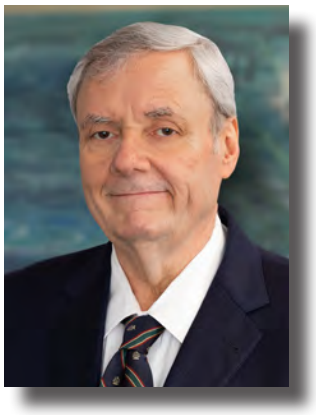
The CMS Managed Care Final Rule: Access Standards, Consumer Surveys, Payment Standards and More for Managed Medicaid and CHIP



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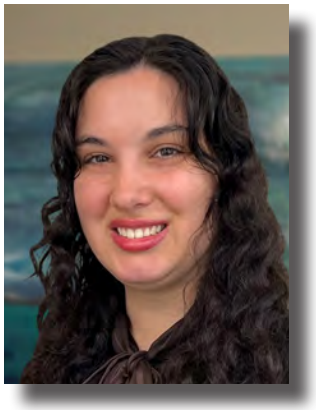

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The Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care final rule (the "2024 final rule") in the May 10, 2024 Federal Register.[1] The Final Rule officially went into effect on July 9, 2024, however additional applicability dates range from sixty days to six years following the effective date.[2]

The new rules will hopefully make Medicaid MCO participation more attractive to providers, as the MCOs are required to meet new access standards and boost customer satisfaction scores.

The 2024 final rule says it further clarifies and bolsters the aims of the "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care" (the "2020 final rule") published by CMS in the November 13, 2020 Federal Register (85 FR 72754).[3] After the publication of the 2020 final rule, the COVID-19 pandemic emphasized the challenges that States face to ensure access to care, adequate provider payment, and adequate program oversight. Subsequent executive orders further established the federal government's intention to protect and strengthen access to Medicaid and the Affordable Care Act.[4]

The 2024 final rule says it is expansive in order to address the changed landscape regulating access to managed care programs and the growing demand for managed care programs. In 2016, approximately 92% of New Jersey's 1,679,572 Medicaid beneficiaries enrolled in a managed care program. In 2022, approximately 96% of New Jersey's 2,022,155 Medicaid beneficiaries enrolled in a type of managed care program.[5] Similarly, the volume of Medicaid beneficiaries enrolled in a managed care program and comprehensive managed care organizations has grown nationwide.[6] Moreover, the 2024 final rule details that health care-related taxes made up approximately 17 percent ($37 billion) of all States' non-Federal share in 2018, the latest year for which data are available.[7]

Therefore, the 2024 final rule has broad aims to address additional critical elements of beneficiary experience: (1) potential access (for example, provider availability and network adequacy); (2) beneficiary utilization (the use of health care and health services); and (3) beneficiaries' perceptions and experiences with the care they did or did not receive.[8]

In particular, the 2024 final rule creates new federal standards for the MCOs and for the States:

For the MCOs, the rule establishes maximum appointment wait time standards of 15 business days for routine primary care (adult and pediatric) and obstetric/gynecological services; 10 business days for outpatient mental health and substance use disorder services (adult and pediatric). States must establish an appointment wait time for a state-selected service (adult and pediatric if appropriate).[9]

For the States, the rule requires:

- The use of 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 and providers that do not offer appointments;
- The States to conduct an annual enrollee experience

survey for each managed care plan;
- Submission of an annual payment analysis comparing 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;
- Implementation of a remedy plan for any managed care plan that needs improvement in meeting required access standards; and
- Maintenance of a single web page readily identifiable to the public, easy to use, and containing required information for public transparency.[10]

Additionally, the rule establishes new provisions relating to exceptions to the general rule prohibiting States from directing the expenditures of MCOs, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These exceptions came to be known as State Directed Payments (SDPs). Specifically, the rule offers further clarity relating to permissible and impermissible SDP redistribution arrangements.[11]

With respect to SDPs, the rule:
- Removes regulatory barriers to help states use state directed payments to implement value-based purchasing payment arrangements and include non-network providers in state directed payments;
- Eliminates written prior approval for state directed payments that are minimum fee schedules set at the Medicare payment rate;
- Requires that provider payment levels for state directed payments for inpatient and outpatient hospital services, nursing facility services, and the professional services at an academic medical center not exceed the average commercial rate;
- Requires states to condition fee schedule based state directed payments upon the delivery of services within the contract rating period and allows state directed payments based on value-based purchasing to tie payment to performance up to one year prior; and
- Prohibits the use of separate payment terms and requires that all state directed payments be included in actuarially sound capitation rates.[12]

