Preparing for New Rules

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Overview of the Access and Managed Care Rules

- Medicaid Access Rule and a Medicaid Managed Care Rule, impose new requirements to enhance and standardize reporting, monitoring, and evaluation of Medicaid access to services
- Effective July 9, 2024, the rules describe complementary policies that often align across managed care and FFS delivery systems

Managed Care Final Rule	Access Final Rule
• Strengthens access to care and monitoring through appt wait time standards, secret shopper and enrollee surveys • Creates new reimbursement transparency requirements • Codifies and revises federal regulations re: State Directed Payments • Codifies recent CMS policy changes related to ILOS • Modifies MLR methodologies and processes • Establishes new quality requirements	• Creates new transparency and consultation requirements for FFS provider payment rates • Modifies the procedures for requesting federal approval to reduce or restructure FFS rates • Strengthens program advisory groups • Establishes new payment standards for certain HCBS • Updates HCBS program standards and processes re: care access and quality

Access Final Rule Key Takeaways

- CMS requires that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead)
- States will be required to establish a grievance process for FFS HCBS beneficiaries to submit complaints
- For critical incident reporting, CMS establishes:
  - Minimum definition of “critical incident”
  - Minimum state performance and reporting requirements for investigation and action
  - Requirements for states to operate and maintain an electronic incident management system
- State required to ensure that the person-centered service plan is reviewed and revised at least every 12 months for at least 90% of individuals continuously enrolled in a state’s HCBS programs
- CMS requires several new reporting requirement:
  - Waiting lists in section 1915(c) waiver programs
  - Service delivery timeliness for personal care, homemaker, home health aide and habilitation services
  - Percent of authorized hours used

Access Final Rule Key Takeaways

- CMS requires states to report biennially on the HCBS Quality Measure Set
  - Also establishes a process for updating the measure set
- States required to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website
- States required to compare their FFS payment rates for primary care, OB/GYN, and outpatient mental health and substance use disorder services to Medicare rates and publish the analysis biennially
  - States must publish the average hourly rate paid for personal care, home health aide, homemaker and habilitation services, and must publish the disclosure biennially
- States required to establish and operate the newly named Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Council (BAC) one year after the rule's effective date
  - MAC/BAC to publish annual recommendations, which states must respond to
  - Must also create an HCBS Interested Parties Advisory Group that meets at least biennially and also makes recommendations

MAC/BAC and FFS

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State Advisory Committees

Medicaid Advisory Committee	Changes the name of the MCACs to the Medicaid Advisory Committee (MAC) with broader scope of topics such as: changes to services; coordination of care; quality of services; eligibility, enrollment, and renewal processes; beneficiary and provider communications by the agency and MCOs; cultural competency, language access, health equity, and disparities and biases in the Medicaid program; and other issues	Recruitment and appointment processes for the MAC must be public and transparent; 25% of the MAC membership will need to be drawn the BAC (phased-in) MAC will meet at least quarterly	MAC meeting minutes must be posted publicly and at least 2 MAC meetings must be open to the public with an opportunity for public comment	MAC required to submit an annual report to the state that the state must post online Unless a longer time frame is specified, states have until July 9, 2025 to comply with MAC requirements
Beneficiary Advisory Council	Requires states to form a Beneficiary Advisory Council (BAC) made up of Medicaid beneficiaries or their representatives	The BAC will meet before each MAC meeting	BAC meetings may be held privately at the discretion of the BAC	

Access to Care & Service Payment Rate Documentation

Publicly accessible fee schedules	States must post all FFS Medicaid fee schedules on a publicly accessible website, including when rates differ by various demographic factors In cases where Medicaid programs use bundled payment rates, states must identify each individual service included in that rate and how much of the payment is allocated to each respective service
Two-tiered analysis of rate reduction impact	States must complete a two-tier access analysis: 1. State must complete an analysis to determine whether certain conditions are not met (e.g., aggregate payments rates are above 80% of Medicare, the rate reduction is less than 4%, and public comments do not identify concerns) 2. If any of those conditions are not met, then states must complete a more extensive analysis demonstrating that approval of the SPA will not impact access to care
Care access monitoring	After SPA approval, states must have monitoring systems to address access issues and, if issues are identified, submit a corrective action plan
Comparative rate analysis	States must complete comparative FFS reimbursement rate analyses for primary care, OB/GYN, and outpatient behavioral health services relative to Medicare rates in the same manner as managed care organizations must complete an analysis in the Managed Care Rule
Payment Rate Disclosure	States must post rates for personal care, home health aides, homemaker services, and habilitation services converted into hourly rates (HCBS hourly rate reporting is discussed in greater detail below in HCBS section)

