Guidehouse

outwit complexity™

Key Actions for States on CMS Access and Managed Care Rules

The CMS final rules on access and managed care require states to fine tune approaches for participant involvement, monitoring access, transparency, and health and welfare protections.

The Centers for Medicare & Medicaid Services (CMS) "Ensuring Access to Medicaid Services" (Access Rule) and "Medicaid, CHIP Managed Care Access, Finance, and Quality" (Managed Care Rule) final rules introduce significant changes that will impact states regarding payment, operations, oversight, reporting, compliance, and staffing. When fully implemented, the final rules will change the way state Medicaid agencies conduct business across a large swath of Medicaid programs, such as:

- Involving Medicaid enrollees to a greater extent in providing input on Medicaid programs
- Measuring and monitoring access to services
- Improving transparency and CMS oversight across all aspects of Medicaid programs, especially provider payment rates and quality indicators
- Enhancing health and welfare protections through the required incident management system

Because of these changes and the related challenges and complexities involved, states should focus on the following key actions. While the final rules formally take effect on July 9, 2024, CMS has defined deadlines over the next six years and outlined various exceptions or flexibilities available to states.

Final Rule: Ensuring Access to Medicaid Services (CMS-2442_F)

The Access Rule builds on continuous efforts to improve healthcare access and quality. It emphasizes enhancing home and community-based services and increasing transparency and public accountability. It also requires more comprehensive data reporting and monitoring for the Medicaid fee-for-service (FFS) and managed care delivery systems.

States will need to consider complexities created by the final rule (which in many cases codifies leading practices across Medicaid programs) and take the following key actions to comply with the requirements if they haven't already done so.

Guidehouse

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

While many of the regulatory requirements issued under the final rule are not new in concept, there are new standards for involving enrollees in the ongoing planning and operations of Medicaid programs. We expect state agencies to face several challenges in meeting these codified requirements:

- **Identify the appropriate BAC participants**: While states routinely include enrollees in their advisory councils, it can be challenging to identify Medicaid enrollees to participate. Identifying and recruiting enrollees for a dedicated BAC will require states to use more creative approaches to securing the required participation.

- **Operate and support advisory councils**: States have a myriad of advisory councils they convene to provide input. The more rigorous requirements around annual reports and composition will require more state resources to operate and support various advisory councils.

Home and Community-Based Services (HCBS)

CMS replaces existing regulations issued a decade ago and extends key protections to the FFS program, particularly around grievances and access. States should expect the following challenges as they take the steps needed to comply with these more rigorous HCBS requirements:

- **Design, educate, and implement a grievances system for FFS programs**: Most states have processes in place for submitting grievances filed directly with the state about such issues as change in service levels and disenrollment. But few have a coordinated system for consumers to file grievances against providers that integrates with anticipated grievance channels like ombudsman units, critical incident submission, or case management records. Meeting the final rule's terms will entail significant change—necessitating a thoughtful design process, education at all levels for providers, enrollees, and state staff, and effective implementation to meet CMS requirements. Providers may experience even greater administrative demands, as all waiver programs must collect this data consistently.

- **Engage in planning for a myriad of technology to support compliance for critical incidents, provider reporting, and grievances**: While many states have designed technological systems to support HCBS delivery and protections, they are often simplistic.

Key MAC and BAC Actions for States

1. Establish the newly named Medicaid Advisory Committee and a dedicated BAC.
2. Develop operating guidelines, including state Medicaid agency attendance.
3. Recruit members, especially for the BAC.
4. Develop annual report.

States will have to invest in new technological solutions and/or upgrade existing ones to meet critical incident management requirements. Solutions will have to enable electronic critical incident data collection, tracking, and trending. CMS also expects states to use claims data, Medicaid fraud control unit data, and data from other state agencies such as Adult Protective Services or Child Protective Services (to the extent permissible under applicable state law) to identify critical incidents that occur during service delivery but are not reported by providers.

- **Provide transparency into 1915(c) waiver wait lists**: The topic of wait lists is highly charged and may elicit strong, often emotional stakeholder responses at all levels. States will need support and guidance around programmatic changes, stakeholder communication, and public perception concerns. States should consider political dynamics around wait list management, especially since it is a subject of particular importance to state legislators.

