Issue Brief

FEDERAL ISSUE BRIEF

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CMS Issues Two Proposed Rules; Ensuring Access to Medicaid Services and Managed Care Access, Finance and Quality

The Centers for Medicare & Medicaid Services (CMS) issued two proposed rules regarding Ensuring Access to Medicaid Services and Managed Care, Access, Finance, and Quality. The proposals are intended "to increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid and CHIP programs."

Copies of the proposals are currently available at: https://public-inspection.federalregister.gov/2023-08959.pdf for the Ensuring Access to Medicaid Services and at: https://public-inspection.federalregister.gov/2023-08961.pdf for the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality proposal.

Both rules are schedule for publication on May 3. Both provide a 60-day comment period ending July 3, 2023.

Comment

We are reporting on both items inasmuch as there is much overlap in the proposals. The rules are lengthy. The Ensuring Access proposal is 410 pages while the Medicaid, CHIP and Managed Care Access is 501 pages.

While this analysis follows the material in the proposals, we are also using some verbiage from the several CMS fact sheets that have been issued regarding the proposals.

Provisions of the Proposed Regulations

Below are aspects of the Ensuring Access to Medicaid proposal

A. Medicaid Advisory Committee and Beneficiary Advisory Group (MCAC) (§ 431.12) (Page 24)

Current § 431.12 requires States to have a MCAC to advise the State Medicaid agency about health and medical care services.

The proposal seeks to: (1) address the gaps in the current regulations and (2) establish requirements to implement more effective advisory committees. States would select members in a way that reflects a wide range of Medicaid interested parties (covering a diverse set of populations and interests relevant to the Medicaid program), "place a special emphasis on the inclusion of the beneficiary perspective, and create a meeting environment where each voice is empowered to participate equally."
The proposed rule would change the MCAC structure and operations to support more meaningful and accessible engagement by all Committee members with a particular emphasis on Medicaid beneficiaries. If finalized, these provisions will:

- Rename and expand the scope and use of states' Medical Care Advisory Committees. States would be required to establish and operate the newly named Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG). The MAC and its corresponding BAG would serve as vehicles for two-way communication between interested parties and the state on topics related to the effective administration of the Medicaid program. The proposals in the proposed rule seek to expand the topics to

be addressed by the Committee beyond health and medical services to include policy development and effective program administration. The specific topics addressed by the MAC would be based on each state's needs and determined in collaboration with the MAC members.

- Establish minimum requirements for stakeholder representation on the MAC. The MAC would include representation from the BAG, and other interested parties, such as consumer advocacy groups, clinical providers or administrators, Medicaid managed care plans, and other state agencies serving Medicaid beneficiaries. States would select members in a way that reflects a wide range of their Medicaid stakeholders (i.e., covering a diverse set of populations and interests relevant to the Medicaid program), places a special emphasis on the inclusion of the Medicaid beneficiary perspective, and creates a meeting environment where each voice is empowered to participate equally.
- Require states to establish a beneficiary-only group with crossover membership with the MAC. Under the proposal, States would be required to establish the BAG, a standalone group, that will meet separately from the MAC. The BAG would include Medicaid beneficiaries, their family members, and/or their caregivers. At least 25% of the MAC membership would be reserved for BAG members.
- Promote transparency and accountability between the state and its stakeholders by making information on the MAC and BAG activities publicly available. In order to be responsive to the needs of its stakeholders, states need to be able to gather feedback from a variety of people that touch the Medicaid program. Under our proposal, the MAC and BAG will serve as the vehicle through which states can obtain this feedback. In turn, states will publicly share information about the feedback they receive. Specifically, states will post MAC and BAG membership lists, meeting schedules, meeting minutes, by-laws, recruitment processes, and an annual report on MAC activities on its website. The annual report will seek to both promote transparency and accountability at the state level by providing a public view into the impact of the MAC and BAG's feedback.

B. Home and Community-Based Services (HCBS) (Page 38)

CMS is proposing new Federal requirements "to improve access to care, quality of care, and health and quality of life outcomes; promote health equity for people receiving Medicaid-covered HCBS; and ensure that there are safeguards in place for beneficiaries who receive HCBS through Fee-for-Service (FFS) delivery systems."

