Policy Update

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

Summary

On April 22, 2024, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality final rule. The rule was largely finalized as proposed but makes technical modifications and expands timelines for compliance. The rule's effective date is July 9, 2024; however, provisions throughout the regulation have varying effective dates. CMS released a fact sheet and a chart on the various effective dates.

The rule also has implications for state directed payments (SDPs), payment transparency, medical loss ratios (MLRs), wait time standards and in lieu of services (ILOS).

Key Takeaways

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

- The final rule includes process and transparency-related changes to SDPs, including a requirement that SDP amounts for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center do not exceed the average commercial rate.
- The final rule creates new payment transparency for states by conducting a managed care provider payment rate analysis for certain services.
- The final rule includes requirements for clinical or quality improvement standards for provider incentive arrangements and for expense allocation reporting. The rule prohibits administrative costs from being included in reporting quality improvement activities.
- The final rule incorporates several requirements to measure and improve access to care, including establishing maximum appointment wait times, requiring secret shopper and enrollee experience surveys, and developing remedy plans for issues that are identified.
- The final rule requires that an ILOS be considered approvable as a service or setting through the Medicaid state plan or a Medicaid section 1915(c) waiver. The rule finalizes new reporting and standard requirements for ILOSs.

Medicaid State Directed Payments

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

SDP Process

The final rule exempts 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. SDPs that propose provider payment rates that are either incomplete or above or below 100% of total published Medicare payment rates remain subject to written prior approval by CMS.

The final rule also requires the managed care plan contract to include certain information about the Medicare fee schedule used in the SDP. The final rule requires 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 must identify the time period for which the Medicare fee

schedule was in effect.

CMS did not finalize the proposed requirement that states submit the SDPs preprint to CMS no later than 90 days in advance of the end of the rating period to which the SDP applies. Instead, CMS notes the need for state flexibility, and that there were concerns regarding the implications of this requirement for contract and rate adjustments. As a result, CMS finalized that the submission timeframe for all SDPs documentation and associated amendments is before the implementation of the payment arrangement as indicated by the start date for the SDP identified in the preprint. The start date specified in the preprint is the date when the managed care plans must implement the payment arrangement.

SDP Transparency and Payments

The final rule includes updates to the transparency of funding in SDPs and creates limitations on funding through SDPs.

The final rule requires that upon request from CMS, the state must provide documentation demonstrating the average payment rate for each service and provider class.

CMS finalized that the SDP amount for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center may not exceed the average commercial rate. This payment ceiling does not apply to any other services. Any SDP that directs plan funding such that the total payment rate is above the average commercial rate for any of these four types of services will not be approved. These changes are effective beginning the first rating period after the rule's effective date.

In the final rule, CMS also examines 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 may not comply with the federal requirements and that SDP funding is being directed to providers serving a low number of Medicaid beneficiaries. Under the final rule, states are required to ensure that each participating provider in an SDP arrangement attests that it does not participate in any hold harmless arrangement. States are also required to obtain attestations from the providers. Under the final 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. Although this policy was finalized as proposed, CMS notes that the failure of one or a small number of providers to submit an attestation will not necessarily lead to disapproval of the state's proposed SDP preprint. CMS also states that even if all providers who are eligible for an SDP attest that they do not participate in a hold harmless arrangement, CMS may disapprove the SDP or initiate actions to defer or disallow federal financial participation under a previously approved SDP if the agency learns that a prohibited hold harmless arrangement is or appears to be in place despite the attestations.

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 final rule codified 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 precludes 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 is prohibited. This will be effective by the first rating period beginning two years after the effective date of the final rule.

CMS finalized enhanced reporting on SDPs. For SDPs that require prior approval, states will be required to

submit an evaluation plan. The evaluation plan must identify at least two metrics that will 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 will also be required to submit SDP evaluations every three years if SDP costs (as a percentage of total capitation payments) exceeded 1.5%. States will not be required to submit evaluation results for SDP arrangements that do not exceed the threshold.

The final rule also requires managed care plans to include SDPs and associated revenue as separate lines in their MLR reports to states. Plans must 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. CMS requires states to report the total dollars expended by each managed care plan for SDPs no later than one year after the end of the rating period to the Transformed Medicaid Statistical Information System. 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 final rule creates new payment transparency for states by conducting a managed care provider payment rate analysis for certain services.