- **Track and report transparently on HCBS timeliness**: In addition to reporting on wait lists, the rule introduces requirements for tracking and reporting the timeliness of HCBS commonly delivered in the home, including personal care, homemaker, home health, and habilitative services. This type of reporting will be new for many states, particularly those that offer HCBS through FFS programs because it will require infrastructure to track the path from service authorization to implementation. Perhaps more challenging, states will need better systems to address barriers that prevent services from being extended in a timely or consistent manner versus what has been approved in a person-centered plan.

- **Review HCBS service definitions and codes**: Because states do not characterize HCBS services consistently, they may need to recodify service definitions to determine which services are subject to the 80% minimum direct care compensation payment requirement.

- **Update HCBS rates**: Current rates in many states are not designed to meet the 80% minimum direct care compensation payment requirement. Compliance may require extensive, new rate development.

- **Monitor provider compliance**: Since states must hold providers individually accountable for 80% minimum payment compliance, they will need to develop sophisticated provider reporting systems and appropriate staffing to monitor and enforce compliance.

- **Consider potential parity issues**: Minimum payment requirements may create parity issues and new complications in the relationship between payment for agency-provided and participant-directed services. States will likely need to develop extensive exemption criteria for small providers or other provider types unable to meet minimum performance level requirements.

Key HCBS Actions for States

1. Demonstrate that a reassessment of functional need was conducted at least annually for at least 90% of individuals continuously enrolled in the waiver for at least 365 days.
2. Demonstrate that they reviewed the person-centered service plan and revised it as appropriate based on the results of the required reassessment of functional need at least every 12 months for at least 90% of individuals continuously enrolled in the waiver for at least 365 days.
3. Meet nationwide incident management system standards for monitoring HCBS programs.
4. Establish a grievance system for HCBS delivered through FFS.
5. For homemaker, home health aide, and personal care services:
    a. Report on state readiness to collect data regarding the percentage of Medicaid payments that goes to direct care.
    b. Report on the percentage of Medicaid payments for these services spent on compensation to the direct care workers furnishing these services, subject to certain exceptions.
    c. Ensure a minimum of 80% of Medicaid payments for these services be spent on compensation for direct care workers furnishing these services, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions (referred to as the HCBS payment adequacy provision).
6. Report annually to CMS on:
    a. Wait lists in section 1915(i) waiver programs
    b. Service delivery timeliness for personal care, homemaker, home health aide, and habilitation services
    c. Standardized set of HCBS quality measures
7. Share information about quality, performance, and compliance measures for the administration of Medicaid covered HCBS to promote public transparency.

FFS Access

The final rule continues to focus on improving provider payment rate transparency. We expect that states will encounter some difficulties to reach compliance in the following areas:

- **Create FFS fee schedules in states relying on managed care delivery systems**: States that deliver all or most of their Medicaid services through managed care will face challenges to meet this requirement because many of them no longer have FFS fee schedules available to post easily. They will likely have to rely on a combination of data sources to develop and publish FFS fee schedules.
- **Compare outpatient mental health and substance use disorder rates to Medicare**: States will need additional guidance from CMS on how to approach this comparison.
- **Organize HCBS advisory groups**: In calculating how to organize required HCBS advisory groups, states will need to keep in mind the broad range of services provided to diverse populations, provider types, and advocacy organizations—all against the backdrop of complementary and competing interests.
- **Streamline administrative burden on providers**: These new HCBS and FFS access requirements will cause service providers to have to report more data to states to enable federal reporting. Requirements for advisory group consultation effectively require bi-annual rate reviews, which are also time-consuming.