If finalized, the HCBS requirements are intended to supersede and fully replace the reporting and performance expectations described in March 2014 guidance for section 1915(c) waiver programs.

Person-Centered Service Plans (42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c)) (Page 39)

The rule proposes that States report annually on the percent of beneficiaries continuously enrolled in the State's HCBS programs for 365 days or longer for whom a reassessment of functional need was completed within the past 12 months. States would also be required to report on the percent of beneficiaries continuously enrolled in the state's HCBS programs for 365 days or longer who had a service plan updated as a result of a re-assessment of functional need within the past 12 months. For both metrics, CMS proposes allowing states to report on a statistically valid random sample of beneficiaries, rather than for all individuals continuously enrolled in the State's HCBS programs for 365 days or longer. CMS proposed that these new performance levels and reporting requirements, if finalized, would be effective three years after the effective date of the final rule.

Grievance System (§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii)) (Page 49)

CMS proposes at § 441.301(c)(7) that States must establish a procedure under which a beneficiary can file a grievance related to the State's or a provider's compliance with the person-centered planning and service plan requirements at §§ 441.301(c)(1) through (3) and the HCBS settings requirements at §§ 441.301(c)(4) through (6).

Incident management system (§§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v)) (Page 59)

CMS proposes a new requirement at § 441.302(a)(6) to require that States provide an assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

CMS proposes to require that States report every 24 months on the results of an incident management system assessment to demonstrate that they meet the new proposed incident management system requirements.

CMS proposes that these requirements would be effective three years after the effective date of the final rule.

HCBS Payment Adequacy (§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi)) (Page 72)

CMS proposes to require that at least 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to the following services be spent on compensation to direct care workers: homemaker services, home health aide services, and personal care services.

CMS is proposing to require states to publish, every other year, the average hourly rate paid to direct care workers delivering these services.

Supporting documentation required (§ 441.303(f)(6)) (Page 83)

CMS proposes to require information from States on waiting lists to improve public transparency and processes related to States' HCBS waiting lists and ensure that CMS is able to adequately oversee and monitor States' use of waiting lists in their section 1915(c) waiver programs.

Home and Community-Based Services (HCBS) Quality Measure Set (§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)) (Page 103)

CMS is proposing to add a new section, at § 441.312, Home and Community-Based Services Quality Measure Set, to require use of the measure set in 1915(c) waiver programs and promote public transparency related to the administration of Medicaid-covered HCBS.

In proposed § 441.312(f), States would be required to provide stratified data for 25% of the measures in the HCBS Quality Measure Set for which the Secretary has specified that reporting should be stratified by 3 years after the effective date of these regulations, 50% of such measures by 5 years after the effective date of these regulations, and 100% of measures by 7 years after the effective date of these regulations.

Website Transparency (§§ 441.313, 441.486, 441.595, and 441.750) (Page 114)

CMS is proposing to add a new section, at § 441.313, titled Website transparency, to promote public transparency related to the administration of Medicaid-covered HCBS.

CMS is proposing to provide States until the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule to implement these requirements.

Documentation of access to care and service payment rates (§ 447.203) (Page 118)

CMS proposes to rescind and replace the access monitoring review plan (AMRP) requirements currently in § 447.203(b)(1) through (8) with a streamlined and standardized process, described in proposed § 447.203(b) and (c).

Payment Rate Transparency (§ 447.203(b)) (Page 123)

CMS proposes to rescind § 447.203(b) in its entirety and replace it with new requirements to ensure FFS Medicaid payment rate adequacy, including a new process to promote payment rate transparency. This new proposed process would require States to publish their FFS Medicaid payment rates in a clearly accessible, public location on the State's website. Then, for certain services, States would be required to conduct a comparative payment rate analysis between the States' Medicaid payment rates and Medicare rates, or provide a payment rate disclosure for certain HCBS that would permit CMS to develop and publish HCBS payment benchmark data.

CMS proposes the initial publication of Medicaid FFS payment rates would occur no later than January 1, 2026, and include approved Medicaid FFS payment rates in effect as of that date, January 1, 2026. CMS proposes this timeframe to provide States with at least 2 years from the possible effective date of the final rule, if this proposal is finalized, to comply with the payment rate transparency requirement.