HCBS Requirements

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HCBS Program Changes

The provisions in the final rule (unless otherwise noted or explicitly waived):

- Apply across Medicaid FFS and managed care
- Apply across HCBS waiver authorities (1915 and 1115) but *not* to HCBS under the Medicaid State Plan
- Certain provisions – including payment – focus on a subset of HCBS Home care (personal care, home health aide, homemaker and habilitation)
- Many non-payment provisions are intended to supersede performance and reporting requirements set forth in CMS' 2014 guidance on HCBS quality assurance systems

Home and Community Based Services

Compensation to HCBS Direct Care Workers

- Key Takeaway: CMS requires that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead)
  - CMS also made many modifications from what was in the proposed rule which altered the applicability of this provision.
- These payment and transparency requirements will be effective 6 years after the effective date of the final rule for FFS, and will apply to the first managed care plan contract rating period that begins on or after the date six years following the final rule's effective date
  - This is delayed from, the proposed rule, which included a four-year effective timeframe

HCBS Person-Centered Planning

Key Takeaway: The final rule requires states to ensure that the person-centered service plan is reviewed and revised at least every 12 months for at least 90% of individuals continuously enrolled in a state's HCBS programs

Home and Community Based Services

HCBS Grievance Procedures and Definition of Critical Incident

Key Takeaway: States will be required to establish a grievance process for FFS HCBS beneficiaries to submit complaints

- Beginning 2 years after the effective date of the final rule, states will need to establish grievance procedures for Medicaid beneficiaries who receive FFS HCBS through section 1915(c) and in the final rule made the requirements applicable to section 1915(j), (k) and (i) Medicaid authorities

Key Takeaway: CMS establishes a minimum definition of "critical incident" and minimum state performance and reporting requirements for investigation and action related to critical incidents; it also requires states to operate/maintain an electronic incident management system

- These requirements are effective 3 years after the effective date of the final rule for FFS, but CMS allows 5 years to implement the electronic incident management system

HCBS Quality Measure Set

Key Takeaway: CMS requires states to report biennially on the HCBS Quality Measure Set and establishes a process for updating the measure set

Beginning December 31, 2026, CMS will solicit comments on the HCBS Quality Measure Set no more frequently than biennially

Managed Care Rule

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Managed Care Final Rule Key Takeaways

- Covers standards for timely access to care, including requirements for states' monitoring and enforcement efforts
- Enhances program integrity standards for implementing some state directed payments (SDPs)
- Enhances certain quality reporting requirements
- Establishes new standards that will apply when states use in lieu of services and settings (ILOS) to promote effective utilization and that indicate the scope and nature of ILOSs
- Specifies certain medical loss ratio (MLR) requirements
- Establishes a quality rating system for Medicaid and Children’s Health Insurance Program (CHIP) managed care plans.

Managed Care Provisions: Network & Access Standards

Network and Access Standards	Sets appointment time standards for certain services, including outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric OB/GYN, and one additional service to be defined by the state	Must develop quantitative network adequacy standard for certain providers	Requires states to use independent "secret shoppers" to validate provider networks. Requires states to conduct annual enrollee experience surveys	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 OB/GYN 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, personal care services, and habilitation services to FFS rates for the same services.

Managed Care Provisions: SDPs

State-Directed Payments (Does *NOT* include a total expenditure limit for SDPs)	SDPs must be incorporated into Medicaid managed care capitation rates as adjustments to base capitation rates and prohibits use of separate payment terms	Requires states to submit SDP preprints and all required documentation no later than the start date specified in the preprint	Exempts states from submitting evaluation reports for SDPs with final cost percentage below 1.5 percent.	Requires SDPs to have an evaluation plan that includes at least two metrics, including one performance metric	Initial evaluation report must include 3 most recent and complete years of annual metric results and be submitted no later than 2 years after the 3-year evaluation period First annual report submitted in year 5
	Prohibits plans from basing interim payments to a provider on historic utilization with a post-payment reconciliation to utilization during the rating period	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	Requires providers to attest that they do not participate in any hold harmless arrangement for any health-related tax Requires states to make written attestations available upon CMS request or provide satisfactory explanation for why providers are unable/unwilling to provide attestation.	Cannot be pay-for-reporting	
	Removes prior written approval requirement for SDPs that adopt a fee schedule of 100% Medicare rates			Evaluation plan must include baseline statistics on all metrics and include performance targets, including one that is calculated as performance over a baseline	

Managed Care Provisions: MLR

Medical Loss Ratio	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: • Amount of the numerator • Amount of the denominator • MLR percentage achieved • Number of member months • 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

