Medicaid Access and Managed Care Final Rules

Overview and Implications for Children's Hospitals

May 23, 2024

Champions for Children's Health

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Agenda

- Introduction
- Overview of CHA Proposed Rule Comments
- Level-setting: CMS Access and Managed Care Final Rules
- Access Standards
  - Access Final Rule
- Payment Policies
  - Provider Payment Transparency
  - State Directed Payments (SDPs)
- Beneficiary Engagement
- Q & A

CHA’s Responses to the Proposed Rules

Process for Proposed Rule Comments

May 2023

Summarized both Access and Managed Care Proposed Rules

- Outlined provisions in both rules that are relevant for children's health and hospitals.

Gathered Feedback from Children's Hospitals

- Conducted focus groups with government relations and finance leaders, to discuss considerations and concerns regarding the proposed policies.

Implemented Feedback from Children's Hospitals into Comments

- Incorporated pediatric considerations and feedback from members into comments submitted to CMS.

July 2023

Ensuring Access to Medicaid Services: CHA Comments

Topic	CHA Comments
Payment Rate Transparency	Supported the requirement for states to publish all Medicaid fee-for-service (FFS) schedule payment rates, by population (pediatric and adult), on a website that is understandable and accessible to the public.
Comparative Rate Analysis	Supported the inclusion of pediatrics in the FFS comparative rate payment analysis.
State Analysis for Rate Reduction or Restructuring	Supported the creation of a two-tiered analysis process for states when a rate reduction is proposed. Also supported the additional analysis requirements for when rates are less than 80% of Medicare, but stated that this should be applied when rates are less than 100% of Medicare.
Medical Advisory Committees (MAC) & Beneficiary Advisory Council (BAC)	Recommended that families of children currently enrolled in Medicaid, especially those with disabilities and medical complexity, are included in each MAC and BAG. Also noted that families should be appropriately compensated for their participation.

Managed Care Access, Finance, and Quality: CHA Comments

Topic	CHA Comments
Appointment Wait Time Standards	Commended CMS for its efforts to align appointment wait time standards with those of marketplace plans. Encouraged CMS to consider the inclusion of provider protections along with the wait time standards.
State Directed Payments (SDPs)	Strongly supported codifying the Average Commercial Rate (ACR) as the upper payment limit for SDPs.
Financing	Did not support the requirement for states to collect attestations from providers stating that they do not participate in a hold harmless arrangement, since the issue is currently being litigated.
Quality Assessment and Review	Supported the requirement for states to draft and implement a written quality strategy. Urged CMS include pediatric-specific requirements for states. Commended CMS for including pediatric measures in the Medicaid Managed Care Quality Rating System (MAC QRS) mandatory measure set.

Level-Setting:
CMS Access & Managed Care Final Rules

Medicaid's Federal Regulatory Landscape

On April 22, 2024, CMS finalized two rules that flow from a years-long process to develop a "comprehensive access strategy" in Medicaid and the Children's Health Insurance Program (CHIP).

2022

CMS Request for Information on issues related to access, payment, and eligibility and enrollment (E&E)*

7,000+ stakeholder comments

2023

Managed Care Access, Finance, and Quality Proposed Rule (the "Managed Care Proposed Rule")

Ensuring Access to Medicaid Services Proposed Rule (the "Access Proposed Rule")

>2,500 stakeholder comments (415 on Managed Care & >2100 on Access)

2024

Managed Care Final Rule

Access Final Rule

These rules will modernize how Medicaid and CHIP define, measure, and enforce the standards for access to care—the most significant change since CMS' 2016 managed care regulations.

***New E&E Rules.** In addition to rulemaking on access and managed care, CMS recently finalized two rules to streamline E&E for Medicaid and CHIP. These are the most significant E&E regulations since 2012 and 2013. See the SHVS webinar for more information, as well as this expert perspective specifically addressing Medicare Savings Programs.

Citation: CMS, Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment (September 2023); CMS, Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (April 2024); and CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Overview: Managed Care and Access Final Rules

The Managed Care and Access Final Rules generally align with the May 2023 proposed rules. Although the two rules focus on different delivery systems, they share common goals and themes.