State Analysis Procedures for Rate Reduction or Restructuring (§ 447.203(c)) (Page 208)

In § 447.203(c), CMS proposes a process for State access analyses that would be required whenever a State submits a state plan amendment (SPA) proposing to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, regardless of the provider payment rates or levels of access to care before the proposed reduction or restructuring.

CMS notes that Medicaid benefits that do not have a reasonably comparable Medicare covered analogue, and for which a State proposes a payment rate reduction or payment restructuring in circumstances when the changes could result in diminished access, would be subject to the expanded review criteria proposed in § 447.203(c)(2), because the State would be unable to demonstrate its Medicaid payment rates are at or above 80% of Medicare payment rates for the same or a comparable set of Medicare-covered services after the payment rate reduction or payment restructuring in circumstances when the changes could result in diminished access.

In § 447.203(c)(1)(ii), CMS proposes that the State would be required to provide a supported assurance that the proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the State fiscal year, would result in no more than a 4% reduction in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a single State fiscal year.

In § 447.203(c)(2)(iv), CMS is proposing to require States to provide information about the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring.

C. Collection of Information Requirements (Page 246)

Comment

This section of the proposal extends nearly 100 pages. We normally do not discuss this material. However, the extreme length here suggests a need for readers to review.

Below are aspects of the Managed Care Access Finance and Quality proposal

As of September 2022, the Medicaid program provided essential health care coverage to more than 83 million individuals, and, in 2020, had annual outlays of more than $671 billion. In 2021, the Medicaid program accounted for 17% of national health expenditures. In 2020, 72% of Medicaid beneficiaries were enrolled in comprehensive managed care.

This proposed rule would advance CMS' efforts to improve access to care, quality and health outcomes, and better address health equity issues for Medicaid and Children's Health Insurance Program (CHIP) managed care enrollees. The proposal would specifically address standards for timely access to care and States' monitoring and enforcement efforts, reduce burden for some State directed payments and certain quality reporting requirements, add new standards that would apply when States use in lieu of services and settings (ILOSs) to promote effective utilization and specify the scope and nature of ILOS, specify medical loss ratio (MLR) requirements, and establish a quality rating system for Medicaid and CHIP managed care plans.

1. Access (Page 14)

a. Enrollee experience surveys (§§ 438.66(b) and (c), 457.1230(b)) (Page 15)

To ensure that States have data from an enrollee experience survey to include in their monitoring activities and improve the performance of their managed care programs, CMS proposes to revise § 438.66(c)(5) to require that States conduct an annual enrollee experience survey.

b. Appointment wait time standards (§§ 438.68(e), 457.1218) (Page 20)

CMS proposes to redesignate existing § 438.68(e) regarding publication of network adequacy standards to § 438.68(g) and create a new § 438.68(e) titled "Appointment wait time standards" for routine primary care (adult and pediatric), obstetric/gynecological services, outpatient mental health and substance use disorder services (adult and pediatric), and a state-selected service (adult and pediatric if appropriate).
CMS proposes maximum appointment wait times at § 438.68(e)(1): State developed appointment wait times must be no longer than 10 business days for routine outpatient mental health and substance use disorder appointments in § 438.68(e)(1)(i) and no longer than 15 business days for routine primary care in § 438.68(e)(1)(ii) and OB/GYN appointments in § 438.68(e)(1)(iii). CMS is not proposing a maximum appointment wait time standard for the State-selected provider type.

CMS proposes to revise the existing applicability date in § 438.206(d) for Medicaid, which is applicable for separate CHIPs through an existing cross-reference at § 457.1230(a) and a proposed cross-

reference at § 457.1200(d), to reflect that States would have to comply with § 438.206(c)(1)(i) no later than the first managed care plan rating period that begins on or after 4 years after the effective date of the final rule. (Page 26)

CMS proposes several revisions: to redesignate § 438.68(e) to § 438.68(g); to replace "and" with a comma after "(b)(1);" add "(b)" before "(2)" for clarity; and add a reference to (e) after "(b)(2)." CMS says it believes these changes make the sentence clearer and easier to read. Lastly, § 438.68(e) currently includes "…the Web site required by § 438.10." For additional clarity in redesignated § 438.68(g), CMS proposes to replace "438.10" with "§ 438.10(c)(3)" to help readers more easily locate the requirements for State websites. These proposed changes apply equally to separate CHIP managed care through existing cross references at §§ 457.1218 and 457.1207.

c. Secret shopper surveys (§§ 438.68(f), 457.1207, 457.1218) (Page 31)

CMS proposes a new § 438.68(f), and proposes to require that States use independent entities to conduct annual secret shopper surveys of managed care plan compliance with appointment wait time standards proposed at § 438.68(e) and the accuracy of certain data in all managed care plans' electronic provider directories required at § 438.10(h)(1).