Key FFS Access Actions for States

1. Comply with payment rate transparency publication, comparative payment rate analysis, and payment rate disclosure provisions regardless of the quantity of services covered or delivered or number of beneficiaries enrolled in managed care.
2. Separately identify Medicaid FFS payment rates in the payment rate transparency publication by category (such as pediatric, adult, provider type, and geographical location), if applicable.
3. Identify each constituent service included in the bundled fee schedule payment rate or rate determined by a similar payment methodology.
4. Identify how much of the bundled fee schedule payment rate or rate determined by a similar payment methodology is allocated to each constituent service under the state's payment methodology.
5. Include the date that the payment rates were last updated on the state Medicaid agency's website. Rates must be kept current, with updates made no later than one month after the effective date of the most recent update to the payment rate.
6. Publish a comparison of FFS payment rates for primary care, obstetrical and gynecological care, and outpatient mental health and substance use disorder services to Medicare rates every two years. CMS will provide states with a hypothetical example list of the E/M CPT/HCPCS codes to be used for comparison in sub-regulatory guidance no later than June 30, 2025.
7. Use the Medicare non-facility payment rates as established in the Medicare Physician Fee Schedule Final Rule for calendar year 2025 for the initial comparative payment rate analysis. Data should include payment rate breakdowns by population (pediatric and adult), provider type, and geographical location, as applicable.
8. Publish the average hourly rate paid for personal care, home health aide, homemaker, and habilitation services, and publish the disclosure every two years. Data should include payment rate breakdowns by population (pediatric and adult), provider type, and geographical location, as applicable.
9. Establish an advisory group for direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties to meet at least every two years and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services. Publicly post recommendations of the interested parties' advisory group for review.
10. Provide an access analysis with any state plan amendment that has a rate reduction or could result in diminished access.

Final Rule: Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-F)

The Medicaid Managed Care Final Rule introduces updates aimed at improving care access, quality, and outcomes. It addresses six primary areas:

1. Access in managed care, including network adequacy
2. State directed payments
3. Medical loss ratio standards
4. In lieu of services and settings
5. Quality
6. Children's Health Insurance Program

The effective date of this final rule is July 9, 2024, though deadlines for state actions vary by requirement. A full summary of the final rule is located on CMS' website.

Access to Care

While many of the regulatory requirements issued under the Final Rule are not new in concept, they emphasize a new enforcement rigor that will create additional complexities in overseeing managed care plans. Examples include:

- **Enforce wait time standards**: While states routinely include wait time standards in managed care contracts, the Final Rule requires specific standards for types of routine appointments and for states to explicitly enforce these standards. Enforcement will require states to contract with an independent entity to conduct annual secret shopper surveys to validate compliance with appointment wait time standards.
- **Address workforce shortages**: States will need to consider the impact of shortages, especially in rural areas, which will make it challenging to hold managed care plans accountable to wait time standards.
- **Deliver training and technical assistance**: States will need to consider the volume of trained resources required for developing and monitoring remedy plans if many managed care plans are not able to meet the wait time and other access standards. CMS will closely monitor any state remedy plans needed and may disallow federal financial participation for the payments made under the state's managed care contract for failure to ensure adequate access to care.
- **Increase in agency expenditures and capitation rates**: More rigorous access standards and monitoring requirements such as secret shopper, wait time, and payment analyses will lead to higher state Medicaid agency oversight and managed care plan operational costs. In order to meet the wait time standards, managed care plans may also advocate for higher capitation rates due to increased reimbursement rates to attract additional providers.

Key Case Access Actions for States

1. Develop or update contracts and enforce wait time standards for routine appointments for covered services, including adult and pediatric outpatient mental health and substance use disorder (10 business days), adult and pediatric primary care (15 business days), obstetrics and gynecology (15 business days), and any additional types of services determined by the state in an evidence-based manner.
2. Contract with an independent entity to conduct annual secret shopper surveys to validate managed care plan compliance with appointment wait time standards and the accuracy of provider directories.
3. Develop and conduct an annual enrollee experience survey (such as the CAHPS® standardized survey or a state-selected survey) and use the results for monitoring activities to improve managed care program performance.
4. Review annual health plan payment analysis results, which show payment levels for covered services using paid claims data from the immediate prior rating period, along with secret shopper survey results to assess compliance with service availability requirements and incorporate them into the assurance of compliance submitted to CMS, per 42 CFR § 438.207(d). Submit a remedy plan to CMS, as appropriate.