Managed Care Final Rule	Access Final Rule	
Managed Care Delivery System Focus*	Fee-for-Service (FFS) Delivery System Focus	Home and Community-Based Services (HCBS) Focus Across Delivery Systems

Once implemented, these rules will transform:

Standards and Monitoring for Access to Care

Engagement of People Enrolled in Medicaid

Transparency and Oversight of Payment Rates

Quality Measurement

Program Accountability

**Most of the Managed Care Rule's requirements apply across Medicaid and CHIP managed care, and apply equally across managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), but not to PAHPs that exclusively provide non-emergency medical transportation (NEMT) or to primary care case management (PCCM) entities.*

Citation: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Summary of Provisions in the Final Rules

= Today's Focus
★ = Significantly Modified from Proposed Rule

As in the proposed rules, the final rules describe complementary policies that often align across managed care and FFS delivery systems.

Managed Care Final Rule

- Strengthens access to care and monitoring through appointment wait time standards and secret shopper/enrollee surveys; and includes guidance on how telehealth can play a role.
- Creates new reimbursement transparency requirements.
- ★ Codifies and revises the federal regulations governing state directed payments, including by prohibiting the use of separate payment terms.
- Codifies and builds on recent CMS policy changes related to in lieu of services (ILOS).
- Modifies medical loss ratio (MLR) methodologies and processes.
- Establishes new quality requirements, including a framework and enhanced requirements for managed care quality rating systems (QRS).

Access Final Rule

- 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 regarding care access, and quality.

Implementation Timeframe*
July 9, 2024 – 2030

Although the final rules formally take effect on July 9, 2024, CMS has defined implementation deadlines over the next six years, in addition to defining new exceptions and areas of state flexibility.

For specific implementation dates of the policies discussed in these slides, see the appendix.

Citation: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Access Standards

(Managed Care Final Rule)

Appointment Wait Time Standards

With only minor modification from the proposed rule, CMS builds upon existing network adequacy standards by establishing managed care national maximum appointment wait time standards for routine appointments for four types of services.

Routine Appointment Type[1]	Wait Time Must Not Exceed…[2]
Outpatient mental health and substance use disorder (SUD) services—adult and pediatric	**10 business days** from date of request
Primary care services—adult and pediatric	**15 business days** from date of request
Obstetrical/gynecological (OB/GYN) services	**15 business days** from date of request
An additional service type(s) selected by the state in an evidence-based manner	**State establishes its own standard(s)**

Note: CMS retains its ability to add additional services to these standards after consulting with stakeholders and providing public notice/opportunity to comment.

Implications for Children's Hospitals

- The onus for implementing these new standards will fall to states and plans. Standards will be most relevant to hospitals with **large numbers of employed physicians**.
- States will need to work with plans to develop a multifaceted approach to strengthen managed care plan networks in the lead-up to July 2027, which could include **supporting providers through timely credentialing, accurate and timely claims payment, and expanding provider networks**, among other strategies.
- These changes will help ensure that Medicaid beneficiaries (including children) enrolled in a managed care plan can access the services they need. This may result in **increased use of preventive and routine care services**, leading to **reduced utilization of the ED**, and fewer instances of enrollees forgoing or delaying necessary care

Notes [1] CMS does not define "routine appointments"—but encourages states to include appointments for well-child visits, annual gynecological exams, and medication management at a minimum. CMS does not describe the "evidence-based" approach to choosing an additional service type; rather, CMS encourages states to consult with stakeholders and consider various sources (e.g., encounter data, provider complaints, grievances and appeals). [2] States have flexibility to: establish standards that are more stringent, but not more lenient, than the national standards; vary wait time standards for appointment types (e.g., adult vs. pediatric, by geography); and set standards for routine appointments to other additional services. (Any appointment standards for telehealth must not be a substitute for in-person services.)

Secret Shopper Surveys

CMS finalized its proposal to requires states, through independent entities, to annually conduct secret shopper surveys in Medicaid and CHIP as a tool to enforce new appointment wait time standards and other aspects of provider network adequacy and access.