Managed Care Provisions: ILOS

In Lieu of Services	Formalizes CMS' previous ILOS guidance from State Medicaid Director Letter #23-001 Defines and provides key principles around ILOS ILOS must: • 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 • 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

Managed Care Provisions: Quality

Quality Improvement – Quality Rating System	Establishes the framework of a Medicaid Quality Rating System (QRS), including mandatory quality measures and a defined process to add or change measures, and 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] Finalizes 16 measures for the mandatory measure list, CMS did not include proposed MLTSS measures Modifies the release date of the first complete technical resource manual from August 1, 2025, to CY 2027			
Quality Assessment and Performance Improvement, State Quality Strategies and External Quality Review	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 3 years, and to submit their quality strategy to CMS every 3 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 did not finalize changes proposed to the EQR report due date; it maintain the April 30 posting requirement CMS did not finalize the proposed change to require states to notify CMS within 14 calendar days of posting their EQR reports

Final Rules Timeline

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2024

	Effective 2024	Rule	Effective
Medical Loss Ratio Standards (MLR)		MC	Sept 9
1	Prohibits inclusion of overhead or indirect expenses related to quality improvement activities in the MLP numerator		
2	MCOs must include descriptions of methodologies used to allocate expenses/other claims		
3	Remove requirement for annual updates to credibility factors used to adjust MLRs for MCOs		
4	State MLP summary reports must include required elements for each MCO contracted		
5	MCO contracts must include provision requiring the prompt reporting of all overpayments within 30 days of identification		
State Directed Payment		MC	July 9
1	Changes to streamline SDPs that are tied to value-based payments become effective		
2	Allow states to appeal to HHS Appeal Board		
3	Allowable adjustments to Base Capitation		
4	Average commercial rate (ACR) demonstration		
5	Attribution and delivery of services requirements for population-based/condition-based payments		
6	Requirements around VBPs conditioning payment upon performance apply		
7	All SDPs be included in plan-level and state summary MLP reports		

2024

Effective 2024		Rule	Effective
In Lieu of Services (ILOS)		MC	Sept 9
1	ILOS limited to those otherwise authorized under the state plan		
2	Costs capped at 5% of total cost		
3	Cost % calculated on projected basis at time of rate development and on final basis for rating period beginning 2 years after the completion of each 12-month period containing ILOS		
4	New requirements on all ILOS around target population and medical appropriateness		
5	Additional documentation requirements for ILOS w/ a cost percentage >1.5%		
6	Optional: Retrospective evaluations of all ILOS		
7	Final ILOS cost percentages >1.5% in any one of the first 5 rating periods an ILO is incorporated into the contract triggers mandatory retrospective evaluation		
8	States must include contractual requirements that MC plans utilize specific codes established by the state to identify each ILO enrollee encounter data		
9	Notify CMS w/in 30 days if state identifies an ILO is no longer medically appropriate or cost affective, or identified another area of noncompliance		

2024

Effective 2024		Rule	Deadline
HCBS Quality Measure Set			
	Implement Participant Survey that runs 7/1/24-6/30/25	Access	July 1
FFS Rate Transparency & Restructuring		MC	July 9
	Replace current Access Monitoring Review Plan process with a new 2-tiered analysis for any FFR rate reduction or restructuring SPAs		

2025

Effective 2025		Rule	Effective
Medical Loss Ratio Standards (MLR)		MC	July 9
	Include specific contract language regarding provider incentive payments		
Enrollee Engagement		Access	July 9
1	Transition from MCAC to MAC and BAC		
2	10% of MAC must be BAC Members from 7/9/24-7/9/25		

2026

	Effective 2026	Rule	Effective
Member Access		MC	July 9
1	Annual Payment Analysis		
2	Enrollee Experience Surveys (CHIP)		
3	Website Transparency		
State Directed Payment		MC	July 9
1	Minimum SDP contract documentation requirements		
2	New SDP submission requirements		
3	All pre-prints must be submitted before start of SDP		
4	Population-based/condition-based payments replace the negotiated rate the negotiated rate		
FFS Rate Transparency & Restructuring		MC	
1	Publish FFS rates current as of 7/9/26, including date of last update, bunded rate components, with stratification by population, provider type and region		July 9
2	Conduct comparative rate analysis to Medicare for primary care, OB/GYN and outpatient mental health		July 1
3	HCBS Payment rate disclosure (disclose payment rates for home health, personal care, homemaker, and habilitation services)		July 1