CMS proposes to consider an entity to be independent of the State if it is not part of the State Medicaid agency and, at § 438.68(f)(3)(ii), to consider an entity independent of a managed care plan subject to a secret shopper survey if the entity is not an Managed Care Organization (MCO), Inpatient Health Plan (PIHP), or prepaid ambulatory health plan (PAHP); is not owned or controlled by any of the MCOs, PIHPs, or PAHPs subject to the surveys; and does not own or control any of the MCOs, PIHPs, or PAHPs subject to the surveys.

CMS also proposes to require States to use secret shopper surveys to determine the accuracy of certain provider directory information in MCOs', PIHPs', and PAHPs' most current electronic provider directories at § 438.68(f)(1)(i).

d. Assurances of adequate capacity and services- Provider payment analysis (§§ 438.207(b), 457.1230(b)) (Page 41)

CMS proposes to require an annual payment analysis that managed care plans would submit to States per § 438.207(b)(3) and States would review and include in the assurance and analysis to CMS per § 438.207(d).

CMS proposes to revise § 438.207(f) to reflect that States would have to comply with § 438.207(b)(3) no later than the first rating period that begins on or after 2 years after the effective date of the final rule

e. Assurances of adequate capacity and services reporting (§§ 438.207(d), 457.1230(b)) (Page 47)

CMS proposes to revise § 438.207(d) to explicitly require States to include the results from the secret shopper surveys proposed in § 438.68(f).

CMS proposes to explicitly require that States submit their assurance of compliance and analyses required in § 438.207(d) in a "format prescribed by CMS."

f. Remedy plans to improve access (§ 438.207(f)) (Page 51)

CMS proposes to redesignate existing § 438.207(f) as § 438.207(g) and propose a new requirement for States to submit remedy plans in new § 438.207(f), titled Remedy plans to improve access. In § 438.207(f)(1), CMS proposes that when the State, MCO, PIHP, PAHP, or CMS identifies an issue with a managed care plan's performance with regard to any State standard for access to care under this part, including the standards at §§ 438.68 and 438.206, States would follow the steps set forth in paragraphs (i) through (iv).

First, in paragraph (1)(i), States would have to submit to CMS for approval a remedy plan no later than 90 calendar days following the date that the State becomes aware of an MCO's, PIHP's, or PAHP's access issue. In § 438.207(f)(1)(ii), CMS proposes that the State would have to develop a remedy plan to address the identified issue that if addressed could improve access within 12 months and that identifies specific steps, timelines for implementation and completion, and responsible parties.

In § 438.207(f)(1)(ii), CMS proposes some approaches that States could consider to address the access issue, such as increasing payment rates to providers, improving outreach and problem resolution to 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.

CMS proposes in § 438.207(f)(1)(iii) to require States to ensure that improvements in access are measurable and sustainable.

In paragraph (f)(1)(iv) CMS proposes that States submit quarterly progress updates to CMS on implementation of the remedy plan so that CMS would be able to determine if the State was making reasonable progress toward completion and that the actions in the plan are effective.

g. Transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285) (Page 54)

At § 438.10(c)(3)(ii), CMS proposes to require that States' websites use clear and easy to understand labels on documents and links so that users can easily identify the information contained in them.

Currently § 438.602(g) specifies four types of information that States must post on their websites; CMS proposes to add nine more as (g)(5) through (g)(13): (5) enrollee handbooks, provider directories, and formularies required at § 438.10(g), (h), and (i); (6) information on rate ranges required at § 438.4(c)(2)(iv); (7) reports required at §§ 438.66(e) and 438.207(d); (8) network adequacy standards required at § 438.68(b)(1) and (2), and (e); (9) secret shopper survey results required at § 438.68(f); (10) State directed payment evaluation reports required in § 438.6(c)(2)(v)(C); (11) links to all required Application Programming Interfaces including as specified in § 431.60(d) and (f); (12) quality related information required in §§ 438.332(c)(1), 438.340(d), 438.362(c) and 438.364(c)(2)(i); and (13) documentation of compliance with requirements in subpart K - Parity in Mental Health and Substance Use Disorder Benefits.

