surveys by managed care plans on state websites. These results must be updated annually and allow for easy comparison among the managed care plans available to Medicaid and CHIP beneficiaries.

States would be required to come into compliance no later than the first managed care plan rating period that begins three years after the effective date of the final rule. CMS requests comment on the cost and feasibility of implementing enrollee experience surveys for each managed care program as well as the appropriate applicability date of the requirements and timeline for implementation.

Access Remedy Plans

Key Takeaway: The proposed rule would require states to develop a remedy plan to address identified access issues.

If CMS, the state or the managed care plan identified an area in which access to care could be improved, including the proposed appointment wait time standards, the proposed rule would require the state to submit a remedy plan to CMS no later than 90 calendar days following the date that the state became aware of a plan's potential access violation. In the remedy plan, the state would have to identify specific compliance steps, timelines for implementation and completion, and responsible parties to address the identified issue within 12 months.

State and managed care plan actions to address an access issue may include increasing payment rates to providers, improving outreach to and problem resolution with providers, reducing barriers to provider credentialing and contracting, providing for improved or expanded use of telehealth, and improving the timeliness and accuracy of processes such as claim payment and prior authorization. Remedy plans must include improvements that are measurable and sustainable, and quarterly progress updates must be submitted to CMS. If the access issue is not addressed within the initial 12 months, CMS may require the state to

continue or revise the remedy plan.

These requirements would be effective by the first rating period four years after the effective date of the final rule.

Medical Loss Ratio Standards

Key Takeaway: The proposed rule includes requirements for clinical or quality improvement standards for provider incentive arrangements and for expense allocation reporting. The rule would prohibit administrative costs from being included in reporting quality improvement activities.

Medical loss ratios (MLR) are one tool that CMS and states can use to assess whether capitation rates are appropriately set and spent on claims and quality improvement activities as compared to administrative expenses. CMS and states can also use MLR to demonstrate that adequate amounts of capitation payments are spent on services for enrollees.

Under current rules, Medicaid and CHIP managed care plans can implement provider incentive arrangements that are not based on quality improvement standards or metrics. The payments must be included as incurred claims when managed care plans calculate their MLR, however. Provider incentive payments may influence the development of future capitation rates, and Medicaid managed care plans may have a financial incentive to inappropriately pay provider incentives when the plans are unlikely to meet minimum MLR requirements. This proposed rule would require states' contracts with managed care plans to specify how provider bonus or incentive payment arrangements would be structured, and to include more specific documentation requirements. CMS also proposes to require that incentive payment contracts between managed care plans and network providers include a defined performance period that can be tied to the applicable MLR reporting period(s), and that all incentive payment contracts include well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment. Managed care plans would continue to have flexibility to determine the appropriate quality improvement or quantitative performance metrics to include in the incentive payment contracts, and contracts would have to specify a dollar amount that could be clearly linked to successful completion of these metrics, as well as a date of payment.

CMS's examinations of current MLR reporting found "wide discrepancies in the types of expenses that issuers include" in quality improvement activity expenses, creating an unequal playing field among issuers. CMS also notes that Medicaid and CHIP MLR quality improvement activity reporting requirements are not aligned with Marketplace requirements. This rule proposes to clarify that indirect or overhead expenses may not be included when reporting quality improvement activity costs in the MLR.

CMS also proposes to discontinue annually updating the credibility factor, which is applied to plans with fewer enrollees to adjust for the higher impact of claims variability on smaller plans. CMS notes that the current statistical model used to calculate the credibility factor (the central limit theorem) produces factors that are not expected to change annually.

As noted above, CMS proposes that Medicaid SDPs and all associated revenue be separately identified in annual MLR reporting. CMS would require reporting of Medicaid managed care plan expenditures to providers that are directed by the state as well as revenue from the state to make these payments. The proposal would require the state to document the following in the managed care plan contracts:

- The total dollars that the state would pay to the plans for the individual SDP
- The timing and frequency of payments that would be made under the separate payment term from the state to the plans
- A description or reference to the contract requirement for the specific SDP for which the separate payment term would be used
- Any reporting that the state requires to ensure appropriate reporting of the separate payment term for purposes of MLR reporting.

CMS also proposes that resubmissions would only be required when the state makes a retroactive change to

capitation rates, not as part of the retroactive eligibility review process.

Currently, managed care plans are required to submit detailed MLR reports to states, and states must submit a summary description of those reports to CMS. Current regulations do not define what the summary descriptions must include, however. CMS notes that it did not intend for reporting to be a statewide aggregation of data across the managed care plans, and now proposes to explicitly require state MLR summary reports to include the required elements for each plan that is contracted with the state.