2026

Effective 2026		Rule	Effective
Quality Rating System		MC	July 1
	Date Collection & Validation		
Enrollee Engagement		Access	
1	20% of MAC must be BAC Members from 7/9/25-7/9/26		July 9
2	MAC & BAC annual reporting		
3	HCBS Interested Parties Advisory Group		
HCBS Quality Measure Set		Access	Sept 9
	Biennial reporting on mandatory measures in the HCBS Quality Measure Set, with state-established performance targets and quality improvement (use 4/11/24 measure set)		
Grievance Systems		Access	July 9
	Establish HCBS grievance system for FFS enrollees to file complaints about state/provider performance with person centered planning, service plans, & HCBS settings requirement (modeled on existing requirements for MCO)		

2027

	Effective 2027	Rule	Effective
Member Access		MC	July 9
1	Annual Payment Analysis		
2	Annual Enrollee Experience Surveys (CHIP & Medicaid)		
3	Minimum Appointment Wait Time Standards		
State Directed Payment		MC	July 9
1	Fee schedule arrangements be conditioned on delivery and utilization of services during the rating period		
2	Prohibition on the use of separate payment terms		
3	Evaluation plans required for SDPs that require written prior approval		
4	Evaluation report required if SDP requires write approval & if the final SDP percentage >1.5%		
Enrollment Engagement		Access	July 9
1	25% of MAC must be BAC Members		
2	MAC & BAC annual reporting		
Direct Care Worker (DCW) Compensation		Access	July 9
	One-time reporting requirement on readiness to collect data on percentage of Medicaid payments spent on DCW compensation		

2027

Effective 2027		Rule	Effective
Person-Centered Services Plan		Access	July 9
1	Report annually on the percentage of individuals continuously enrolled for at least 365 days (statistically valid random)		
2	Compliance threshold changes - state required to show review/reassessment steps were completed for at least 90% of individuals		
Incident Management System		Access	July 9
1	Implement an electronic indecent management system that "identifies, reports, triages, investigates, resolves, tracks and trends critical incidents"		
2	Use CMS definition of "critical incident" as minimum, state can build upon it		
3	Use a variety of data sources to identify critical incidents		
4	Establish data-sharing agreements with any other entities not identified in the final rule that investigate critical instances		
5	Report annually on how state initiates/completes investigations into critical incidents & complete corrective actions		
6	Report biennially on the residents on an "incident management system assessment"		

2027

	Effective 2026	Rule	Effective
HCBS Access Reporting		Access	July 9
	~~Report annually on waitlists~~ (does not apply to RI)		
1	Report annually on timely access to services		
2	Readiness report on the percent of authorized HCBS hours that were actually provided		
3	Share HCBS reporting data with Interested Parties' Advisory Group		

Website Transparency

	Website
	Material that Should Already be Easily Accessible Online
1	Managed Care Plan Contract
2	Documentation demonstrating plan compliance with requirements for availability & accessibility of services
3	Information on ownership & control of the plan, including names & titles of individuals
4	Results of periodic audits of the accuracy, truthfulness & completeness of the encounter, & plan financial data

Website Transparency

	Website
	July 1- 9, 2026
	User Accessibility
1	Links to specific content about an MCO need to link directly to the specific information referenced (not a landing page)
2	All information or links required under the final rule need to be posted on the state's website and be available on a single page
3	Website needs to use clear, easy to understand labels on documents and links
4	At lest quarterly, verify website function and accuracy
5	Indicate availablity of assistance to access information
6	Comply with 504 and ADA

Website Transparency

	Website
	July 1- 9, 2026
	Information Posted
1	FFS Rate Schedule (July 1)
2	HCBS Comparative Rate Analysis (July 1)
3	HCBS Payment Rate Disclosure (July 1)
4	Enrollee handbooks, provider directories & formularies
5	Information on rate ranges
6	Managed Care program annual reports
7	Assurances of adequate capacity & services
8	Network adequacy standards
9	Secret Shopper Surveys
10	State Directed Payment evaluation reports
11	Information on and links to all required application programming interfaces
12	Quality-related information
13	Documentation of compliance with mental health/SUD parity
14	MAC & BAC annual reporting

Website Transparency

	Website
	By July 9, 2027
	User Accessibility (HCBS)
1	All Content must be included in a single website (posted directly or by linking to MC plans)
	Information Posted
2	Person-centered planning reports
3	Incident management and critical incident reports
4	HCBS Quality Measure Set
5	HCBS Access reporting data
6	HCBS payment adequacy (DCW compendation percentage)
	2028
1	Medicaid Payment Transparency by May 10 (minimum staffing rule)
2	QRS (or state alternative) by December 31