CMS proposes to add § 438.602(j) to require States to comply with § 438.602(g)(5) through (13) no later than the first managed care plan rating period that begins on or after 2 years after the effective date of the final rule.

h. Terminology (§§ 438.2, 438.3(e), 438.10(h), 438.68(b), 438.214(b)) (Page 61)

CMS proposes to replace "behavioral health" with "mental health and substance use disorder." CMS also proposes to change "psychiatric" to "mental health" in § 438.3(e)(2)(v) and § 438.6(e).

2. State Directed Payments (SDP) (42 CFR 438.6, 438.7, 430.3) (Page 62)

As the volume of SDP preprint submissions and total dollars flowing through SDPs continues to increase, CMS recognizes the importance of ensuring that SDPs are contributing to Medicaid quality goals and objectives as part of the review process, as well as ensuring that SDPs are developed and implemented with appropriate fiscal and program integrity guardrails.

The proposed changes in this notice of proposed rulemaking are intended to ensure the following policy goals:

- *Medicaid managed care enrollees receive access to high-quality care under SDP payment arrangements;*
- *SDPs are appropriately linked to Medicaid quality goals and objectives for the providers participating in the SDP payment arrangements; and*
- *CMS and States have the appropriate fiscal and program integrity guardrails in place to strengthen the accountability and transparency of SDP payment arrangements.*

A more detailed outline of the remaining parts of this section are provided below*:*

- *Contract Requirements Considered to be SDPs (Grey Area Payments)* (Page 69)
- *Medicare Exemption, SDP Standards and Prior Approval (§ 438.6(c)(1)(iii)(B), (c)(2), and (c)(5)(iii)(A)(5))* (Page 73)
- *Non-Network Providers (§ 438.6(c)(1)(iii))* (Page 78)
- *SDP Submission Timeframes (§ 438.6(c)(2)(viii) and (ix))* (Page 80)
- *Standard for Total Payment Rates for each SDP, Establishment of Payment Rate Limitations for certain SDPs and Expenditure Limit for All SDPs (§ 438.6(c)(2)(ii)(I) and (c)(2)(iii))* (Page 87)
- *Financing (§ 438.6(c)(2)(ii)(G) and (H))* (Page 117)
- *Tie to Utilization and Delivery of Services for Fee Schedule Arrangements (§ 438.6(c)(2)(vii))* (Page 133)
- *Value-Based Payments and Delivery System Reform Initiatives (§ 438.6(c)(2)(vi))* (Page 140)
- *Quality and Evaluation (§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7))* (Page 151)
- *Contract Term Requirements (§ 438.6(c)(5))* (Page 164)
- *Including SDPs in Rate Certifications and Separate Payment Terms (§§ 438.6(c)(2)(ii)(J), (c)(6), and 438.7(f))* (Page 169)

- *SDPs included through Adjustments to Base Capitation Rates (§ 438.7(c)(4) through (6)* (Page 187)
- *Appeals (§ 430.3(d))* (Page 188)
- *Reporting Requirements to Support Oversight (§ 438.6(c)(4))* (Page 194)
- *Applicability Dates (§ 438.6(c)(4), 438.6(c)(8), and 438.7(g)(2) and (3))* (Page 200)

3. Medical Loss Ratio (MLR) Standards (§§ 438.8, 438.3, and 457.1203) (Page 202)

a. Standards for Provider Incentives (§§ 438.3(i), 438.8(e)(2), 457.1201, and 457.1203) (Page 204)

In a new § 438.3(i)(3) and (4) for Medicaid, and included in separate CHIP regulations through an existing cross-reference at § 457.1201(h), CMS proposes to require that the State, through its contract(s) with a managed care plan, must include specific provisions related to provider incentive contracts. Specifically, the proposed changes would require in § 438.3(i)(3)(i) and (ii) that incentive payment contracts between managed care plans and network providers have a defined performance period that can be tied to the applicable MLR reporting period(s), and such contracts must be signed and dated by all appropriate parties before the commencement of the applicable performance period.