CMS proposes updates to the contract requirements for overpayments, including a definition of "prompt." Currently, states must include a provision in their managed care contracts requiring prompt reporting of all identified or recovered overpayments, but the term "prompt" is not defined in regulation. Some states do not define "prompt" in contracts, while other states do not use a consistent timeframe across contracts, which can result in inconsistent overpayment reporting. CMS proposes to define "prompt" in this circumstance as "within 10 business days of identifying or recovering an overpayment."

CMS also clarifies that states were always intended to report "identified or recovered" overpayments, but the language is not consistent throughout the current regulations. This created an unintentional effect of some managed care plans reporting partial overpayment data for capitation rate calculations and not investing in recovering identified overpayments in the interest of maintaining a higher MLR. Thus, CMS proposes that any overpayment (whether identified or recovered) must be reported by Medicaid or CHIP managed care plans to the state. This proposal should help ensure that capitation rates account for only reasonable, appropriate and attainable costs covered under the contract.

In Lieu of Services

Key Takeaway: The proposed rule would create new reporting and standard requirements for in lieu of services (ILOS).

ILOS are substitute services or settings provided in lieu of a covered state plan service or setting, and are allowable for states and managed care plans to utilize to meet beneficiary needs. ILOS are most commonly used for inpatient behavioral health treatment, which currently has limitations in coverage due to the Medicaid institution for mental diseases exclusion. The Biden Administration is seeking to expand services that would address the social determinants of health. Accordingly, in the proposed rule, CMS specifies that ILOS "can 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 service or setting." This specification would help states expand ILOS that address social determinants of health.

The proposed rule would limit ILOS expenditures to 5% of total capitation payments. This requirement would be effective for the first rating period beginning 60 days following the effective date of the final rule. CMS notes that the state's actuary would have to calculate the projected ILOS cost percentage and final ILOS cost percentage on an annual basis to ensure consistent application across all states and managed care programs.

States also would be required to submit to CMS a summary report of the actual managed care plan costs for delivering ILOS based on claims and encounter data provided by managed care plans. States with an ILOS cost percentage less than or equal to 1.5% would have a streamlined CMS review process, while states with a higher ILOS percentage would be required to submit additional documentation to CMS, including evaluation reporting and monitoring. States would also be required to develop a transition plan to arrange for state plan services and settings to be provided timely if an ILOS was terminated.

Quality

Quality Strategy and External Quality Review

Key Takeaway: The proposed rule would increase transparency and opportunities for meaningful ongoing public engagement around states' managed care quality strategies.

Currently, states are required to draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished. States are required to make their quality strategy available for public comment when drafting or revising it, and states are required to submit their initial quality strategy to CMS for feedback prior to adopting it in final form.

The proposed rule seeks to increase opportunities for interested parties to provide input into states' managed care quality strategies. The proposed rule would require states to make their quality strategy available for public comment at the three-year renewal, regardless of whether the state intends to make significant changes.

Current regulations require primary care case manager (PCCM) entities to have an external quality review (EQR). CMS proposes to remove the EQR requirement for PCCM entities, because it can disincentive these providers from entering into risk bearing arrangements. The proposed rule would also establish a 12-month review period for the annual EQR activities, and would require that each state's annual EQR report be submitted to CMS by December 31 of each year.

Medicaid and CHIP Managed Care Quality Rating System

Key Takeaway: The proposed rule would establish a framework for states to implement a Medicaid or CHIP quality rating system as a "one-stop-shop" for enrollees to compare Medicaid or CHIP managed care plans based on quality of care, access to providers, covered benefits and drugs, cost and other plan performance indicators.

The Medicaid and CHIP Managed Care Quality Rating System (MAC QRS) are intended align and enhance states' Medicaid quality measurement and improvement at multiple levels of accountability. The policy objectives of the MAC QRS are threefold: to hold states and plans accountable for the care provided to Medicaid and CHIP beneficiaries, to empower beneficiaries with useful information about the plans available to them, and to provide a tool for states to drive improvements in plan performance and the quality of care provided by their programs. However, states are not yet required to implement MAC QRS, and MACPAC reports that as of 2021 only 13 states use this system.

Many states have implemented rating systems for Medicaid and CHIP managed care plans, but under the proposed rule states would be held to a minimum federal standard for their rating systems. It also represents the first time that Medicaid and CHIP beneficiaries in every state contracting with a managed care plan would be able to access quality and other performance data at the plan level, supporting the ability of Medicaid and CHIP beneficiaries to select plans that meet their needs.

The proposal would establish the MAC QRS as a one-stop-shop where beneficiaries in each state could access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to beneficiary decision making, such as the plan's drug formulary and provider network; and ultimately select a plan that meets their needs.

Conclusion

This summary represents are our initial and high-level overview of the Medicaid managed care proposed rule. The notice of proposed rulemaking is followed by a 60-day comment period, and comments must be submitted to the *Federal Register* no later than July 3, 2023. If you have additional questions about the rule or wish to comment on the rule, please contact the McDermottPlus team.