Compliance With Wait Time Standards

- Plans will be:
  - Determined compliant by achieving a rate of routine appointment availability that meets the state-established standards at least 90% of the time.
  - Held accountable for compliance with any additional service type(s) selected as well as any service types that CMS adds at a later date.
- Telehealth may count if the provider also offers in-person appointments, and telehealth visits are separately identified in survey results.

Accuracy of Plans' Electronic Provider Directories

- For certain provider types, states must determine the accuracy of electronic provider directory information:
  - Active network status with the plan.
  - Provider street address and telephone number.
  - Whether the provider is accepting new patients.
- Plans must make necessary corrections within 30 calendar days of receiving updated provider information.
- By July 1, 2025, managed care plans must make their provider directories searchable and inclusive of information on whether each provider offers telehealth services.

States have significant flexibility related to survey design, subject to a minimum set of methodological standards established by CMS. States will be required to post secret shopper survey results on their website within 30 calendar days of submission to CMS and include secret shopper survey results in the Network Adequacy and Access Assurances Report.

Implications for Children's Hospitals

- Coupled with appointment wait time standards, **improvements to provider directory dat**a—which is often inaccurate or out of date—will help ensure children receive timely care (e.g., to preventive services, well-child visits, screenings).
- CMS will continue to allow exceptions to network adequacy requirements; however, exceptions need to consider applicable provider types in the plan's service area and the payment rates offered by the plan for the relevant provider or service type.

Remedy Plans to Improve Access

CMS finalized without modification the requirement that states develop remedy plans when the state, CMS, or a plan identifies access issues—including standards regarding availability of services, network adequacy, appointment wait time, secret shopper, and provider directory.

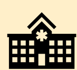
Month:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

- Start of month 1: CMS, state, or plan identifies an access issue[1]
- End of month 3: State submits remedy plan[2] to CMS within 90 calendar days of becoming aware of the issue
- End of month 6: State submits quarterly update to CMS on plan implementation
- End of month 9: Quarterly update due to CMS
- End of month 12: Quarterly update due to CMS
- End of month 15: Quarterly update due to CMS

Remedy plan should address compliance issue within 12 months

If the plan fails to address the access issue within 12 months, CMS may require continued actions for another 12 months and/or revisions to the plan[3]

1. An access issue refers to an area in which the plan's performance "under the access standards … could be improved".
2. Remedy plans need to: identify the responsible party that will be required to take action; articulate the specific steps to be taken; and include a proposed implementation and completion timeline.
3. CMS has existing authority to disallow federal financial participation (FFP) for managed care contract payments when an access issue has risen to the level of violating federal statutory standards.



Implications for Children's Hospitals:

- If access issues are identified (including with respect to appointment wait times and the provider directory), CMS could take compliance action in the form of this new enforcement mechanism as soon as July 2028. States (and their managed care plans) will be **held responsible for addressing access issues**.
- Per CMS, potential remedies could include: **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.

Payment Policies: Provider Payment Transparency

(Access & Managed Care Final Rules)

Analyses of Provider Payment Rates

CMS is establishing a new set of parallel processes for increasing payment rate transparency and monitoring the sufficiency of Medicaid FFS and managed care payment rates.

*All states will be required to publish **all** approved Medicaid FFS fee schedule payment rates on a website, with rates listed separately to the extent that they vary based on patient population, provider type, and/or geographic location. For certain bundled payments, states will be required to disaggregate the bundle into its constituent services.* Also, for a subset of services, CMS proposes additional reporting for both FFS and managed care.*

Final Rule Requirements**	Frequency of Reporting
Service Categories: Primary Care, OB/GYN, Outpatient Mental Health and SUD	
FFS Rates (§ 447.203(b)): For each E/M code that CMS defines per category, **states** must compare the ***Medicaid FFS fee schedule payment rate*** *to the* ***non-facility rate in the Medicare Physician Fee Schedule*** (supp. payments are excluded).	States must publish a new analysis every other year.
Managed Care Payments (§§ 438.207(b), 457.1230(b)): For each E/M code that CMS defines per category, **plans** must calculate the ***total amount paid under Medicaid and CHIP for each service category in the aggregate*** *and compare that amount against* ***the total amount Medicare FFS would have reimbursed for those same services*** (reported as a percentage).	Reports are required for new managed care contracts (as part of readiness review), and thereafter, annually or whenever there has been a "significant change."