CMS also proposes, in § 438.3(i)(3)(iii), that all incentive payment contracts must include well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment. In addition, in § 438.3(i)(3)(iv), CMS proposes that incentive payment contracts must specify a dollar amount that can be clearly linked to successful completion of these metrics as well as a date of payment.

In § 438.3(i)(4)(ii), CMS proposes that the State must prohibit managed care plans from using attestations as documentation to support the provider incentive payments. In § 438.3(i)(4)(iii), CMS proposes that the State's contracts require that managed care plans must make the incentive payment contracts and supporting documentation available to the State both upon request and at any routine frequency that the State establishes.

CMS proposes in § 438.8(e)(2)(iii)(A) for Medicaid, which is included in separate CHIP regulations through an existing cross-reference at § 457.1203(c), to require that for a provider bonus or incentive payment to be included in the MLR numerator, the provider bonus or incentive arrangement would have to require providers to meet clearly-defined, objectively measurable, and well documented clinical or quality improvement standards to receive the bonus or incentive payment.

b. Prohibited Costs in Quality Improvement Activities (§§ 438.8(e)(3) and 457.1203(c)) (Page 210)

CMS proposes to amend § 438.8(e)(3)(i) for Medicaid, which is included in separate CHIP regulations through an existing cross-reference at § 457.1203(c), to add a reference to the Marketplace regulation that prohibits the inclusion of overhead or indirect expenses that are not directly related to health care quality improvement.

c. Additional Requirements for Expense Allocation Methodology (§§ 438.8(k)(1)(vii) and 457.1203(f)) (Page 211)

CMS proposes that States and managed care plans would be required to comply with these requirements 60 days after the effective date of this final rule as CMS believes these proposals are critical for fiscal integrity in Medicaid and CHIP.

4. In Lieu of Services and Settings (ILOSs) (§§ 438.2, 438.3, 438.7, 438.16, 438.66, 457.1201, 457.1207) (Page 226)

Overview of ILOS requirements (§§ 438.2, 438.3(e), 438.16, 457.1201(e))

ILOSs are utilized by States and their managed care plans to strengthen access to, and availability of, covered services and settings, or reduce or prevent the need for covered services and settings.

To ensure clarity on the use of the term "in lieu of service or setting" and the associated acronym "ILOS," CMS proposes to add a definition in § 438.2 for Medicaid to define an "in lieu of service or setting (ILOS)" as a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State plan in accordance with § 438.3(e)(2) and acknowledge that an 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.

CMS proposes to create a new § 438.16 titled ILOS requirements for Medicaid, and proposes to amend § 457.1201(c) and (e) to include cross-references to § 438.16 to adopt for separate CHIP. (Page 229)

CMS proposes to limit allowable ILOS costs to a portion of the total costs for each managed care program that includes ILOS(s), hereinafter referred to as an ILOS cost percentage. CMS says it believes 5% is a reasonable limit on ILOS expenditures because it is high enough to ensure that ILOSs would be used effectively to achieve their intended purpose, but still low enough to ensure appropriate fiscal safeguards. (Page 235)

Applicability Dates (§§ 438.3(e), 438.7(g), 438.16(f), 457.1200(d)) (Page 270)

CMS proposes that States and managed care plans would be required to comply with the provisions outlined in §§ 438.2, 438.3(c)(1)(ii) and (e)(2)(i) through (iv), 438.10(g)(2)(ix), 438.66(e)(2)(vi) and applicable cross-references for separate CHIP at §§ 457.10, 457.1201(c) and (e), and 457.1207 no later than the effective date of the final rule.

Comment

This is an extensive section spanning some 50 pages.

5. Quality Assessment and Performance Improvement Program (QAPI), State Quality Strategies and External Quality Review (§§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250) (Page 270)

a. Quality assessment and performance improvement program (§ 438.330)

CMS is proposing that States must comply with the update in § 438.330(d)(4) no later than the rating period for contracts beginning after the effective date of the final rule in the applicability date provision at § 438.310(d)(1).

b. Managed Care State Quality Strategies (§§ 438.340, 457.1240) (Page 272)

Current regulations at § 438.340(c) require States to make their quality strategy available for public comment when drafting or revising it, and require States to submit their initial quality strategy to CMS for feedback prior to adopting in final. These regulations also stipulate that States must review and update their quality strategy as needed, but no less than once every three years and submit the Strategy to CMS whenever significant changes are made to the document or whenever significant changes occur within the State's Medicaid program.

