September 19, 2024

Overview of Recent CMS Final Rules

Relation to MACPAC work

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Overview

- Summary of recent CMS rulemaking and how it relates to MACPAC's work
- Final rules for discussion
  - Eligibility and enrollment (CMS-2421-F and CMS-2421-F2)
  - Access to services (CMS-2442-F)
  - Managed care access, finance, and quality (CMS-2439-F)
  - Nursing facility staffing and payment (CMS-3442-F)
- Commissioners will have an opportunity to ask questions after each rule is discussed
- Next steps

Final Rule: Eligibility and Enrollment (CMS-2421-F and CMS-2421-F2)

Background

- Proposed rule published on September 7, 2022
- Rule finalized in two parts:
  - Medicare Savings Programs (MSPs) (CMS-2421-F); published on September 21, 2023
  - Remaining provisions related to Medicaid, the State Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP) (CMS-2421-F2); published on April 2, 2024
- MACPAC expressed overall support for the objectives of streamlining enrollment and renewal process, while balancing program integrity obligations
- Most provisions finalized as proposed

Facilitating Medicaid Enrollment

- Permits states to account for anticipated costs that a noninstitutionalized individual would likely incur when determining financial eligibility for Medicaid (i.e., medically needy)
- Clarifies that the use of electronic data sources and reasonable compatibility standards apply to verification of resources
  - MACPAC's prior work shows that states may realize efficiencies with use of electronic data sources
- Eliminates the requirement that individuals provide additional proof of identify when citizenship is verified through the Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program or a state vital statistics agency (also applies to CHIP)

Promoting Enrollment and Retention of Eligible Individuals

- Aligns enrollment and renewal policies for people who are eligible for Medicaid based on modified adjusted gross income (MAGI) with people who are not, referred to as non-MAGI populations
  - States must accept applications submitted in person, by mail or phone, or online
  - States may not require an in-person interview
  - States must renew eligibility no more than every 12 months (except for people in the Qualified Medicare Beneficiary (QMB) group)
  - States must send a prepopulated renewal form if a renewal cannot be completed based on available information (i.e., ex parte process)
  - MACPAC noted that streamlined processes promotes equity for those over age 65 or with disabilities
- Specifies required steps for acting on changes in circumstances
  - States must verify the information using available information
  - State must provide at least 30 days to provide requested information, and a 90-day reconsideration period

Promoting Enrollment and Retention of Eligible Individuals, cont.

- Establishes timeframes for submission of information and for timely eligibility determination
  - Requests for additional information at application, renewal, and when changes in circumstances are reported
  - State action on new applications, transferred accounts, renewals, reported changes in circumstance
  - MACPAC supported efforts to provide beneficiaries opportunity to respond information requests but suggested a longer than 10-day response period proposed. CMS increased the response period to 15 days
- Requires state action on updated address information
  - Beneficiary updates
  - In-state and out-of-state changes
  - No forwarding address
  - MACPAC expressed support for CMS efforts to address missing contact information

Promoting Enrollment and Retention of Eligible Individuals, cont.

- Requires state Medicaid and CHIP agency actions to facilitate transitions between the programs
  - Determine eligibility for the other program
  - Accept determination from the other program
  - Transition individuals to the program for which they are eligible
  - Coordinate a single notice
  - MACPAC agreed with focusing on coordinating across Medicaid and CHIP, suggested examining factors that lead to gaps in coverage and improving transitions to exchanges. MACPAC raised concerns about the state burden related to combined notices

Eliminating Barriers to Access in Medicaid

- Eliminates state option to limit the number of 90-day reasonable opportunity periods to provide documentation to verify citizenship
- Removes requirement to apply for other benefits
  - Veteran's compensation and pensions
  - Old-age, survivors, and disability insurance benefits
  - Railroad retirement benefits
  - Unemployment compensation

Eliminating Access Barriers in CHIP and the Basic Health Program (BHP)