*CMS initially proposed to require states to "break down" all Medicaid bundled payment rates. However, in the final rule, CMS narrowed this requirement to apply only to bundled payments that are based on fee schedule payment rates for each constituent service.

**For additional information on requirements of these analyses, see the appendix.

Implications for Children's Hospitals: Increased transparency around primary care, OB/GYN, and behavioral health payment rates—both for managed care and FFS—would **shine a light on payment issues**, particularly with the new requirement that states distinguish **between adult and pediatric patients**. This information will likely inform states' decisions on investments in improvements to access and CMS's review of compliance with access requirements.

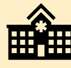
State Analysis for Rate Reduction/Restructuring

The final rule establishes a new process for CMS review of state plan amendments (SPAs) that propose to reduce rates.

Threshold Access Analysis

Aggregate Payments
Assess how payments for relevant benefit category would be affected as compared to Medicare FFS rates.

Magnitude of Proposed Change
Cumulative effect of all rate reductions or restructurings.



Public Comment
Comments from the public regarding the proposed change.

Secondary Analysis Required if…

- Rates for benefit category (including supplemental payments) would **fall below 80% of comparable Medicare rates.***
- State expects **more than a 4% reduction in aggregate Medicaid expenditures** for the benefit category during the state's fiscal year.
- Public comments yield **significant concerns about access to care** and the state is unable to respond or mitigate those concerns.

Requirements of Secondary Analysis

Proposed Payment Change
Analysis of cumulative effect of all reductions or restructurings on aggregate FFS Medicaid expenditures for each benefit category.

Overview of Payment Rates
Analysis and comparison of before and after proposed reduction (including base and supplemental payments).

Additional Data
- Number of participating providers.
- Number of Medicaid enrollees receiving FFS services.
- Number of services furnished through FFS delivery system.

State Mitigation Plan
Responses to access to care concerns.

CMS may disapprove a SPA if a state fails to submit all required information under one or both tiers of the analysis.

Implications for Children's Hospitals: The onus to submit this information will largely fall to states. However, children's hospitals should be cognizant of the process, particularly to the extent that a reduction in rates may impact their reimbursement level.

Citation: § 447.203(c). **Although this approach is not entirely clear from the regulatory text, CMS's preamble confirms its intent that states examine the average Medicaid-to-Medicare percentage across the entire benefit affected by the rate reduction or restructuring.*

Payment Policies: State Directed Payments (SDPs)

(Managed Care Final Rule)

Overview of New Requirements for SDPs

In the final rule, CMS recognizes the important role of SDPs in promoting access and quality goals, but also identifies concerns over the size of such payments and certain state approaches to financing the non-federal share of SDPs.

Key policies finalized as proposed (with relatively minor changes and/or effective date delays):

Codify the ACR as the SDP payment ceiling for hospitals and other key providers, with new flexibility to calculate the ACR.

Grant new flexibilities, including permitting SDPs for non-network providers and exempting SDPs that match Medicare rates from formal pre-approval.

Mandate that states collect attestations from providers receiving SDPs that they do not participate in **"hold harmless" arrangements** associated with provider taxes.

Require **provider-level reporting** on SDPs, limit formal evaluation reports to large SDPs, and heighten SDP evaluation requirements to improve links to quality.

Policies that represent a departure from original proposals:

Prohibit the use of separate payment terms, a mechanism by which states reimburse plans for SDPs separate from the capitation rates.

Require states to **submit SDP preprints** to CMS before the SDP effective date.

Citation: §§ 438.6, 438.7, 430.3.

SDPs: Payment Levels

In the final rule, CMS codifies the Average Commercial Rate (ACR) as the upper limit of most SDPs.