State Directed Payments (SDPs)

The final rule builds on existing regulations to add further specificity and standards for SDPs. CMS will be closely scrutinizing SDPs moving forward, especially financing for the non-federal share of Medicaid funds. The final rule is expected to present the following complexities and challenges:

- **Consider broader Medicaid quality goals and less traditional Medicaid providers**: States can think more broadly about SDPs since dollars can be directed to providers that are outside of the managed care plan's network.

- **Develop stronger analyses and detailed documentation related to the Average Commercial Rate (ACR), if using**: CMS is requiring an ACR demonstration using state-specific payment data that is no older than three years and is specific to the services addressed by the SDP. States will likely need help with completing an ACR analysis. Some states with SDPs for hospital services have provided CMS analyses using hospital cost reports and all-payer claims databases. Others have relied on actuaries and outside consultants, who may use provider surveys, to produce an ACR analysis.

- **Plan more proactively for SDPs given CMS submission timeline requirements**: State legislation often requires Medicaid agencies to implement SDPs by a certain date, leaving little leeway for a thoughtful SDP strategy tied to meaningful quality measures and provider engagement. Because of that, states will frequently go back and update pre-print methodology and quality measures. CMS now requires that SDP pre-prints be submitted no later than the start date for the SDP, and states will have to submit a rate amendment and managed care contract reflecting the SDPs to CMS for approval.

- **Implement systems updates to enable provider-level reporting**: States often encounter long lead times for change orders with their Medicaid Management Information System (MMIS) vendors. As states implement SDPs, they will need to plan ahead to comply with provider-level reporting in the Transformed Medicaid Statistical Information System (T-MSIS).

Key SDP Actions for States

1. For SDPs that are not set at the Medicare payment rate for the minimum fee schedule, submit pre-prints/amendments and all associated documentation for approval no later than the pre-print/amendment start date.
2. Submit revised rate certification/amendments and managed care contracts no later than 120 days after the preprint start date or CMS approval, whichever is later.
3. For programs paying up to ACR, submit an ACR demonstration using CMS' parameters (must be specific to the state, no older than the three most recent and complete years, and specific to the services addressed by the SDP, excluding payments to federally qualified health centers and rural health clinics) and a total payment rate comparison.
4. Ensure all SDPs are built into the capitation rates.
5. Report provider-level payment details in T-MSIS.
6. Collect attestations from providers who would receive an SDP attesting that they do not participate in any hold harmless arrangements.

Medical Loss Ratio

CMS looks to align Medicaid managed care medical loss ratio (MLR) requirements with the private market and Medicare Advantage. CMS has issued guidance to further delineate acceptable costs in the MLR "numerator" and enhance transparency. The following complexities and challenges are anticipated:

- **Include SDPs within MLR calculations**: SDPs must be reported in MLR reporting. SDPs can be consolidated into a single line item, even if the state operates multiple SDPs.
- **Incorporate tighter managed care plan allocation within MLR calculations**: States must now include provider bonuses and incentives, overpayment reporting (required whether the amounts were recovered or not), and disallowed quality improvement activity expenses (cannot include direct or overhead costs). Managed care plans must now follow private market expense allocation requirements from 45 CFR 158.170(b) for Medicaid and CHIP lines of business.
- **Implement updates to MMIS systems and encounter data requirements to collect and report minimum data**: States should implement systems changes to enable CMS reporting on required elements such as provider, enrollee, and managed care plan identifiers, procedure and diagnosis codes, and allowable, billed, and paid amounts. States and managed care plans will require encounter system changes to report SDPs through T-MSIS.

Key Medical Loss Ratio Actions for States

1. Make annual MLR reporting changes to include SDP amounts in both the MLR numerator and the denominator.
2. Make annual summary MLR reporting changes to contractual and plan reporting requirements, including:
    a. SDP amounts in both MLR numerator and denominator
    b. New reporting of data to T-MSIS (or any successor format or system designated by CMS) specifying the total dollars expended by each managed care organization, prepaid inpatient health plan, and prepaid ambulatory health plan for SDPs that were in effect for the rating period, including amounts paid to individual providers

In Lieu of Services (ILOS)

The final rule builds on existing guidance from State Medicaid Director letters to promote fiscal protections and accountability of ILOS expenditures. As states continue to use ILOS as a pathway to address health-related social needs, they should:

- **Consider ILOS in the broader context of Medicaid benefits available**: The final rule requires that ILOS are considered approvable as a service or setting under the Medicaid state plan or a Medicaid Section 1915(c) waiver.
- **Develop more detailed documentation related to ILOS**: States will need to ensure that ILOS are included in the overall actuarial sound rate certification and that managed care plan reporting (based on SMD 23-001) is collected and submitted to CMS.
- **Provide detailed guidance for ILOS to managed care plans**: Whereas CMS required contract language and reporting to CMS for ILOS, states will need to outline more specific information such as definitions, covered service or setting, protections, and codes. All enrollee records, including plan of care and medical records, will also need to document how ILOS would address the enrollee's needs.

Key ILOS Actions for States

1. Submit a projected ILOS cost percentage to CMS as part of the rate certification, as well as a final ILOS cost percentage and summary of actual ILOS costs as a separate actuarial report concurrently with the rate certification.
2. Submit to CMS an evaluation of ILOS cost effectiveness and medical appropriateness, with a final cost percentage of greater than 1.5% of the capitation rate.
3. Develop a transition plan to arrange for state plan services upon termination of ILOS.
4. Update managed care contracts to document specific ILOS information.

Quality Strategy and External Quality Review

The final rule codifies leading practices among state Medicaid agencies and outlines CMS expectations shared through unofficial guidance related to the Medicaid Managed Care Quality Strategy and various external quality review (EQR) expectations. As states consider how to comply with these regulations, they should:

- **Assess the optimal approach for evaluating the Quality Strategy, SDPs, and ILOS**: States have the option to add a new EQR activity to support evaluation. States can choose to perform the evaluation themselves, use an agent that does not qualify as an external quality review organization (EQRO), or use an EQRO vendor. An EQRO is still needed to compile and write the final EQR report.

- **Require timelier EQRO activities**: Some state EQR reports take significant time to finalize and be made public, but now CMS is requiring that EQR-related activities be performed in the 12 months preceding the finalization and publication of the annual report.

Key Quality Strategy and External Quality Review Actions for States

1. Re-evaluate the Managed Care Quality Strategy at least every three years and allow public comment.
2. Exempt primary care case management from EQR requirements (an optional action) if desired.
3. Determine the 12-month review period for applicable EQR-related activities.
4. Update the EQRO contract to ensure that EQR-related activities are performed in the 12 months preceding annual report finalization.
5. Review and update EQRO contracts to require inclusion of additional data associated with performance measurement (such as percentages of enrollees who participated in the performance improvement plan, and patient satisfaction data based on plan services received) within the EQR reports as well as data from the network adequacy validation.

Quality Ratings System

The final rule issues guidance on how states must implement the Quality Ratings System (QRS) that establishes a "one-stop shop" where enrollees can access information about Medicaid and CHIP eligibility and managed care. States will need to consider the following complexities and challenges:

- **Align data elements collected from managed care plans and FFS with the required QRS measures**: Updating required measures and data collected from managed care plans, and writing programming to calculate measures, can require significant lead time. States should immediately start comparing the finalized guidance to the current measures to understand the new data elements required.

- **Design a section of the state Medicaid agency website to display the required information**: Given the level of detail and functionality required (such as stratification of quality ratings and ratings by managed care plan), states will need to engage their business enterprise and communications teams as soon as possible to design a QRS that meets CMS' timelines.

- **Consider alternate QRS approaches**: Many states already have existing scorecards that provide insights into managed care plan performance, and some are required to publish scorecard information based on legislative mandates. CMS allows for alternate QRS approaches, assuming the information would yield substantively comparable data when taking into account differences in covered populations, benefits, and stage of delivery system transformation. States wishing to use an alternate QRS approach should begin discussions with CMS and prepare a written request for CMS review and approval.

- **Prepare for an increase in agency expenditures**: QRS will require a number of additional steps for states to collect data that might be new for their program as well as to validate, summarize, and publicize this information to a detail that has not been previously required. States will likely need to modify vendor contracts to meet the new requirements, which will lead to increased agency expenditures.