- Prohibits premium lock-out periods for those disenrolled from CHIP or BHP for non-payment of premiums
- Prohibits states from requiring payment of past due premiums or enrollment fees as a condition of eligibility for CHIP or BHP
- Prohibits waiting periods in separate CHIP
- Prohibits annual, lifetime, or other aggregate dollar limits on state plan covered medical and dental services
- MACPAC supported eliminating lock-out periods and referred to our 2017 recommendation to eliminate separate CHIP premiums for families with income under 150 percent of the federal poverty level

Simplifying Eligibility and Enrollment Determination in the MSPs

- Facilitating enrollment through Medicare Part D Low-Income Subsidy (LIS) program “leads” data
- Defining family size for the MSPs to include at least the individuals that are included for purposes of LIS
- Automatically enrolling certain Supplemental Security Income (SSI) recipients into the QMB group
- CMS finalized these provisions largely as proposed but extended the timeframe for states to comply from 12 months after enactment to April 1, 2026
- Changes align with our June 2020 recommendations aimed at improving participation in the MSPs

Questions?

- Staff welcome any Commissioner questions or feedback on areas that Commissioners would like to monitor

Final Rule: Access to Services (CMS-2442-F)

Background

- Rule finalized on May 10, 2024; finalized largely as proposed but with a few changes
- Focuses on increasing payment rate transparency, standardizing reporting, and promoting beneficiary engagement
- MACPAC submitted comments expressing general support for selected provisions in the proposed rule where the Commission has prior work

Medicaid Advisory Committee and Beneficiary Advisory Council

- Restructures existing requirement for states to establish Medical Care Advisory Committees (MCACs)
  - Renames MCACs as Medicaid Advisory Committees (MACs); expands scope of topics to be addressed; requires states to establish a Beneficiary Advisory Council (BAC)
- MACPAC recommended in March 2024 that CMS address state concerns related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation

Home- and Community-Based Services

- Grievance system
  - Requires states to establish written policies and procedures for beneficiaries to submit grievances to states for Section 1915(c) waiver services delivered via FFS, something that already exists in managed care
  - MACPAC commented on this section in the proposed rule by supporting the requirement that states establish grievance procedures for Medicaid beneficiaries receiving services under Section 1915(c) through a FFS delivery system

Home- and Community-Based Services, cont.

- Payment adequacy
  - Requires at least 80 percent of all Medicaid payments for homemaker services, home health aide services, and personal care services be spent on compensation to direct care workers
    - final rule establishes three exemptions to the HCBS payment adequacy provision: small providers, providers who would experience hardship, and Indian Health Service
    - excludes three types of costs: training, travel, personal protective equipment
  - MACPAC commented in support of bolstering the direct care workforce

Home- and Community-Based Services, cont.

- Reporting requirements
  - Final rule requires states to report every other year on the HCBS quality measure set and to establish performance targets for mandatory metrics
  - Final rule requires states to describe the quality improvement strategies they will use to meet their performance targets
  - MACPAC comments highlighted concerns on lack of coordination on quality metrics across HCBS programs, which this rule addresses by applying the HCBS Quality Measure Set requirements at § 441.312 to section 1915(j), (k), and (i) state plan services
  - The Commission also highlighted the challenge that data limitations, especially around race and ethnicity data stratification, continue to pose to states

Fee-for-Service

- Payment rate transparency
  - States must publish all Medicaid FFS payment rates for primary care services, obstetrics and gynecology, outpatient behavioral health services, personal care, home health aide, homemaker, and habilitation services on a publicly accessible website
  - Payment rates must be published by July 1, 2026, for rates in effect as of July 1, 2026, and the agency must update the rates no later than one month after the approval or effective date of a rate change (whichever is later)
- MACPAC commented in support of payment rate transparency and raised several concerns
  - How supplemental payments would be factored in
  - The availability of guidance on calculating payment based on site of care and disaggregating bundled payments
  - Measuring provider payment rates without considering all factors
- In the final rule, CMS addressed these comments by noting that the agency will issue subregulatory guidance and by requiring reporting on a variety of factors

Fee-for-Service, cont.

