Sellers Dorsey Summary - Key Provisions:

# CMS Final Medicaid Managed Care Rule (CMS-2439-F)

sellers dorsey
realize the opportunity.

# EXECUTIVE SUMMARY

On April 22, 2024, the Centers for Medicare & Medicaid Services (CMS) released for public inspection a final rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. The final rule will be published in the Federal Register on May 10, 2024. In the unlikely event CMS makes changes to the final rule published on May 10, Sellers Dorsey will reissue this document with updates. Building on the access and quality standards established in the 2016 and 2020 managed care final rules and informed by the results of a 2022 request for information related to access, the final rule adopts new standards for access to care for services delivered through a managed care model, and new and enhanced requirements related to program quality and finance. CMS largely adopted the rules as proposed, with key revisions to state directed payment and quality provisions based on its request for public comment. Effective dates vary, with some provisions applicable on the effective date of the rule (July 9, 2024), and other provisions with longer implementation periods.

The proposed rule was published in the Federal Register on May 3, 2023. CMS accepted public comment on the proposed rulemaking through July 3, 2023. CMS received a total of 415 timely comments, including comments from nineteen state Medicaid agencies and numerous managed care organizations, hospital systems, providers, and other stakeholders. In their comments, many stakeholders requested additional time, resources, and flexibility to comply with the rule.

Of note, CMS simultaneously released a companion final rule, "Medicaid Program; Ensuring Access to Medicaid Services," addressing broader topics related to access in Medicaid, including new requirements around home- and community-based services (HCBS) and rate transparency. Sellers Dorsey is creating a separate summary of the access rule, coming soon.

# KEY PROVISIONS IN THE FINAL RULE INCLUDE

## ACCESS

| PROPOSED | FINAL |
| --- | --- |
| Requires states to conduct annual enrollee experience surveys. | Requires states to conduct annual enrollee experience surveys. |
| Sets appointment time standards for certain services, including outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology, and one additional service to be defined by the state. | Sets appointment time standards for certain services, including outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology, and one additional service to be defined by the state. |
| Requires states to use independent "secret shoppers" to validate provider networks. | Requires states to use independent "secret shoppers" to validate provider networks. |
| Requires states to conduct an analysis comparing managed care plan payment rates for outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology to Medicare rates for the same services. | Requires states to conduct an analysis comparing managed care plan payment rates for outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology to Medicare rates for the same services. |
| Requires states to conduct an analysis comparing managed care plan payment rates for homemaker services, home health aide services, and personal care services to fee-for-service (FFS) rates for the same services. | Requires states to conduct an analysis comparing managed care plan payment rates for homemaker services, home health aide services, personal care services, and habilitation services to fee-for-service (FFS) rates for the same services. |

## STATE DIRECTED PAYMENTS (SDPs)

### PROPOSED

Proposes limits on total SDP program payments and seeks comment on the level of this cap and how it would be calculated.

Codifies guidance related to provider taxes and hold harmless arrangements from CMS' February 2023 informational bulletin.

Requires new reporting and evaluation plans for SDPs.

Proposes states require an average commercial rate (ACR) demonstration specific to the type of service, but not specific to the provider class and the use of ACR as upper limit for four service areas.

Requires states to submit SDP preprints for approval no later than 90 days before the end of the rating period.

### FINAL

- Does NOT include a total expenditure limit for SDPs
- Requires that all SDPs be incorporated into Medicaid managed care capitation rates as adjustments to base capitation rates and prohibits use of separate payment terms.
- Prohibits plans from basing interim payments to a provider on historic utilization with a post-payment reconciliation to utilization during the rating period.
- Removes prior written approval requirement for SDPs that adopt a fee schedule of 100% Medicare rates.
- Requires states to submit SDP preprints and all required documentation no later than the start date specified in the preprint.

Sets an SDP total payment rate limit up to the ACR, for four services:

- Inpatient hospital services
- Outpatient hospital services
- Qualified practitioner services at an academic medical center
- Nursing facility services

Exempts states from submitting evaluation reports for SDPs with final cost percentage below 1.5 percent.

Requires providers to attest that they do not participate in any hold harmless arrangement for any health-related tax, and requires states to make written attestations available upon CMS request or provide satisfactory explanation for why providers are unable/unwilling to provide attestation.

Requires SDPs to have an evaluation plan that includes at least two metrics, including one performance metric.

Cannot be pay-for-reporting.

- Evaluation plan must include baseline statistics on all metrics and include performance targets, including one that is calculated as performance over a baseline.
- Initial evaluation report must include three most recent and complete years of annual metric results and be submitted no later than 2 years after the 3-year evaluation period (First submitted in year 5).

Approval in other years will be based on the evaluation plan and meeting the other SDP requirements in the rule.

