Mercer

welcome to brighter

New Medicaid and Medicaid Managed Care Proposed Rules

Centers for Medicare & Medicaid Services (CMS) releases two major proposed rules for Medicaid Managed Care and Medicaid Access, including Home- and Community-Based Services (HCBS) and Children's Health Insurance Program (CHIP).

Mercer colleagues are working to understand the full impacts to better advise our internal teams and clients. We will continue to review and share additional information with you. Our intention is to also provide educational sessions for clients in the coming months.

An initial summary of the key proposed provisions is provided below.

Background

On May 3, 2023, CMS published two significant notices of proposed rules (NPRMs) describing new requirements targeted to enhance access to care in Medicaid managed care as well as fee-for-service (FFS):

- **Medicaid and Children's Health Insurance Program (CHIP) Managed Care (proposed "Managed Care Rule")** This NPRM builds on the 2016 Managed Care Rule with several new requirements and modifications to managed care payment, operations, and evaluation (e.g., state directed payments (SDPs), in lieu of services (ILOS), quality ratings). This NPRM also proposes new access standards for managed care to align with new proposed FFS standards.
- **Ensuring Access to Medicaid Services ("Access Rule")** This NPRM primarily focuses on new CMS requirements for access in FFS, including new requirements for HCBS programs and attempts to better align managed care and FFS access policies.

Significant and Broad Changes

Both NPRMs impact managed care, but the majority of the provisions impacting managed care are in the Managed Care NPRM. These NPRMs will have a tremendous impact on State Medicaid programs, if adopted.

CMS has published other final rules since 2016 making changes and clarifications on the Medicaid managed care regulations and FFS access monitoring requirements. However, these NPRMs mark the first time since the 2016 Medicaid Managed Care Final Rule and the 2015 Medicaid Fee-For-Service Access Rule where CMS has proposed sweeping changes to State Medicaid Agency and Medicaid managed care plan operations, oversight, and compliance standards.

Comment Period and Effective Dates

The proposed rules have a 60-day comment period closing on July 3, 2023. It may take a year before CMS finalizes these rules, but we expect final rules to be released by mid-year 2024. While many provisions will be effective immediately, some requirements will be phased in over several years.

Medicaid Access Proposals

In response to CMS's 2022 Request for Information on Medicaid Access, CMS has proposed a set of managed care and FFS access standards, including new standards for HCBS programs. These standards are intended to align CMS's access strategy across delivery systems.

Access in Medicaid Managed Care

- CMS proposes moving away from time and distance standards and more closely **aligning Medicaid standards with Marketplace policies**.
- The NPRM establishes **maximum appointment wait time standards** for routine primary care (adult and pediatric), obstetric/gynecological services (OB/GYN), outpatient mental health and substance use disorder services (adult and pediatric), and a state-selected service (adult and pediatric if appropriate).
- States would be required to use an **independent entity to conduct annual secret shopper surveys** to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider directories.
- States would have to conduct annual enrollee experience surveys.
- States would have to **submit an annual payment analysis** that compares managed care plans' payment rates for E&M Current Procedural Terminology codes for primary care, OB/GYN, mental health, and substance use disorder (SUD) services as a proportion of Medicare's payment rate.
- States would have to also 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. This analysis will be an issue for states with longstanding managed care programs that have not updated Medicaid fee schedules for these services or may not have a Medicaid fee schedule at all.
- States would be required to **implement a remedy plan** for any managed care plan that has an access issue that needs improvement. This plan would be comparable to a Corrective Action Plan in FFS and would need to go to CMS for approval no later than 90 calendar days following the date that the State becomes aware of an access issue.

Access in Medicaid FFS

CMS is overhauling its requirements for access in FFS by rescinding the rules for Access Monitoring Review Plans (AMRPs) and replacing them with new standards. CMS is proposing that States must:

- **Publish and regularly update Medicaid FFS payment rates** for all services on a state website that is accessible and easy for the public to use.
- Every other year, **compare Medicaid FFS and Medicare payment rates** for critical services, including primary care, OB/GYN services, and outpatient behavioral health.
- Demonstrate that any **state plan amendments** to reduce provider payment rates or restructure provider payments will not put access to care at risk. CMS would have a two-tier analysis system, whereby States would need to provide a more extensive Access analysis if certain conditions are not met (e.g., aggregate payments rates are at or below 80% of Medicare).