- Beneficiary and provider input
  - CMS requires that states have ongoing mechanisms for beneficiary and provider input on access to care, such as hotlines, surveys, or ombudsman
  - States must establish an interested parties advisory group to advise and consult on FFS rates paid to DCWs for self-directed and agency-directed HCBS
    - HCBS includes for example, personal care, homemaker services, and a new category of services added under the final rule – habilitation services
    - advisory group must include direct care workers and beneficiaries; first meeting must occur by July 9, 2026, and group must meet at least every two years to advise and consult on HCBS payment rates
  - In MACPAC's June 2022 report to Congress, the Commission urged CMS to implement a new system to monitor access that specifically incorporates beneficiary input; recommended that CMS field a federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care

Questions?

- Staff welcome any Commissioner questions or feedback on areas that Commissioners would like us to monitor

Final Rule: Managed Care Access, Finance, and Quality (CMS-2439-F)

Background

- Final rule published May 10, 2024
- CMS implemented a broad range of regulations regarding:
  - Access
  - Payment
  - Quality
- MACPAC's comments on proposed rule focused on its prior research
  - Recommendations on access monitoring and state directed payments made in its June 2022 report to Congress
  - Technical comments based on prior analyses of external quality review and quality rating systems

Managed Care Access

- Annual enrollee experience survey for each managed care plan (2027)
  - CMS did not establish a federal survey or standardized survey instrument as specified in MACPAC's recommendation
- Maximum wait time standards for routine services in primary care, obstetrics/gynecological (OB/GYN), outpatient mental health and substance abuse, and an additional service determined by state (2027)
  - CMS acknowledged MACPAC's comments about collecting baseline data prior to establishing benchmarks but indicated data collection and implementation could occur simultaneously
- Secret shopper surveys to validate compliance with wait time standards and accuracy for provider directories (2028)
  - Compliance if survey reflects appointment availability within standards of 90 percent

Managed Care Access, cont.

- Annual provider payment analysis for primary care, OB/GYN, outpatient mental health and substance abuse, and home- and community-based services (2026)
- Network Adequacy and Access Assurances Report (2025)
- States must submit a formal remedy plan when a plan needs improvement in meeting these access to care standards (2028)

Managed Care Payment and Financing: State Directed Payment (SDP)

- SDP design and approval
  - Exempt minimum fee schedules at 100 percent of Medicare from preprint requirement (2024)
  - All documentation must be submitted before specified start date of SDP (2026)
  - Prohibition of post-payment reconciliation processes (2027)
  - Elimination of separate payment terms in a change from NPRM (2027)
- Total payment limited to average commercial rate for hospitals, nursing facilities, and qualified practitioners at academic medical centers (2024)
  - CMS acknowledged MACPAC concerns that the ACR limit could incentivize states to raise total payment rates based on the source of non-federal share instead of access or quality goals. CMS will mitigate financing concerns through other regulatory changes

Managed Care Payment and Financing: State Directed Payment (SDP), cont.

- Evaluation plan and report (2027)
  - For SDPs that exceed 1.5 percent of total capitation, states are required to submit an evaluation report and publish the report online
  - Addresses MACPAC's recommendation about making evaluations more rigorous and improving transparency by making the information publicly available
- Provider attestation of compliance with hold harmless arrangements (2028)
- Report provider-level SDPs in T-MSIS (Once CMS releases reporting instructions)
  - Aligns with MACPAC's recommendation on collecting provider-level data on SDPs

Managed Care Payment and Financing: MLR and In lieu of services (ILOS)

- Aligns Medicaid MLR standards with those established for Medicare Advantage and private market plans
  - Clearly defined provider incentives (2025)
  - Allowable cost in quality improvement activities (2024)
  - Report MLRs for each managed care plan (2024)
- Codifies recent guidance on ILOS (2024)
  - Defines ILOS
  - Limits ILOS to five percent of total capitation payments
  - Establishes enrollee rights and protections
  - Requires documentation of ILOS parameters
  - For states with an ILOS cost percentage above 1.5 percent, states must provide evidence that ILOS is medically appropriate and cost effective and submit a retrospective evaluation

Managed Care Quality

- New requirements on transparency of state quality strategies (2025)
- Requires external quality review (EQR) annual technical report include outcomes and quantitative data for three mandatory activities (one year after protocols released)
  - MACPAC's research noted the need for more outcomes data to help place a greater emphasis on performance outcomes and comparability
- New optional EQR activities for evaluation of quality strategies, SDPs, and ILOS (2024)
- Remove primary care case management from scope of mandatory activities (2024)

Managed Care Quality, cont.