The final rule requires plans to submit to the state a payment analysis and annual documentation that demonstrates their level of payment for certain services compared to Medicare rates. The analysis must 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 will compare Medicaid managed care payment of these services to Medicare payment for these services.

The rule requires another payment analysis for the total amount paid for homemaker services, home health aide services, personal care services and habilitation services. Habilitation services is a new addition to the payment analysis that was included in the final rule. The state will be required to compare the managed care payment rates for these services to the Medicaid fee-for-service (FFS) rates for these services. The analysis will 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 will be paid for the same codes on the claims at 100% of the appropriate published Medicare rate, or the Medicaid/Children's Health Insurance Program (CHIP) FFS rate.

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

Access

Wait Time Standards

Key Takeaway: CMS established maximum appointment wait time standards of 10 and 15 business days for Medicaid or CHIP managed care enrollees in four service areas.

The final rule requires 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).
- State selected service type and maximum appointment wait time.

As proposed, CMS will require 90% compliance with the 10- and 15-business-day maximum appointment wait time standards, which is consistent with standards set for Marketplace plans. Responding to comments about 90% compliance being difficult to attain, CMS notes that three of the four selected service types are the most commonly used on a frequent and repetitive basis, and that it is "critically important that managed care plans have robust networks for these services with sufficient capacity to provide timely appointments to meet the needs of the plan's enrollees." The wait time standards only apply to routine services, and not to complex conditions or patient-specific protocols for urgent or emergency care. CMS encourages states to work with managed care plans and their network providers to develop a definition of "routine" that reflects usual patterns of care and current clinical standards. These requirements will be effective by the first rating period beginning three years after the effective date of the final rule, as proposed.

Secret Shopper Surveys

Key Takeaway: CMS requires 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.

This rule was finalized as proposed to include a requirement that states use 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 should include verification of certain providers' active network status, street address and 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 rule also requires 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. Appointments offered via telehealth are only counted towards compliance with appointment wait time standards if the provider also offers in-person appointments. Telehealth visits offered during the secret shopper survey must be separately identified in the survey results.

States must receive information on all provider directory data errors identified in secret shopper surveys no later than three business days from identification and must send that data to the applicable managed care plan within three business days of receipt. The results of these surveys should be reported to CMS and posted on the state's website. Updating provider directory data after it was counted as an error in secret shopper survey results will not change a managed care plan's compliance rate. This rule goes into effect in the first rating period beginning on or after four years after the effective date of the final rule.

Enrollee Experience Surveys

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

The final rule requires states to conduct an annual enrollee experience survey for each managed care program in the state, largely finalized as proposed. 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. CMS will allow states to select the enrollee experience survey that will best aid in their monitoring, oversight and quality improvement activities. CMS declined to define minimum survey characteristics or a satisfaction index, develop evidence-based questions or provide a template.

Responding to comments about the potential for beneficiary survey fatigue, CMS finalized a new exemption for managed care plans in which all enrollees are enrolled in a Medicare Advantage dual eligible special needs plan (D-SNP) because an annual Consumer Assessment of Healthcare Providers and Systems survey is already required for D-SNP enrollees.

All Medicaid managed care plans are required to participate regardless of the number of enrollees in the program. CMS encourages states to share the detailed response data with their plans as soon as it is available. CMS did not include a requirement that states conduct provider surveys, but encourages states to use robust provider surveys in their monitoring and oversight strategy as a complement to enrollee surveys to capture a comprehensive view of the operations of their managed care programs.

Access Remedy Plans

Key Takeaway: The final rule requires states to develop a remedy plan to address identified access issues.

CMS finalized the remedy plan requirements as proposed. When CMS, the state or the managed care plan identifies an access issue, the state must perform the following steps:

- Submit a remedy plan to CMS no later than 90 calendar days following the date the issue is identified.
- Develop a remedy plan that identifies specific steps, timelines for implementation and completion, and responsible parties, that could improve access within 12 months.
- Ensure that improvements in access are measurable and sustainable.
- Submit quarterly progress updates to CMS on implementation of the remedy plan.

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. If the access issue is not addressed within the initial 12 months, CMS may require the state to continue or revise the remedy plan.

Medical Loss Ratio Standards

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

Medical loss ratios are one tool that CMS and states can use to assess whether capitation rates are appropriately set and spent on claims, quality improvement activities and services for enrollees as compared to administrative expenses.