	Current Practice	Final Rule
Upper Limit on SDPs	▪ CMS **evaluates SDPs** to ensure provider rates are “reasonable, appropriate, and attainable,” aligned with the federal requirement for actuarially sound capitation. ▪ CMS has considered the **ACR as the upper limit** for SDPs.	▪ **Codifies the “reasonable, appropriate, and attainable” standard.** ▪ **Establishes the ACR as the upper payment limit for SDPs** made for: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. ▪ CMS has **not** set a formal SDP upper limit for other services, but notes that in practice it will use the ACR for assessing the "reasonable, appropriate, and attainable” standard for other services.
ACR Calculation	▪ CMS requires states to **demonstrate that any SDPs that exceed 100% of Medicare do not exceed the ACR** for the class of services, but only for providers included in the SDP.	▪ **Codifies the ACR Demonstration requirement**, with some significant departures from current practice, such as **not restricting the demonstration to the provider class**. Change benefits high Medicaid providers that often receive lower commercial rates compared to providers with a larger share of commercial patients. ▪ States will need to **demonstrate the ACR** during the first year of the SDP, and then every 3 years thereafter while the arrangement remains in place. (Though increasing ACR for trend will require a new demonstration.)

Implications for Children’s Hospitals

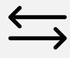
- By codifying the ACR as the upper payment limit, CMS **preserves a critical funding source** for children’s hospitals.
- Further, the additional flexibility on how the ACR is calculated (such as not restricting by provider class) will enable continued access to SDPs for providers that serve a large volume of Medicaid patients.

Citation: § 438.6(c)(2)(iii).

SDPs: Non-Federal Share Financing

The final rule reinforces CMS's hold harmless policy but delays the effective date of a key provision until 2028.

Hold Harmless Requirements



- CMS reinforces (as in other guidance) that prohibited "indirect" hold harmless arrangements include those where Medicaid payments are redistributed among providers subject to the provider tax, **even if this redistribution happens without state involvement.**
- CMS notes that because hold harmless arrangements affect the validity of the tax and payments, **CMS will disapprove any SDPs where it identifies hold harmless arrangements are in place**.

Provider Attestation

- To promote compliance, the final rule **requires states to collect attestations from each participating provider eligible for the SDP that they do not participate in a hold harmless arrangement** (to be made available to CMS upon request). This applies to all SDPs, including those that do not require CMS prior approval.
- CMS will **allow states to provide an explanation as to why specific providers are unable or unwilling to make attestations** in response to concerns that individual providers could prevent states from implementing SDPs by not complying with attestation requirements.

New compared to CMS's original proposal

- **Provider attestation requirements are effective January 1, 2028** (a two-year delay compared to CMS's original proposal to allow states to establish attestation collection processes and restructure any noncompliant SDPs).
- **CMS indicated it will not enforce the prohibition on hold harmless arrangements related to redistribution of provider payments until January 1, 2028,** in an Informational Bulletin. However, CMS noted that new health care-related taxes that involve the redistribution of provider payments may result in CMS disapproval.

Implications for Children's Hospitals

- The hold harmless requirements could lead to non-federal share and payment changes in states where these arrangements do exist, potentially **impacting the size and distribution of payments**. However, the impact of this is likely to **vary by state**.

Citation: § 438.6(c)(2)(ii)(H).

SDPs: Payment Methodologies

The final rule provides new flexibilities related to SDPs, but also places new restrictions on the use of common payment arrangements and methodologies.

New Flexibilities

Non-Network Providers

Permits SDPs for network and non-network providers, allowing states to set minimum provider payment levels regardless of whether a provider is in network with a plan.

Effective July 9, 2024

Preprints: Medicare Rates

Exempts SDPs at Medicare rates from the preprint process.

Effective July 9, 2024

VBP Directed Payments

Permits states to direct timing and amount of expenditures related to VBP directed payments, among other changes.

Effective dates vary

New Limitations

Interim Payments with Reconciliation

Prohibits states from making interim lump sum payments to providers based on historical utilization from prior rate years, with reconciliation to actual utilization at the end of the rate year.

Effective July 9, 2027

Separate Payment Terms

Prohibits the use of separate payment terms (a departure from CMS's original proposal).

See next slide.