CMS is proposing that States must comply with these updates in § 438.340 no later than 1 year from the effective date of the final rule, and is proposing to codify this applicability date at § 438.310(d)(2) for Medicaid, and through a proposed amendment at § 457.1200(d) to include a cross-reference to § 438.310(d) for separate CHIP.

c. External Quality Review (§§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250) (Page 275)

Current regulations at §§ 438.350, 438.354, 438.358, 438.360, 438.364, and 457.1250 provide requirements for the annual External Quality Review (EQR) on quality, timeliness, and access to the health care services furnished to Medicaid and CHIP beneficiaries enrolled in managed care.

CMS is proposing several changes to the EQR regulations that seek to accomplish two overarching goals: (1) eliminate unnecessary burdensome requirements; and (2) make EQR more meaningful for driving quality improvement.

6. Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240) (Page 289)

CMS is proposing to create a new subpart G in 42 CFR part 438 to implement the Medicaid and CHIP Managed Care (MAC) quality rating system (QRS) framework required under § 438.334 of the current regulations and establish the standards which States must meet for CMS to approve adoption of an alternative QRS and related requirements. Existing regulations at § 438.334 are redesignated to newly-created proposed sections in Subpart G with proposed revisions. (Page 295)

Comment

This is another extensive section extending 75 pages. Perhaps the most helpful item is the proposal's table 1 starting on page 308. This table identifies an initial set of 18 mandatory measures that represents the collective input CMS received during prior consultations.

Fact Sheet Table

The following table is from one of the several fact sheets CMS issued supporting these two proposals. They succinctly identify the regulatory revisions being proposed.

Topic:	**NPRM Proposes to:**	**Applicability and Compliance Deadline Dates**
Access		
	Establish **maximum appointment wait time standards** for routine primary care (adult and pediatric), obstetric/gynecological services, outpatient mental health and substance use disorder services (adult and pediatric), and a state-selected service (adult and pediatric if appropriate).	By the first rating period beginning on or after 3 years after the effective date of the final rule.
	Require states 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 to identify errors as well as providers that do not offer appointments.	By the first rating period beginning on or after 4 years after the effective date of the final rule.
	Require states to **conduct an annual enrollee experience survey** for each Medicaid managed care plan.	By the first rating period beginning on or after 3 years after the effective date of the final rule.
	Require states to **submit an annual payment analysis** that compares managed care plans' payment rates for certain services as a proportion of Medicare's payment rate and, for certain home and community-based services, the state's Medicaid state plan payment rate.	By the first rating period beginning on or after 2 years after the effective date of the final rule.
	Require states to **implement a remedy plan** for any managed care plan that has an access issue that needs improvement.	By the first rating period beginning on or after 4 years after the effective date of the final rule.
	Require states **to maintain a single web page that is readily identifiable to the public**, easy to use, and contains required information for public transparency.	By the first rating period beginning on or after 2 years after the effective date of the final rule.
Medicaid State Directed Payments (SDPs)	Note: The applicability and compliance dates noted below for SDPs are based on the rating period approved in the SDP, not the date of preprint submission.	
	Remove unnecessary regulatory barriers to help states use state directed payments to implement value-based payment arrangements and include non-network providers in state directed payments.	By the first rating period beginning on or after the effective date of the final rule.
	Eliminate written prior approval for state directed payments that are minimum fee schedules at the Medicare payment rate and include non-network providers in state directed payments.	By the effective date of the final rule.
	Require that provider payment levels for inpatient and outpatient hospital services, nursing facility services, and the professional services at an academic medical center **not exceed the average commercial rate**.	By the first rating period after the effective date of the final rule. Note: CMS is proposing to codify our current operational practice.
	Require states to **condition state directed payment fee schedule payments upon the delivery of services** within the contract rating period and prohibit the use of post-payment reconciliation processes.	By the first rating period beginning on or after 2 years after the effective date of the final rule.
	Require states to **report to CMS the total dollars expended** for each state directed payment.	By the first rating period following the release of reporting instructions by CMS.
	Require states to **submit state directed payment evaluations every three years if the SDP costs** (as a percentage of total capitation payments) exceed 1.5%.	Evaluation plans will have to comply with the proposed standards by the first rating period

