NHeLP Summary of Proposed Access and Managed Care Rules

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Last week, the Centers for Medicare and Medicaid Services (CMS) released two proposed rules intended to improve access to care, quality and health outcomes, and address health equity issues. The first, *Medicaid Program: Ensuring Access to Services* (Access Rule), addresses in Medicaid fee-for-service, managed care, and HCBS program. The second, *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, (Managed Care Rule) is aimed at managed care enrollees in the Medicaid and CHIP programs. Here are some highlights of these proposed regulations.

Access Rule

- *Medicaid Advisory Committee (MAC).* States must establish a MAC that participates in program administration and policy development. The regulation:
  - Establishes a new requirement that a MAC have a dedicated Beneficiary Advisory Group (BAG) that includes current and former beneficiaries and their family members to advise the agency. At least 25% of the members of the MAC must be from the BAG.
  - Would require more requirements for MAC and BAG member composition recruitment, appointment, and selection.
  - Would impose more requirements for meeting transparency, timing, and access, including for people with LEP or disabilities.
  - Requires administrative and financial support from the agency.

- *HCBS Waivers.* The proposed regulation adds a variety of new requirements governing waivers. It would require:
  - Specifics about the person-centered planning process, including timing for review and reassessment.
  - Establishment of a grievance procedure for compliance with these requirements applicable to non-managed care delivery systems, with detailed requirements for the system.

- Reporting on the waiver's impact and make assurances that it meets minimum performance levels.
- Assurances that payment rates "are adequate to ensure a sufficient direct care workforce" and defines key terms such as compensation and direct care worker.
- Reporting on compliance with requirements including those governing incident reporting, person centered planning, and waiting lists.
- Use of a Home and Community Based Services Quality Measure Set, to be identified by the Secretary no later than December 31, 2025, in consultation with the states and other interested parties, including providers, consumer organizations, and national organizations with expertise in HCBS quality measurement.

- *Fee-for-service payment rates*. The proposed rule "establishes an updated process through States would be required to document, and [CMS] would ensure" compliance with Medicaid's requirement that states assure that payments are sufficient to ensure quality and a sufficient supply of providers. It replaces a number of the current requirements for documenting rates and analyzing payments with a "new, streamlined process."
  - Starting January 1, 2026, States would be required to publish all fee-for-service payment rates on a website accessible to the public.
  - The required comparative rate analysis would have to include primary care services, obstetric and gynecological services, and outpatient behavioral health services.

Managed Care Rule

- *In Lieu of Settings.* CMS is proposing to add a new regulation governing in lieu of services and settings (ILOS), codifying subregulatory guidance and significantly expanding on and supplementing existing requirements. The regulation:
  - Explicitly requires managed care plans to calculate and report the "ILOS cost percentage," which is the proportion of all capitation payments devoted to ILOS.
  - Requires states to report the name and definition of each ILOS, the service or setting for which it is substituting, the target population, process for determining medical necessity, and enrollees' rights and protections.
  - Provides for CMS monitoring and oversight and provides for termination of use of an ILOS.
  - Reaffirms that an enrollee cannot be required to accept an ILOS and provides that they retain the right to receive a service as if the ILOS were not an option.
  - States that enrollees who is offered or uses an ILOS retains "all rights and protections afforded under part 438."

- *State-directed payments.* These proposed regulations:
  - Add definitions and requirements expanding the scope of states' ability to direct managed care plans to make payments to providers at a certain level.

- *Network adequacy standards and availability of services.* CMS proposes to add to existing regulations governing network adequacy. Under the proposed rules, states would be required to:
  - Enforce wait time standards for routine appointments in outpatient mental health and substance use disorder (10 business days from request); adult and pediatric, including primary care; OB/GYN (15 business days from request); and one additional service determined by the state.
  - Use independent secret shopper surveys as a part of their monitoring activities, including determining accuracy of provider directory information. The regulation includes requirements for conducting those services.
  - To ensure adequate capacity and availability of services, perform a payment analysis of certain services, including primary care, OB/GYN, mental health and SUD, homemaker, home health aide, and personal care services in an effort to provide assurances that the managed care plan has adequate capacity and services. Also requires states to submit a remedy plan to improve access if it is found that access to care could be improved.

- *External quality review.* Expands current requirements governing activities related to EQR.

- *Medicaid managed care quality rating system.* The proposed rule would add a new subpart G describing a Medicaid Managed Care Quality Rating System. (QRS) and require states to adopt the QRS framework developed by CMS or an alternative developed by the state.