Effective July 9, 2027

Implications for Children's Hospitals

- These new flexibilities **may enable broader adoption of SDPs**.
- Adoption of VBP directed payments has been relatively low compared to SDPs. These new flexibilities may **increase utilization of VBP directed payments** arrangements.
- Children's hospitals should be aware of the new policies on interim payments with reconciliation since this may have **implications for cash flow**.

Citation: (§§ 438.6(c)(1)(iii), 438.6(c)(2)(vi), 438.6(c)(2)(vii), 438.6(c)(5), 438.6(c)(6), 438.7(c))

SDPs: Separate Payment Terms

In a departure from the proposed rule, the final rule prohibits the use of separate payment terms — a mechanism by which states reimburse plans for SDPs separate from capitation rates.

Current State

States currently have two options to account for SDPs in the managed care rate certification:

Option 1: Adjustments to the **base capitation rate**, incorporating the SDP. Under this option, plans are at financial risk for SDPs.

Option 2: A **separate payment term**, where an aggregate pool of funding is reserved for the SDP, separate from the base capitation rate. Under this option, plans are *not* at financial risk for SDPs.

Final Rule (Effective July 9, 2027)

✓ → States must incorporate SDPs into capitation

X → Separate payment terms are prohibited

Over half of SDPs (55% in 2021) are structured as separate payment terms. States and providers often prefer this approach because it:

- Removes the incentive for plans to steer utilization to providers not eligible for the SDP
- Simplifies nonfederal share financing calculations

The phaseout of separate payment terms will have **significant implications** for states and providers.

Provider taxes and **intergovernmental transfers** used to finance the non-federal share of separate payment term SDPs will likely need to be restructured.

Implications for Children's Hospitals

- This change will have **significant implications** for states and providers given the prevalence of SDPs structured as separate payment terms
- This may necessitate **restructuring of provider taxes and IGTs** for certain states and SDPs

SDPs: Evaluation and Reporting Requirements

The final rule includes (1) requirements for evaluation of all SDPs as well as a subset of SDPs that exceed a specified expenditure threshold, and (2) near-term reporting of actual aggregate directed payments through updates to state MLR reporting and longer-term provider-level reporting via T-MSIS.*

Evaluation

- For all SDPs that require pre-approval, states must:
  - ✓ Include at least two measures in an **SDP evaluation plan**; one must be a performance measure, the other can measure access.
  - ✓ Include baseline measures and performance targets.
  - ✓ Achieve stated goals and objectives in alignment with the state's evaluation plan.
- States are required to submit an **evaluation report** to CMS if the size of the SDP exceeds 1.5% of the managed care program. **CMS will not approve the renewal of any SDP requiring pre-approval for which performance targets are not met for two successive evaluation reports.**

Evaluation reports are required **every 3 years (rather than annually)** and must include 3 years of performance data. States have **2 years after the end of the first three-year cycle** to submit the evaluation report.

Reporting

- **Minimum data requirements for the T-MSIS reporting would include detailed individual payment components** (including the negotiated rate, SDP payment, etc.) made to each provider.
- Because CMS did not include the reporting in the Medicaid Budget and Expenditure System (MBES), where FFS supplemental payments are collected under reporting requirements enacted under the 2021 Consolidated Appropriations Act, **CMS will not have one location where all supplemental and directed payments are stored.**

*T-MSIS = Transformed Medicaid Statistical Information System.

Implications for Children's Hospitals

- Increased rigor of evaluations will mainly increase **administrative burden to states** and would have **limited hospital impact**, except to the extent states require additional reporting from hospitals.
- Substantial new **public, provider-level reporting** will be required on SDPs.
- Hospitals should provide **additional context** as these data emerge for stakeholders to interpret this information correctly (including on uncompensated care costs and Medicaid utilization)

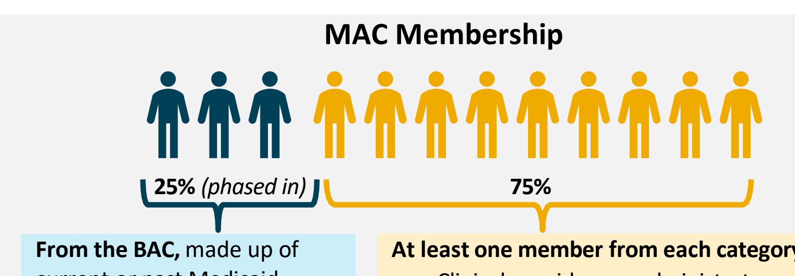
Beneficiary Engagement

(Access & Managed Care Final Rules)

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

CMS finalized, with few changes, its proposal to replace the Medical Care Advisory Committee with two new groups: a MAC and a BAC.