Further, the rule clarifies the use of substitute services or settings provided in lieu of a covered State plan services or settings (In Lieu of Service and Setting or ILOSs). ILOSs are used by States and their managed care plans to increase the availability of covered services and settings. The rule revised the regulatory requirements for ILOSs to: (1) specify the nature of the ILOSs that can be offered; (2) ensure appropriate and efficient use of Medicaid and CHIP resources; and (3) advance the objectives of the Medicaid and CHIP programs.[13]

In addition, the rule revises medical loss ratio standards to align with medical loss ratios standards for the private market and Medicare Advantage standards. Medicaid managed care plans are required to submit actual expenditures and revenues for state directed payments as part of their medical loss ratio reports to states, provide medical loss ratios for each managed care plan, and makes technical revisions for quality improvement expenditures, provider incentive payments, and expense allocation reporting to align with recent regulatory changes for Marketplace plans. CMS states that this alignment will promote administrative efficiency and consistency of outcomes. Similarly, the final rule establishes new standards for managed care quality rating systems in order to ensure the managed care quality rating systems align with Medicare Advantage standards, qualified health plan rating systems, and other similar CMS initiatives. Lastly, the rule also establishes a numerical floor for fee-for-service Medicaid rates.[14]

In conjunction with the Final Rule, the Center for Medicaid and CHIP Services, issued a CMS Information Bulletin establishing a period of enforcement discretion that will remain in effect until January 1, 2028.[15] The Final Rule identified instances in which states are funding the non-Federal share of Medicaid SDPs and other Medicaid payments through health care-related tax programs that appear to involve prohibited hold-harmless arrangements. Accordingly, the Final Rule requires an SDP comply with Federal legal requirements relating to hold-harmless arrangements and providers receiving an SDP must attest that they do not participate in any hold-harmless arrangement for any health care-related tax. CMS expects to use the period before January 1, 2028, to assist states to identify and transition to allowable sources of non-Federal share while mitigating any program disruption to the greatest extent possible.[16]

Suits are pending in both Texas and Florida regarding the final rule's interpretation of hold-harmless arrangements and CMS's authority to enforce SDP programs. On June 30, 2023, a Federal district court in Texas issued a preliminary injunction staying the effective date of the requirement to obtain attestations from providers that would receive an SDP.[17] In Florida, the District Court dismissed the action which is now pending appeal.[18]

In conclusion, the expansive nature of the final rule attempts to address a growing and complex managed care system. The Final Rule's new standards will impact how states, health care providers, and health plans navigate the Medicaid landscape.

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Assistant Commissioner of the New Jersey Department of Banking and Insurance from 2010-2014, where he oversaw the Office of Life and Health during a period of fundamental change in both the healthcare and insurance sectors. His areas of responsibility encompassed the implementation of the Affordable Care Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act. Neil concentrates his legal practice on insurance law and regulatory counseling, as well as Medicare Advantage, Medicaid and commercial managed care contracting and litigation. Neil can be reached by email at nsullivan@greenbaumlaw.com.

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1 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 (May 10, 2024)
2 Id.
3 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, 85 Fed. Reg. 72754 (November 13, 2020)
4 Executive Order 14009 and Executive Order 14070
5 https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html
6 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 (May 10, 2024)
7 Id.
8 Id.
9 Id.
10 Id.
11 Id.
12 Id.
13 Id.
14 Id.
15 https://www.medicaid.gov/federal-policy-guidance/downloads/cib042224.pdf
16 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 41002 (May 10, 2024)

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them that drives a culture of success.

Denny: What's next for you in your career?

Aaron: I don't know and quite frankly, I am not thinking that far ahead. What I do know is that my experience with Jefferson Health has been very gratifying. I think that's a product of me really enjoying my role, the people I work with, and the impact I'm able to make. I also love what we are doing with the university, health plan, and care delivery network - building an integrated health delivery system. Very fun and exciting!

Denny: That sounds like a great place to be, both fulfilling and aligned with your values.

Aaron: Absolutely. When you're in a really good spot, other things become less relevant. Earlier in your career, you're focused on climbing the proverbial ladder and eager to get to the next rung. Now, I feel very fulfilled and grateful to get up and do what I love each day.

Denny: Thank you, Aaron. Your insights into leadership, communication, and healthcare administration have been invaluable.

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