Under current rules, Medicaid and CHIP managed care plans can implement provider incentive arrangements that are not based on quality improvement standards or metrics. This final rule requires 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 requires 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 quality improvement or performance metrics that the provider must meet to receive the incentive payment. Managed care plans will continue to have flexibility to determine the appropriate quality improvement or quantitative performance metrics to include in the incentive payment contracts, and contracts must specify a dollar amount or a percentage of a verifiable 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 notes that Medicaid and CHIP MLR quality improvement activity reporting requirements are not aligned with Marketplace requirements. As a result, this rule establishes that indirect or overhead expenses may not be included when reporting quality improvement activity costs in the MLR. CMS also finalized technical revisions for quality improvement expenditures, provider incentive payments and expense allocation reporting to align with recent regulatory changes for Marketplace plans.

CMS finalized its proposal 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. CMS clarifies that it commits to reviewing the credibility factors on a regular basis and will publish updates if the factors change.

As noted, this final rule requires Medicaid managed care plans to submit actual expenditures and revenues for SDPs as part of their MLR reports to states. CMS made changes in the final rule to require that all SDPs be incorporated into Medicaid managed care capitation rates as adjustments to base capitation rates and to prohibit the use of separate payment terms. The final capitation rates for each plan must account for all SDPs, and each SDP must be accounted for in the base data, as an adjustment to trend or as an adjustment. States are prohibited from withholding a portion of the capitation rate to pay the plan separately for an SDP, and from requiring a plan to retain a portion of the capitation rate separately to fulfill the contractual requirement of an SDP.

CMS initially proposed that resubmissions only be required when the state makes a retroactive change to capitation rates, but after reviewing commenters' concerns, CMS decided *not* to finalize this proposal. CMS determined that restricting managed care plan MLR resubmissions to when states make capitation rate changes might result in inaccurate MLRs.

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. CMS notes that it did not intend for reporting to be a statewide aggregation of data across the managed care plans. As a result, CMS finalized an explicit requirement that state MLR summary reports include the required elements for each plan that is contracted with the state.

CMS updated the contract requirements for overpayments to define "prompt" as "within 30 business days of identifying or recovering an overpayment." CMS initially proposed to define "prompt" as "within 10 business days of identifying or recovering an overpayment." However, after commenters expressed concern, CMS revised its proposal. The final rule requires managed care plans to report identified or recovered overpayments within 30 calendar days from the date of identification or recovery of an overpayment.

CMS also clarifies that states were always intended to report "identified or recovered" overpayments, but the language has not been consistent throughout 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 finalized that any overpayment (whether identified or recovered) must be reported by Medicaid or CHIP managed care plans to the state.

In Lieu of Services

Key Takeaway: The final rule requires that an ILOS be considered approvable as a service or setting through the Medicaid state plan or a Medicaid section 1915(c) waiver, and finalizes new reporting and standard requirements for ILOSs.

ILOSs 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. ILOSs are most commonly used for inpatient behavioral health treatment, which currently has limitations in coverage due to the Medicaid institution for mental diseases exclusion. Seeking to expand services that would address the social determinants of health, CMS specifies that ILOSs "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."

In the final rule, CMS requires that an ILOS be considered approvable as a service or setting through the Medicaid state plan or a Medicaid section 1915(c) waiver.

The final rule limits ILOS expenditures to 5% of total capitation payments. CMS notes that the state's actuary must 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 are also 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% will have a streamlined CMS review process, while states with a higher ILOS percentage will be required to submit additional documentation to CMS, including evaluation reporting and monitoring. CMS requires ongoing monitoring of each ILOS and an evaluation after five years if the ILOS costs (as a percentage of total capitation payments) exceed 1.5%.

CMS also requires states to develop a transition plan to arrange for the timely provision of services and settings if an ILOS is terminated. CMS believes that a transition plan is necessary to protect the health and wellbeing of Medicaid and CHIP enrollees for whom the sudden termination of an ILOS, without an adequate transition plan, could have a significant negative impact. States will be allowed up to 30 calendar days from the termination decision date to submit an ILOS transition plan to CMS for review. This rule is effective for the first rating period beginning 60 days following the effective date of the final rule.

Quality

Quality Strategy and External Quality Review

Key Takeaway: The final rule increases transparency and opportunities for meaningful ongoing public engagement around states' managed care quality strategies. The final rule also maintains the April 30 due date for the annual state external quality review (EQR) report publication.