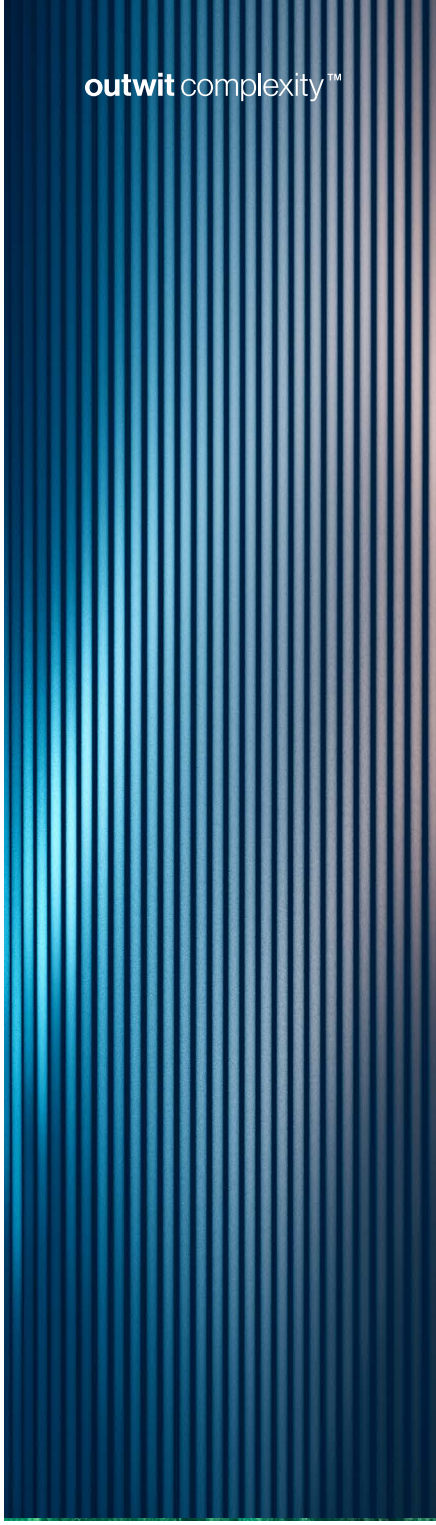
Guidehouse

outwit complexity™

Key Quality Rating System Actions for States

1. Establish an enrollee-facing web-based Medicaid and CHIP QRS that includes an interactive tool enabling users to view quality ratings stratified by different factors.
2. Collect and post on the website eligibility and managed care information from programs and managed care plans to enable comparison of managed care plans based on quality and other factors key to beneficiary decision-making, such as the plan's drug formulary and provider network.
3. Prepare announcements and trainings for enrollees on how to access, use, and understand the site.
4. Perform gap analysis to identify and then implement system changes to receive, store, and analyze data.
5. Identify data that must be collected from managed care plans, FFS, Medicare (for dually eligible beneficiaries), and other sources.
6. Validate data for quality ratings for each mandatory measure for each managed care plan annually.
7. Determine whether to conduct optional EQR activity and use EQRO to support the calculation and validation of quality ratings.
8. Decide whether to seek CMS approval for an alternate QRS methodology.
9. Determine whether to include additional measures beyond the mandatory minimum measure set (16) in the QRS.

Guidehouse is available to help states navigate these actions and related complexities.



Contact

Tamyra Porter, Partner
State Health
tporter@guidehouse.com

About Guidehouse

Guidehouse is a leading global provider of consulting services to the public sector and commercial markets, with broad capabilities in management, technology, and risk consulting. By combining our public and private sector expertise, we help clients address their most complex challenges and navigate significant regulatory pressures focusing on transformational change, business resiliency, and technology-driven innovation. Across a range of advisory, consulting, outsourcing, and digital services, we create scalable, innovative solutions that help our clients outwit complexity and position them for future growth and success. The company has more than 16,000 professionals in over 55 locations globally. Guidehouse is led by seasoned professionals with proven and diverse expertise in traditional and emerging technologies, markets, and agenda-setting issues driving national and global economies. For more information, please visit guidehouse.com.

guidehouse.com/industries/health/state-health

linkedin.com/showcase/guidehouse-health