- The MAC and BAC are required to meet at least once per quarter.
  - At least 2 MAC meetings per year must be open to the public, with dedicated time for public comment.
  - The BAC must meet separately and in advance of MAC meetings.
- States must offer a rotating variety of meeting attendance options (in-person, virtual, hybrid) and always offer a telephone dial-in option.
- States must post publicly the MAC/BAC annual report (including state responses to recommendations), along with bylaws, membership lists, meeting minutes, and the member recruitment and selection process.
- CMS requires states to provide staffing, financial, and other administrative support. States may claim FFP at the standard administrative match rate of 50%.

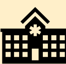


From the BAC, made up of current or past Medicaid enrollees or family members and paid or unpaid caregivers of enrollees.

At least one member from each category:

- Clinical providers or administrators.
- State, local, or community-based organizations.
- Participating plans/state associations.
- Other state agencies as ex officio members (non-voting).

CMS plans to issue a toolkit with “guidance on model practices, recruitment strategies, and ways to facilitate beneficiary participation.”



Implications for Children’s Hospitals

- The MAC/BAC requirements have potential to transform the operation of state Medicaid programs, making them more attuned and responsive to the lived experiences of enrollees—**including children and families**.
- States will need to include representation in the MAC from clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries. CMS recommends states include a **wide range of providers or administrators.**
- Participation in the MAC will facilitate the sharing of provider perspectives related to Medicaid program administration.

Enrollee Experience Surveys

CMS finalized its proposal requiring states to (1) conduct an annual Medicaid enrollee experience survey, and (2) use existing enrollee data in CHIP to evaluate network adequacy.

Medicaid Enrollee Experience Survey

- States are newly required to:
  - Conduct an annual enrollee experience survey of their choosing for each of their Medicaid managed care programs (except for those exclusively serving Medicare Advantage dual eligible special needs plan enrollees).
  - Evaluate the enrollee experience data as part of their Managed Care Program Annual Report and post the report on their website 30 calendar days after submission to CMS.

Reminder: *States may use external quality review organizations (EQROs) for the administration and validation of these surveys and receive a 75% enhanced federal match.*

CHIP Enrollee Experience Data

- States are also required to:
  - Use CHIP CAHPS survey data (which states already collect) to evaluate network adequacy.
  - Annually post comparative summary results of CHIP CAHPS surveys by plan on their website.

Implications for Children's Hospitals

- These surveys will assess whether plan networks provide an appropriate range of services and sufficient number, mix, and geographic distribution of providers. Pending the results, states and plans may feel pressure to **work with providers to identify solutions to improve access to services**.
- CMS did not mandate state use of a provider survey (which could have been administratively burdensome to providers).

Q&A

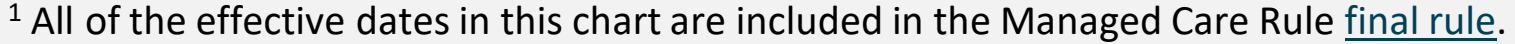
Appendix

Implementation Timeline of Key Provisions

The final rules impose significant new requirements on states and managed care plans, which CMS seeks to mitigate with a staggered implementation timeline over a six-year period and other flexibilities.

