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CMS Medicaid Access Final Rules Summary

CMS has issued two final rules regarding Medicaid - its Ensuring Access to Medicaid Services final rule, regarding fee-for-service (FFS) and managed care, inclusive of home- and community-based services (HCBS), and its final rule on access to managed care plans in Medicaid and Children's Health Insurance Program (CHIP). CMS fact sheets for these rules can be found respectively here and here. Both final rules are scheduled for formal publication in the Federal Register on May 10, 2024 with effective dates in July 2024 (CMS has provided an outline of the various applicability dates for each of these rules here and here). For reference, National Council's comments on the proposals can be found here and here.

I. Ensuring Access to Medicaid Services Final Rule (CMS-2442-F)

HCBS Payment Adequacy

CMS finalized as proposed that at least 80 percent of Medicaid payments to HCBS providers (including both base payments and supplemental payments) with respect to three components of HCBS—homemaker services, home health aide services, and personal care services—be spent on compensation to direct care workers.

CMS is finalizing modifications to their proposed HCBS payment adequacy requirements at § 441.302(k) by:

- Adding a definition of excluded costs to ensure certain costs are not included in the minimum performance level calculation of the percentage of Medicaid payments to providers that is spent on compensation for direct care workers;
    - Excluded costs are those that are not included in the State's calculation of the percentage of Medicaid payments that is spent on compensation for direct care workers required at § 441.302(k)(3); meaning that states would ensure providers deduct these costs from their total Medicaid payments before performing the calculation. CMS specifies that excluded costs are limited to: training costs (such as costs for training materials or payment to qualified trainers); travel costs for direct care workers (such as mileage reimbursement or public transportation subsidies); and costs of personal protective equipment for direct care workers.
- Revising the definition of direct care worker to clarify that clinical supervisors are included in the definition;
- Revising policy to allow states to set a separate minimum performance level or hardship exemption for small providers;
- Adding provisions for states to develop reasonable, objective exemption criteria for to the minimum performance level requirement; and
- Adding a new provision to exempt the Indian Health Service (IHS) and Tribal health programs from these requirements.

Notably, this finalized policy applies to FFS and managed care. States are required to comply with this HCBS payment adequacy policy beginning 6 years after the effective date of this final rule. CMS also plans to provide technical assistance to states to help ensure that states understand what are

considered administrative and other expenses that are included in the percentage calculation and what are considered excluded costs.

Documentation of Access to Care and Service Payment Rates

CMS is finalizing as proposed recission of the current requirements in 42 C.F.R. 447.203 relating to access monitoring review plans (AMRPs) that states submit to CMS to ensure Medicaid payment adequacy and replacing them with a new approach to testing the adequacy of states' Medicaid FFS provider payment levels.

CMS is finalizing a replacement for the existing AMRP process with requirements for rate transparency and adequacy that include:

- States to publicly display Medicaid FFS payment rates on their websites beginning July 2026;
    - Notably, CMS clarifies that prospective payment system (PPS) rates for CCBHC demonstration services authorized under section 223 of the Protecting Access to Medicare Act of 2014 are not subject to the payment rate transparency publication requirement, including the bundled rate breakdown requirement, because these payments rates are outside of Medicaid FFS State plan authority. For CCBHC services covered and paid for under Medicaid FFS State plan authority, States that use Medicaid FFS fee schedule rates within the meaning of this rule to pay for CCBHC services must include these payment rates in the payment rate transparency provisions. Additionally, Medicaid FFS fee schedule rates that are bundled payment rates within the meaning of this rule paid to clinics (as defined in § 440.90), are subject to the bundled rate breakdown requirement.
- States to conduct a comparison of Medicaid FFS payment rates with comparable Medicare payment rates for specific services inclusive of outpatient mental health and substance use disorder services to be published by July 2025;
    - Regarding concerns about comparing community mental health center payments to Medicare rates, CMS states that mental health services provided in a facility-based setting, such as FQHC, RHC, CCBHC, or clinics (as defined in § 440.90) are excluded from the comparative payment rate analysis due to the challenges they expect States to face in disaggregating their rates for comparison to Medicare.
    - Also to note, for this final rule, CMS revised the outpatient behavioral health services category of service in § 447.203(b)(2)(iii) to outpatient mental health and substance use disorder services.
- States to establish an "interested parties' advisory group" to advise and consult on FFS rates paid to direct care workers providing self-directed and agency directed HCBS; and
- Creation of a new two-tiered approach for determining the level of access analysis states must meet when states seek to reduce provider payment rates or restructure provider payments via a state plan amendment (SPA).
    - CMS is finalizing their statement in preamble that for any service for which a state has proposed to reduce or restructure the Medicaid payments in circumstances when the changes could result in diminished access, for which there are no comparable Medicare services, the State is required to conduct the secondary analysis required under § 447.203(c)(2).