Access to State Plan and Waiver HCBS

Regardless of delivery system or authority (except for PACE), CMS has proposed the following for HCBS services:

- At least 80% of Medicaid payment for personal care, homemaker, and home health aide services must be spent on **compensation for the direct care workforce**, as opposed to administrative expenses or profit. Mercer is not yet clear on how this will be applied to managed care or whether it creates a new CMS-required State Directed Payment (SDP).
- Every other year, states must **disclose the average hourly rate paid to direct care workers (DCWs)** providing certain HCBS: personal care, home health care, and homemaker services. This information would separately disclose rates for individual direct care providers and direct care providers employed by an agency.
- States would have to establish an advisory group to advise and consult on provider rates for DCWs.
- States must report information on their section **HCBS waiver waitlists**, including the length of the waitlists. They also must report whether people can access services across section HCBS authorities once the services are approved.
- States must demonstrate that as part of person-centered planning, **reassessment of need** is completed at least once a year for people continuously enrolled in HCBS programs. They also must demonstrate that service plans are reviewed and revised annually based on that reassessment.
- States must operate and maintain an **electronic incident management system** (using a common minimum definition for what is considered a “critical incident”) and investigate, address, and report on the outcomes of the incidents within specified timeframes.
- States must establish and manage an **FFS grievance process** for people receiving HCBS.
- States must report on a set of **nationally standardized quality measures** specifically for HCBS established by CMS.

New Medicaid and CHIP Managed Care Quality Rating System

CMS finalized the requirement for a Quality Rating System in the 2016 Final Rule but did not establish the framework required for implementation. This NPRM picks up where the 2016 rule left off and proposes this framework.

- A state would have to create a **Managed Care Quality Rating System website** so that beneficiaries can access information about eligibility, compare plans on a variety of factors, and ultimately select a plan.
- The proposed rules establish an initial set of **mandatory measures**, a methodology for the quality ratings, and a process to update the mandatory measures.
- CMS proposes flexibility for a state to implement **alternative quality rating systems**.
- States would be required to **display quality ratings** for the initial set of mandatory measures by the end of the fourth calendar year following the effective date of the final rule. Such ratings must be for the performance year that is two calendar years following the effective date of the final rule.

Medicaid Advisory Committees and Benefit Advisory Groups

CMS is proposing to replace the current Medical Care Advisory Committee (MCAC) requirements and **replace the MCAC with a newly named Medicaid Advisory Committee (MAC) and a new Beneficiary Advisory Group (BAG)**. The membership of this group must crossover with the proposed MAC. The goal is that MAC, and its corresponding BAG, would advise the state not only on issues related to health and medical services, as the MCAC did, but also on matters related to policy development and to the effective administration of the Medicaid program.

Other Medicaid and CHIP Managed Care Proposals

In addition to the access issues addressed above, CMS proposed vast changes to Medicaid and CHIP managed care operations and quality. **We will focus on the standalone CHIP provisions at a later date.** Summaries of the various changes are below.

Medicaid SDPs

As CMS explains in the proposed rules, SDPs grew in number and cost since they were first proposed in 2016. In 2022, CMS received almost 300 SDP pre-prints to review. In these rules, CMS is proposing a host of changes to SDP requirements and processing. The NPRM would:

- While not specifically proposed in the regulatory text, CMS is using the preamble to seek comments **on an overall expenditure limit for SDPs**. Comments are requested on both the overall approach of using a percent of total costs as well as on the appropriateness of 10 to 25 percent or what a reasonable percentage limit for SDP expenditures could be. It is expected that CMS will set a limit in the final rules based on comments received.
- Eliminate CMS written **prior approval** for SDPs that use 100% of Medicare as the minimum fee schedule.
- Apply SDP requirements to **out-of-network provider** arrangements.
- Provide additional regulatory pathways for approval of **value-based payment** initiatives (e.g., population- or condition-based SDPs).
- Require **MCO contracts** to detail SDP dates, amounts, fees, procedure codes, provider classes, and other SDP details as applicable.
- Establish several regulatory standards to determine when the total payment rates for certain SDPs are **reasonable, appropriate, and attainable**.
- Codify current CMS policy that payment levels for certain providers (inpatient hospital services, outpatient hospital services, qualified practitioner services at an academic medical center, and nursing facility services) not exceed the **average commercial rate** (ACR). These proposals would require an ACR demonstration and a total payment rate comparison to the ACR annually.
- Condition SDP fee schedule provider payments upon delivery of services within the rating period and **prohibit a post-payment reconciliation process**. Post-payment reconciliation is different from separate payment terms.
- Require states to report to CMS the **total dollars expended for each SDP**.