Key Provisions		Effective Date*
Coverage, Financing, and Payment	**SDPs**	*See below*[1]
	Payment Methodologies: 1) *non-network providers* 2) *preprint submission requirements* 3) *value- based payment (VBP) directed payments* 4) *interim payments with reconciliation* 5) *prohibition on separate payment terms*	1) **July 9, 2024** 2) **July 9, 2024** 3) ***Varies by provision*** *(between July 9, 2024 and July 9, 2026)* 4) **July 9, 2027** (first rating period beginning on/after) 5) **July 9, 2027** (first rating period beginning on/after)
	Payment Levels: *codifying the ACR as the maximum expenditure limit and ACR demonstration requirements*	**July 9, 2024** (first rating period beginning on/after)
	Reporting Requirements: *1) near-term reporting of actual aggregate directed payments* *2) longer- term provider-level reporting*	1) **September 9, 2024**; *thereafter, SDP data must be included in states' annual MLR reports* 2) First rating period after CMS releases reporting instructions
	Non-Federal Share Financing: *provider attestation requirements*	**January 1, 2028** (first rating period beginning on/after)
	Evaluation Plan Standards and Reporting Requirement	**July 9, 2027** (first rating period beginning on/after)

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.



[1] All of the effective dates in this chart are included in the Managed Care Rule final rule.

Implementation Timeline of Key Provisions (Cont'd)

Key Provisions		Effective Date*	Source
Access Monitoring	Appointment Wait Time Standards	**July 9, 2027** (first rating period beginning on/after)	Managed Care Rule
	Secret Shopper Surveys	**July 10, 2028** (first rating period beginning on/after)	
	Remedy Plans to Improve Access	**July 10, 2028** (first rating period beginning on/after)	
Enrollee Engagement	Medicaid Advisory Committee and Beneficiary Advisory Council	**July 9, 2025**	Access Rule
	Enrollee Experience Surveys	**July 9, 2026** (for CHIP, first rating period beginning on/after)	Managed Care Rule
		July 9, 2027 (for Medicaid, first rating period beginning on/after)	
Provider Payment Transparency	Analysis of Provider Payment Rates in Managed Care	**July 9, 2026** (first rating period beginning on/after)	Managed Care Rule
	Analysis of Provider Payment Rates in FFS	**July 1, 2026** (using Medicaid payment rates in effect as of July 1, 2025)	Access Rule
	State Analysis for Rate Reduction/Restructuring	**July 9, 2024**	

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.

Analyses of Provider Payment Rates

CMS is establishing a new set of parallel processes for increasing payment rate transparency and monitoring the sufficiency of Medicaid FFS and managed care payment rates.

*All states will be required to publish **all** approved Medicaid FFS fee schedule payment rates on a website, with rates listed separately to the extent that they vary based on patient population, provider type, and/or geographic location. For certain bundled payments, states will be required to disaggregate the bundle into its constituent services.* Also, for a subset of services, CMS proposes additional reporting for both FFS and managed care.*

Final Rule Requirements	Frequency of Reporting
Service Categories: Primary Care, OB/GYN, Outpatient Mental Health and SUD	
FFS Rates (§ 447.203(b)). ▪ For each E/M code that CMS defines per category, **states** must compare the ***Medicaid FFS fee schedule payment rate*** *to the* ***non-facility rate in the Medicare Physician Fee Schedule*** (supp. payments are excluded). ▪ Separate reporting is required if rates vary based on provider type, adult vs. pediatric patient, or geographical location. ▪ States must publish the analysis on a publicly accessible website.	States must publish a new analysis every other year.
Managed Care Payments (§§ 438.207(b), 457.1230(b)). ▪ For each E/M code that CMS defines per category, **plans** must calculate the ***total amount paid under Medicaid and CHIP for each service category in the aggregate*** *and compare that amount against* ***the total amount Medicare FFS would have reimbursed for those same services*** (reported as a percentage). – The aggregate analysis must account for rate variation based on provider type, geographical location, or site of service. – With respect to patient age (adult vs. pediatric), separate percentages must be reported if the percentages vary. ▪ States must submit an "assurance and analysis" to CMS and publish it on their website, including reported percentages at the plan-level plus a weighted statewide average for each service category.	Reports are required for new managed care contracts (as part of readiness review), and thereafter, annually or whenever there has been a "significant change."

*CMS initially proposed to require states to "break down" all Medicaid bundled payment rates. However, in the final rule, CMS narrowed this requirement to apply only to bundled payments that are based on fee schedule payment rates for each constituent service.

Resources

- **CHA Medicaid Final Rules Summaries**
  - Access Final Rule Summary
  - Managed Care Final Rule Summary