Currently, states are required to draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished. The quality strategy is intended to serve as a foundational tool for states to set goals and objectives related to quality of care and access for their managed care programs. 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 final rule seeks to increase opportunities for interested parties to provide input into states' managed care quality strategies. The final rule requires 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. The final rule also requires states to submit a copy of their revised or renewed quality strategy to CMS at minimum every three years to allow CMS to provide feedback periodically to help states strengthen their managed care quality strategies before they are finalized.

CMS removed the EQR requirement for primary care case manager entities because it can disincentivize these entities from entering into risk-bearing arrangements. The final rule also establishes a 12-month review period for the annual EQR activities. CMS requires that the EQR-related activities must be performed in the 12 months preceding the finalization and publication of the annual report to ensure that the report contains the most recent data and information. However, while CMS initially proposed to require that each state's annual EQR report be submitted to CMS by December 31 of each year, it did not finalize this proposal and maintains the current requirement of posting the report annually on April 30. CMS decided not to finalize its initial proposal because of commenter concerns regarding the burden and challenges associated with completing mandatory EQR activities under the revised timeframe.

The final rule adds a new optional EQR activity to assist in evaluations of quality strategies, SDPs and ILOSs that pertain to outcomes, quality or access to healthcare services. CMS aims for this optional activity to provide states with critical technical assistance via a CMS-developed protocol that will enable more robust evaluations, which could lead to greater transparency and quality improvement in states' implementation of their quality

strategy, SDPs and ILOSs.

The final rule also makes it easier for states to use accreditation reviews for EQR by removing requirements for private national accreditation organizations (PAOs) to obtain Medicare deeming authority. CMS intends for this change to reduce administrative burden in the private accreditation industry and to create more flexibility for states to leverage PAO reviews for nonduplication.

CMS finalized its proposal to require more meaningful data and information in the annual EQR reports. CMS requires that the EQR technical reports include "any outcomes data and results from quantitative assessments" for the applicable EQR activities in addition to whether the data has been validated, and requires that this type of data from the mandatory network adequacy validation activity also be included in the EQR technical report.

Medicaid and CHIP Managed Care Quality Rating System

Key Takeaway: The final rule establishes a framework for states to implement a Medicaid and CHIP quality rating system (MAC QRS) 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. CMS finalized five modifications to its initial proposal to further reduce MAC QRS implementation burden with minimal impact on beneficiaries' access to information.

The MAC QRS is intended to 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 used this system.

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

The final rule establishes 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. Based on commenter feedback, CMS finalized five modifications to its initial proposal to further reduce MAC QRS implementation burden with minimal impact on beneficiaries' access to information:

- CMS finalized an option for states to request a one-time, one-year extension to fully comply with one or more of the requirements of the MAC QRS rating methodology.
- CMS narrowed the scope of mandatory measures for which a quality rating must be displayed in a state's MAC QRS to only those that are applicable to the managed care program(s) established by the state (meaning those MAC QRS mandatory measures that assess a service or action covered by one or more of the state's managed care contracts).
- CMS removed the requirement for states to obtain input from the state's Medical Care Advisory Committee and providing an opportunity for public comment of at least 30 days on a request for, or modification of a previously approved, alternative Medicaid managed care quality rating system.
- CMS initially proposed that states would be required to display a search tool that enables users to identify available managed care plans that provide coverage for a drug identified by the user and a search tool that enables users to identify available managed care plans that include a specific provider in the plan's network. In the final rule, CMS narrowed the scope of these

proposed MAC QRS requirements to apply only to managed care plans that participate in managed care programs with two or more participating plans.

- CMS requires states to collect Medicaid FFS and Medicare data, validate the collected data and use the validated data to calculate quality ratings for managed care plans for MAC QRS mandatory measures to the extent feasible without undue burden.

Conclusion

As noted, the final rule's effective date is July 9, 2024, but provisions throughout the regulation have various effective dates. Stakeholders should review the final rule to assess the changes and their implications for their business lines.

CMS clarifies that if any provision of this final rule is held to be invalid or unenforceable by its terms or as applied to any person or circumstance, or is stayed pending further agency action, that provision shall be severable and will not affect the remainder of the final rule or the application of the provision to other persons not similarly situated or to other dissimilar circumstances.

Should you have any questions regarding the Medicaid Managed Care final rule, please contact the McDermottPlus team below.

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