- Require states to **evaluate SDPs** every three years if the SDP exceeds 1.5% of the total capitation payments. CMS proposes to allow external quality review organizations **(EQROs)** to perform this evaluation as a new optional activity eligible for 75% enhanced federal match.
- Grant states **appeal rights for disapproved SDPs**.
- Require states to comply with all **Medicaid financing** rules and be able to document that provider receiving SDPs are not participating in unallowable "hold harmless" arrangements associated with **provider taxes**.
- **Define "separate payment terms"** as a predetermined and finite funding pool that the State establishes and documents in the contract and establish new regulatory requirements for separate payment terms.

Medical Loss Ratio

The rules would:

- Require contracts to include more detail on **provider bonuses or incentives** such as: effective dates, well-defined quality or performance metrics, and dollar amounts. CMS is concerned that MCOs have used these payments to avoid paying potential medical loss ratio (MLR) remittances or moving funds to an affiliated company.
- Require MCOs to better describe **methodologies used to allocate expenses**, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs.
- No longer hold CMS to updating **credibility factors** annually (initial 2017 credibility factors remain).
- Require states' **MLR summaries** to CMS to report separate amounts for SDP revenue and SDP payments made to MCOs. States also need to collect these amounts from MCOs' MLR reports.
- Require managed care plans to submit actual expenditures and revenues for **SDPs** and states must include those amounts as a separate line item in the annual MLR report to CMS.
- Require managed care plans to report identified or recovered **overpayments** to states within 10 business days.

ILOS

Earlier this year, CMS released State Medicaid Director Letter (SMDL) 23-001 describing new, detailed requirements for ILOS. States with existing ILOS were required to comply with the new guidance, including a 5% cap on ILOS expenditures, by the contract rating period beginning on or after January 1, 2024. States adding new ILOS were required to comply with the new guidance immediately. **The NPRM proposes to codify the guidance in this letter, and Mercer does not repeat that guidance here.** However, the NPRM proposes an effective date of the first rating period beginning on or after 60 days following the effective date of the final rule.

- Mercer does not yet know whether the NPRM signals a delay in the implementation of the **SMDL 23-001**; however, states may take issue with CMS enforcing policy before a rule is finalized.
- CMS clarified in the preamble that they do not intend to allow states to **aggregate programs** for the purpose of calculating the ILOS cost-percentage.

- CMS expects the actuary that certifies the **projected and final ILOS cost percentages** should be the same actuary that developed and certified the capitation rates that included ILOS.
- CMS is proposing to codify its position that a medically appropriate and cost effective substitute means that an ILOS may serve as an ***immediate or longer term substitute*** for a covered service or setting, or when the ILOS can be expected to reduce or prevent the *future need* to utilize a covered service or setting. This may present new opportunities for states and managed care plans with longer periods of continuous eligibility.
- CMS proposes to allow **EQROs** to perform ILOS evaluations as a new optional activity eligible for 75% enhanced federal match.

External Quality Reviews and State Quality Strategies

In addition to proposing a new optional external quality review (EQR) activity to assist in the evaluation SDPs and ILOS, CMS proposes to:

- Allow EQROs to assist with the **quality rating** of managed care plans at the 75% enhanced rate of federal match.
- Require **increased public engagement** around states' managed care quality strategies.
- Exempt Primary Care Case Management programs from EQR.
- Make it easier for states to use **accreditation reviews** for EQR.
- Update the **12-month review periods** and report due dates for annual EQR.
- Require additional data and information to be included in **annual EQR reports** after updated protocols are released.

Resources

CMS Webinars

CMS is hosting a series of webinars and stakeholder meetings on the NPRMs.
Our NPRM team will be attending these and will share notes and our insights with you.

CMS Resource Links

- Summary of CMS's Access-Related Notices of Proposed Rulemaking:

  https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p

- Summary of Medicaid and CHIP Payment-Related Provisions: https://www.cms.gov/newsroom/fact-sheets/summary-medicaid-and-chip-payment-related-provisions-ensuring-access-medicaid-services-cms-2442-p
- Summary of Key Home and Community-Based Services (HCBS) Provisions: https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking

- Summary of the Medical Care Advisory Committee and Beneficiary Advisory Group Provisions: https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking-0
- For a fact sheet about the Medicaid or Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality NPRM, please see: https://www.cms.gov/newsroom/fact-sheets/notice-proposed-rulemaking-medicaid-and-childrens-health-insurance-program-chip-managed-care-access

Caveats and limitations

Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commentary on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Mercer recommends that readers secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this document or otherwise.

Questions for your specific state?

Please contact your Mercer consultant to discuss the impact of this change for your specific state programs. You may also email us at mercer.government@mercer.com or visit www.mercer.com/government.