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

Appointment Wait Time Standards

The final rule requires states to establish and enforce wait time standards no longer than 10 business days from the date of request for outpatient mental health and substance use disorder services if covered in the MCO's, PIHP's, or PAHP's contract.

Secret Shopper Surveys

CMS is finalizing its requirement for 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, inclusive of outpatient mental health and substance use disorder providers.

Assurances of Adequate Capacity and Services—Provider Payment Analysis

The final rule requires states to submit an annual payment analysis using E/M codes in the paid claims data for four service categories (primary care, OB/GYN, mental health, and substance use disorder services) that compares managed care plans' payment rates as a proportion of Medicare's payment rate and, for certain HCBS, the state's Medicaid state plan payment rate.

State-Directed Payments

The final provides several changes regarding State Directed Payments (SDPs) inclusive of removing regulatory barriers to help states use SDPs to implement value-based purchasing payment arrangements and include non-network providers in SDPs. The final rule also eliminates written prior approval for SDPs that are minimum fee schedules set at the Medicare payment rate. CMS is also finalizing its proposal to permit states to include contract requirements directing managed care plans on how to pay non-network providers. CMS states that they believe that the minimum requirements for SDP contract terms finalized in § 438.6(c)(5)(i) through (iv) will ensure that managed care plans receive detailed direction on each SDP, facilitate CMS's review of managed care contracts, and facilitate compliance with the approved SDP preprint so that providers receive timely and accurate payments.

In the final rule, CMS provides clarification that statutorily required PPS rates to CCBHC demonstrations under Section 223 are not considered SDPs. CMS further noted that if states elect to adopt payment methodologies similar to those under the CCBHC demonstration but the state or facilities are not part of an approved section 223 demonstration, those payment arrangements would need to comply with SDP requirements in § 438.6(c) as the Federal statutory requirements only extend to those States and facilities participating in an approved demonstration.

Medical Loss Ratio (MLR) Standards

The final rule requires Medicaid managed care plans to submit actual expenditures and revenues for SDPs as part of their MLR reports to states, and specifies that states must provide MLR for each manage care plan. The final rule also requires managed care plans to report any identified or recovered overpayments to states within 30 calendar days. Additionally, CMS is finalizing contractual requirements for provider incentive payments. CMS finalized as proposed, 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, and 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 Lieu of Services and Settings (ILOS)

CMS is finalizing several changes to the ILOS requirements and authorities. CMS is finalizing its proposal to revise the definition of ILOS to specify it as a service that is provided as an immediate or long-term substitute for state plan-covered services or settings, or when the ILOS can be expected to prevent or reduce the future need for such services. CMS notes that this specified definition is intended to better support health related social needs (HRSN) and address other unmet enrollee needs. CMS is finalizing its proposal to limit the types of services that can be offered as an ILOS by requiring an ILOS to be considered approvable as a service or setting through either a state plan or a waiver under section 1915(c) of the Social Security Act. CMS is also finalizing the requirement for ILOS cost percentages to be calculated based on capitation rates and payments at a five percent expenditure limit on ILOS percentages. Notably, CMS is finalizing that the only Medicaid exception is short term stays in an IMD from this change to the calculation for an ILOS cost percentage. The agency highlights that one of the most commonly used ILOS is for inpatient mental health or substance use disorder treatment during a short term IMD stay and, due to already specific requirements for coverage of services during short term IMD stays, is excluded from the finalized changes.