CMS Medicaid Proposed Rules

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CMS's Proposed Rules: Overview

- Ensuring Access to Medicaid Services
  - Access to Medicaid services in fee-for-service (FFS)
  - Home and community-based services (HCBS)
  - Medicaid Advisory Committees
- Managed Care Access, Finance, and Quality
  - Access to Medicaid services in managed care and CHIP
  - Transparency
  - Addressing health-related social needs with In Lieu of Services and Settings (ILOS)
  - State Directed Payments (SDPs)
  - Medical Loss Ratio (MLR) and program integrity
  - Quality Rating System

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Access to Services

- Rescind and replace the FFS access monitoring review plan (AMRP) requirements for states with new requirements to analyze and publish:
  - Base payment rates of E&M codes for primary care, OB/GYN, and outpatient behavioral health services by comparing them to Medicare
  - Average hourly payment rates for certain providers of HCBS
- Advisory group on FFS rates for personal care, home health aide, and homemaker services, to be comprised of beneficiaries, providers, and other interested parties
- Publish and update all FFS Medicaid fee schedule rates on a publicly available and accessible state website
- New analysis process when states propose to reduce or restructure rates

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Home and Community-Based Services (HCBS)

- New reporting and transparency requirements
  - Waiting lists in waiver programs
  - Service timeliness for personal care, homemaker, and home health aide services
  - Standardized set of quality measures
- Require states to establish grievance systems in FFS Medicaid to ensure opportunities to file complaints on HCBS
- At least 80% of Medicaid payments for personal care, homemaker, and home health aide services must be spent on compensation for the direct care workforce (not administrative, overhead, or profit)

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Medicaid Advisory Committees (MAC)

- Renaming the “Medical Care Advisory Committees” to “Medicaid Advisory Committees” to focus on every aspect of Medicaid
- Require states to establish a Beneficiary Advisory Group (BAG) with crossover membership to the MAC (at least 25%)
  - People with lived experience, family members, caregivers, authorized representatives…etc.
  - Strengthen the role of the individual voice in the Medicaid program
- Make information on both groups’ activities publicly available, including an annual report

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Improving Access to Care in Managed Care

- Require states to develop and enforce maximum appointment wait time standards for routine outpatient services, both adult and pediatric (consistent with Marketplace plans)
  - Primary care = within 15 business days
  - OB/GYN = within 15 business days
  - Mental health and substance use disorder = within 10 business days
  - States pick one more category and standards
- Managed care plans must meet 90% compliance rate

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Improving Access to Care in Managed Care

- Use an independent entity to conduct an annual secret shopper survey to assess appointment wait time standards and provider directory accuracy and to identify and correct inaccuracies
  - Active network status
  - Street address
  - Telephone number
  - Whether accepting new enrollees
- Telehealth
  - Provider directories have to include information on whether each provider is offering covered services via telehealth
  - Appointments offered via telehealth would only be counted towards compliance with appointment wait times if the provider also offers in-person appointments
  - Telehealth visits offered during the secret shopper survey would be separately identified in the survey results

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Improving Access to Care in Managed Care

- Annual enrollee experience survey for each Medicaid managed care plan
- Annual state payment analysis of primary care, OB/GYN, mental health, substance use disorder, personal care, homemaker, and home health aide services
  - For primary care, OB/GYN, and MH and SUD: using E&M codes and comparing to Medicare
  - For HCBS services: using all codes and comparing to FFS Medicaid (because no E&M codes or comparable Medicare rates for these services)
- Require states to submit remedy plans to address access problems including specific steps, timeframes, and parties responsible to achieve improvement within 12 months

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Transparency & Terminology

- New requirements for States' websites
  - Enrollee handbooks, provider directories, and formularies
  - Information on rate ranges
  - Network adequacy standards
  - Secret shopper survey results
  - State directed payment evaluation reports
  - Links to all required Application Programming Interfaces (APIs)
  - Quality-related information
  - Documentation of compliance with the Mental Health Parity and Addiction Equity Act
- Terminology change from "behavioral health" to "mental health" and "substance use disorder"

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Quality Rating Systems

- Modify existing quality strategies and external quality review (EQR) requirements and increase public engagement around states' managed care quality strategies
- Establish a framework for Medicaid and CHIP quality rating system (MAC QRS)
  - Establish the MAC QRS website a "one-stop-shop" for beneficiaries to access information about Medicaid and CHIP eligibility and managed care, compare plans based on quality and other factors, and select a plan that meets their needs
  - Establish state requirements, including an initial set of mandatory measures, quality rating methodology and requirements for displaying information on the website

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Resources

- **Proposed Rule – Ensuring Access to Medicaid Services**: https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services
- **Proposed Rule – Managed Care Access, Finance, and Quality**: https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance
- CMS Fact Sheet on both rules: https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p
- CMS Fact Sheet on payment provisions in both rules: https://www.cms.gov/newsroom/fact-sheets/summary-medicaid-and-chip-payment-related-provisions-ensuring-access-medicaid-services-cms-2442-p
- CMS Fact Sheets on FFS Proposed Rule:
  - MAC & BAG: https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking-0
  - HCBS: https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking
- CMS Fact Sheet on Managed Care Proposed Rule: https://www.cms.gov/newsroom/fact-sheets/notice-proposed-rulemaking-medicaid-and-childrens-health-insurance-program-chip-managed-care-access

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