Specifies that SDPs using population-based or condition-based payment (PMPMs) must use attribution methodology with data no more than 3 years old, accounts for member preference, and described when and how patients/panels are attributed.

## MEDICAL LOSS RATIO (MLR) STANDARDS

**PROPOSED**

Requires Medicaid managed care plans to submit actual expenditures and revenues for SDPs as part of their MLR reports to states, and requires states to submit these amounts as separate line items in their annual MLR summary reports to CMS.

Specifies when managed care plans are required to resubmit reports to states.

Requires managed care plans to report any identified or recovered overpayments to states within 10 business days.

Requires states to provide MLRs for each plan.

**FINAL**

Requires Medicaid managed care plans to submit actual expenditures and revenues for SDPs as part of their MLR reports to states.

Requires managed care plans to report any identified or recovered overpayments to states within 30 calendar days.

Requires states to annually submit a summary MLR report for each MCO, PIHP and PAHP under contract that includes at a minimum: the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each plan for the MLR reporting year.

Provides additional flexibility to allow incentive payment contracts between plans and providers to be based on a percentage of a verifiable dollar amount or specific dollar amount.

## IN LIEU OF SERVICES (ILOS)

**PROPOSED**

Formalizes CMS' previous ILOS guidance from State Medicaid Director Letter #23-001

Defines and provides key principles around ILOS. ILOS must:

- Meet general parameters, including appropriately documented in managed care plan contracts and considered in the development of capitation rates;
- Be provided in a manner that preserves enrollee rights and protections;
- Be medically appropriate and cost-effective substitutes for state plan services and settings;
- Be subject to monitoring and oversight; and
- Undergo a retrospective evaluation, when applicable (i.e., if the final ILOS cost percentage exceeds 1.5%)

Requires state actuary to calculate both a projected ILOS cost percentage and a final ILOS cost percentage.

Requires states to identify specific codes and modifiers for each ILOS and provide them to managed care plans.

**FINAL**

Formalizes CMS' previous ILOS guidance from State Medicaid Director Letter #23-001

Defines and provides key principles around ILOS. ILOS must:

- Meet general parameters, including appropriately documented in managed care plan contracts and considered in the development of capitation rates;
- Be provided in a manner that preserves enrollee rights and protections;
- Be medically appropriate and cost-effective substitutes for State Plan services and settings;
- Be subject to monitoring and oversight; and
- Undergo a retrospective evaluation, when applicable (i.e., if the final ILOS cost percentage exceeds 1.5%)

Removes language related to SDPs that are paid as separate terms from the projected and final ILOS cost percentage denominator calculations.

Revises the retrospective evaluation requirement to include language that the evaluation includes all ILOS in that managed care program.

Makes minor revisions to the completion date of the retrospective evaluations.

Requires states to identify specific codes and modifiers for each ILOS and provide them to managed care plans.

## QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM, STATE QUALITY STRATEGIES AND EXTERNAL QUALITY REVIEW

**PROPOSED**

Allows managed care plans exclusively serving duals to use a Medicare-Advantage Chronic Care improvement program in place of Quality Improvement Program (QIP).

Requires states to solicit public comment on their managed care quality strategy every three years, and to submit their quality strategy to CMS every three years.

Removes PCCM entities from the scope of mandatory EQR review.

Proposes changes to what data should be in EQRO reports.

**FINAL**

Allows managed care plans exclusively serving duals to use a Medicare-Advantage Chronic Care improvement program in place of Quality Improvement Program (QIP).

Requires states to solicit public comment on their managed care quality strategy every three years, and to submit their quality strategy to CMS every three years.

Removes PCCM entities from the scope of mandatory EQR review.

Specifies more meaningful data and information to be included in EQR reports.

Establishes consistent 12-month review periods for the annual EQR activities.

CMS is not finalizing changes proposed to the EQR report due date and will instead maintain the April 30 posting requirement.

CMS is not finalizing the proposed change to require states to notify CMS within 14 calendar days of posting their EQR reports.

## QUALITY IMPROVEMENT-QUALITY RATING SYSTEM

**PROPOSED**

Establishes the framework of a Medicaid Quality Rating System (QRS), including mandatory quality measures and a defined process to add or change measures, as well as requirements for states to publicly post QRS data to allow beneficiaries to compare plans.

**FINAL**

Establishes the framework of a Medicaid Quality Rating System (QRS), including mandatory quality measures and a defined process to add or change measures, as well as requirements for states to publicly post QRS data to allow beneficiaries to compare plans

Permits states to submit a request for a one-time, one-year extension for the methodology requirements if the State would be unable to fully implement the requirements
Finalizes 16 measures for the mandatory measure list after removing the MLTSS measures based on public comment.

Modifies the release date of the first complete technical resource manual from August 1, 2025 to CY 2027.