- Finalized framework for quality rating system (QRS) (2028)
  - Finalized set of mandatory measures
  - Quality rating for each managed care plan for each measure
  - In MACPAC's research, stakeholders generally agreed that a uniform set of measures in state QRSs was important
- State must prominently display QRS on its website
  - Interactive features that allow users to tailor information
  - Standardized information to allow comparisons of programs and plans

Questions

- Staff welcome any Commissioner questions or feedback on areas that Commissioners would like us to monitor

Final Rule: Nursing Facility Staffing and Payment (CMS-3442-F)

Background

- Proposed rule published September 6, 2023; finalized May 10, 2024
  - Sets new federal minimum staffing requirements for nursing facilities
  - Creates new reporting requirements for long-term care facilities, which apply to nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs)
- MACPAC comment letter to CMS highlighted various technical considerations, as well as the Commission's nursing facility payment transparency recommendations included in the March 2023 report to Congress

Minimum Staffing Standards

- Final rule adds a minimum staffing standard of 3.48 HPRD for all staff (facilities may meet with registered nurses or nurse assistants)
- Clarifies required components of the facility assessment as well as how facilities must use assessment results to inform staffing decisions
- Includes hardship exemptions from minimum staffing requirements, taking into account workforce shortages but with several changes
  - Did not finalize a distance requirement included in the NPRM
  - Added a public transparency requirement for nursing facilities that receive an exemption
  - Added exemption to RN on-site requirements

Minimum Staffing Standards, cont.

- Facilities must comply beginning 90 days after publication of the final rule, an increase from 60 days in the NPRM.
  - Urban facilities must comply with the on-site RN requirement and the 3.48 HPRD total staffing standard in 2 years, and with other minimum staffing requirements in 3 years.
  - Rural facilities must comply with the on-site RN requirement and the 3.48 HPRD total staffing standard in 3 years, and with other minimum staffing requirements in 5 years.
- Legal challenges are underway that could affect these timelines

Payment Rate Transparency

- Medicaid institutional payment rate transparency
- Final rule requires states to report annually on the share of Medicaid payments to long-term care facilities that is spent on compensation for direct care workers and support staff.
  - The payment provisions included in the final rule focus exclusively on transparency and stop short of any minimum reimbursement or payment standards for states. Federal minimum staffing standards do not apply to ICF/IIDs.
- Final rule excludes some Medicaid payments from state calculations where Medicaid is not the primary payer, such as Medicaid payments for Medicare cost sharing for dually eligible individuals
- States have 4 years to implement these requirements
  - After June 21, 2028 for FFS or the first rating period for managed care contracts beginning on or after June 21, 2028

Payment Rate Transparency, cont.

- CMS acknowledged MACPAC's March 2023 recommendation that the agency require nursing facilities to report a broader array of payment information
  - MACPAC suggested that CMS make nursing facility payment rates publicly available beyond the share of payments spent on staffing, and collect data on provider contributions to the non-federal share of Medicaid payments needed to calculate net provider payments
  - MACPAC also suggested that states reporting these data should compare payments to all costs of care for Medicaid-covered residents, not only staffing costs, and that these analyses should include assessments of quality outcomes and health disparities
  - In the final rule, CMS deferred to states on whether to make this information available. CMS stated that the reporting requirement will provide data that may not be entirely captured in the data elements recommended by MACPAC in its report to Congress
  - CMS did not fully implement MACPAC's recommendations for nursing facility payments but new institutional payment transparency reporting will provide access to some data elements the Commission considers necessary for evaluating nursing facility payments relative to costs

Questions?

- Staff welcome any Commissioner questions or feedback on areas that Commissioners would like us to monitor

Next Steps

Next Steps

- In the coming months, staff will monitor implementation of the final rules, including, for example, the publication of subregulatory guidance and state experience
- There is no specific action required of the Commission at this time but staff welcome any Commissioner questions or areas that Commissioners would like us to monitor

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