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		beginning on or after 3 years after the effective date.
	Establish a process for states to **appeal state directed payment disapprovals to the Department Appeals Board**.	By the effective date of the final rule.
	Require that states **comply with all federal laws concerning funding sources** of the non-federal share as a condition of state directed payment approval.	By the effective date of the final rule.
	Require that states **ensure each provider receiving a state directed payment attest** that it does not participate in any arrangement that holds taxpayers harmless for the cost of a tax in violation of federal requirements.	By the first rating period beginning on or after 2 years after the effective date of the final rule.
Medical Loss Ratio		
	Require Medicaid managed care plans **to submit actual expenditures and revenues for state directed payments** as part of their medical loss ratio reports to states, and require states to submit these amounts as separate line items in their annual medical loss ratio summary reports to CMS.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Specify when managed care plans are required to **resubmit medical loss ratio reports to states**.	Sixty (60) days after the effective date of the final rule.
	Specify that states **must provide medical loss ratios** for each managed care plan.	Sixty (60) days after the effective date of the final rule.
	Make **technical revisions for quality improvement expenditures**, provider incentive payments, and expense allocation reporting to align with recent regulatory changes for Marketplace plans.	Sixty (60) days after the effective date of the final rule.
	Require managed care plans to **report any identified or recovered overpayments to states** within 10 business days.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
In Lieu of Service and Setting (ILOS)		
	Specify that ILOSs can be used as immediate or longer-term substitutes for a covered service or setting under the state plan, including an acute care episode, or when the ILOSs can be expected to **reduce or prevent the future need for such service or setting to better support HRSNs** (e.g., certain allowable housing and nutritional supports that are medically appropriate and cost effective).	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Require that an ILOS be **considered approvable as a service or setting** through the Medicaid state plan or a Medicaid section 1915(c) waiver.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Require specific information to **be documented in managed care plan contracts** for each ILOS.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Require additional documentation from states on their processes to determine an ILOS medically appropriate and cost effective if the ILOS costs (as a percentage of total capitation payments) exceed 1.5%.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Impose a limit of five percent on total ILOS costs as a percentage of total capitation payments for each program.	By the first rating period beginning on or after 60 days following the effective date of the final rule.

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	Require 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%.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
	Require states to develop a transition plan to arrange for state plan services and settings to be provided timely if an ILOS will be terminated.	By the first rating period beginning on or after 60 days following the effective date of the final rule.
Quality: Quality Strategy and External Quality Review (EQR)		
	Increase public engagement around states' managed care quality strategies.	One year following the effective date of the final rule.
	Eliminate EQR requirements from PCCM providers.	The effective date of the final rule.
	Make it easier for states to use accreditation reviews for EQR.	The effective date of the final rule.
	Establish consistent 12-month review periods for the annual EQR activities to ensure the reports contain the most recent data and information.	By December 31, 2025.
	Establish that each state's annual EQR report be submitted to CMS by December 31.	By December 31, 2025.
	Require more meaningful data and information to be included in the annual EQR reports.	No later 1 year from the issuance of the associated protocol.
Quality: Medicaid and CHIP Quality Rating System (MAC QRS)		
	Establish the **MAC QRS website as a state's "one-stop-shop" where beneficiaries 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.	States would be required to implement the website and publish certain information on it by the end of the fourth calendar year following the effective date of the final rule.
	Establish the **MAC QRS framework and state requirements for the MAC QRS** (including an initial set of mandatory measures for the quality ratings), and the process by which the mandatory measures would be updated in the future.	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.
	Establish the **methodology for calculating the quality ratings displayed** on each state's MAC QRS.	The effective date of the final rule and applied beginning with the first set of ratings under these rules.
	Broaden flexibility for states to implement an alternative QRS.	The effective date of the final rule.
Children's Health Insurance Program		
	Require separate CHIPs to **align with Medicaid on most proposed provisions related to access**, ILOS, medical loss ratio, and quality.	Aligns with proposed Medicaid applicability dates.