Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
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Jill Darling: Great. Thank you so much. Welcome, everyone. My name is Jill Darling, and I am in the CMS Office of Communications, and welcome to today's Rural Health Open Door Forum. Again, thank you for your patience as we are getting folks in. Before we begin with our agenda, I have a few announcements. For those who need closed captioning, I will provide a link for you located in the chat function of the webinar. I will do that throughout the webinar if needed. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link is on the agenda, and I will also provide it in the chat as well. If you are a member of the press, please refrain from asking questions during today's webinar. If you have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar there are no slides, just the agenda slide you see on your screen. We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda for the Rural Health Open Door Forum call. We ask that any live questions, I'm sorry, here we go. Sorry about that. We ask that any live questions relate to the topics presented during today's Open Door Forum call. If you have questions unrelated to those agenda items, we may not have the appropriate person on the call to answer your questions. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox, and we will try to get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen when it is time for Q&A, and we will call on you when it's time. Please introduce yourself and what organization or business you are calling from. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. And we will do our best to get to all your questions today. And now I will turn the call over to our co-chair, Heather Grimsley.

Heather Grimsley: Thanks, Jill. Welcome, everybody. Good morning and good afternoon. John and I appreciate everybody taking the time to join today's Rural Health Open Door Forum and also appreciate our speakers that are going to present today. We have two presentations today, both talking about recent final rules that we think will be interesting for this audience. So, we're going to get right to it, and I'm going to turn it over to Karen to talk about, to provide an overview of the Ensuring Access to Medicaid Services Final Rule. Thanks, Karen.

Karen Llanos: Sure, thank you. So, my name is Karen Llanos. I work at the Center for Medicaid and CHIP (Children's Health Insurance Program) Services, and I am really happy to talk to you all today about one of the topics under the Ensuring Access to Medicaid Services

Final Rule, which we released in April, just a month ago. I put in the chat box our webpage, where you can find a fact sheet and additional information about this final rule.

So, the Ensuring Access to Medicaid Services Rule covers three main topics. I'll be covering the Medicaid Advisory Committee's topic. I believe the home- and community-based services topic was covered in a different meeting, so we won't be talking about that one. And then my colleague, Jeremy Silanskis, will cover the fee-for-service provisions in this rule.

So, the Medicaid Advisory Committees, this is a, it used to be called Medical Care Advisory Committees or MCACs—some of you might be familiar with this. It's a long-standing provision dating back to, I believe, the seventies. This provision required state Medicaid agencies to have a Medical Care Advisory Committee in place to advise Medicaid agencies about health and medical care services. When we were doing our research for this, preparing for rule writing, we found out that Medicaid beneficiaries were not always aware that their state had these types of committees, or they didn't know that they were meeting or the different topics that were discussed. So, we really felt that these regulations had really limited details and requirements for how a state should operate their MCACs. This really resulted in wide variation across the country in terms of how the committees were operated and the quality of the committees across the different states. They also made very little mention about how beneficiary perspective and the lived Medicaid experience should be considered. The final rule includes new requirements and standards to ensure that the redesigned MCACs, now named Medicaid Advisory Committees, really achieve their purpose. Specifically, these new MAC—that's the acronym that we use, Medicaid Advisory Committee, MAC—provisions in the final rule amend existing and add new federal requirements in a variety of different areas. And I'll touch upon each of them briefly. The first is that we expanded the scope and the use of the Medical Care Advisory Committees. Now these committees can be used by states to really serve as a venue that enhances bidirectional communication across the different members and really focuses on trying to get more active engagement and discussion between states and the members of the committee.

Second, we established minimum requirements for the MAC membership. So, in the final rule, we set parameters for the types of representatives of the Medicaid committee that should be sitting around the table advising the state on the Medicaid program. Now, a state must engage with different types of heterogeneous groups that are impacted by the Medicaid program. In the rule, we give examples, and we set minimum requirements for representation, but we want providers, advocates, Medicaid beneficiaries, health plans, etc. Specifically, we also state in the regulation that a minimum of this larger committee, the MAC, needs to be members from the newly required Beneficiary Advisory Council, or the BAC. In addition to having that 25% membership coming from beneficiaries, their family members, or their caregivers, the rest of the Medicaid Advisory Committee would need at least one from each of the following categories. So, state and local consumer advocacy groups or other community-based organizations that represent the interests of Medicaid or direct services to Medicaid beneficiaries, clinical providers, or administrators who are familiar with the health and social needs of Medicaid beneficiaries. If the state has Medicaid Managed Care, then we want managed care

representation around the table. And then, finally, state agencies that serve Medicaid beneficiaries. For example, agencies like foster care, mental health agencies, public health departments, different state agencies that might be delegated to conduct eligibility determinations, state units on the aging and needs, etc., and needs state representatives which serve as ex officio, non-voting members. We also talk about, and we encourage the state to consider, geographical diversity when selecting members for this committee. So, for example, urban and rural representation. We also asked for the state to consider the demographic representation of their membership by looking at members who represented pediatric health care, behavioral health, preventive and reproductive health services, health services pertaining specifically to people over 65, and health or services pertaining specifically to people with disabilities. So, we really wanted to create a broad bucket of the types of people that represent the Medicaid community in each state, but we also wanted to allow flexibility for the states to determine their membership based on their particular Medicaid environment.

Next, we required states to establish the Beneficiary Advisory Council, or BAC, that I mentioned, and we talked about what that means in terms of who could fit those requirements. I mentioned people with past or current Medicaid experience, their family members, and/or their caregivers. So, we set that 25% minimum threshold of that council to serve on this broader committee, and we really wanted that interactivity. We also set a glide path for reaching that 25% crossover, understanding that it might take a while for states to recruit members for the Beneficiary Advisory Council. So, in year one, 10%, in year two, 20%, and thereafter, 25%. In the final rule, we also talk about different ways to promote transparency and accountability between the state and the interested parties, and we added requirements that make information on the activities publicly available, and that includes meeting agendas, minutes, and membership lists. These were not requirements before, but we know that we want to make sure that the public and the community is aware of the activities of these two of this committee and the council. Another example is that we required the state to make at least two of the MAC committees per year open to the public, and those meetings must include a dedicated time during the meeting for the public to make comments.

Then, finally, we required states to create and post an annual report that summarized the activities for both the MAC and the BAC. So, just to note, for those of you that we're tracking with the notice for proposed rulemaking, we really did take into account, to the extent possible, the comments that we got. We wanted to make sure that we did things like renamed the beneficiary group to Beneficiary Advisory Council. We provided states with additional time to achieve that 25% minimum threshold because we heard that states needed more time to set these different committees up and to recruit members. We also adjusted the implementation time frame for the completion of that first annual report. So, we really wanted to make sure that we solidified the importance of enhancing the beneficiary voice by creating different avenues for the states to implement, increase bidirectional feedback with interested parties, and promote transparency and in-house accountability in different ways. So, with that, Jeremy, I'll turn it over to you.

Jeremy Silanskis: Great, thanks, Karen. Good afternoon, everyone. I'm Jeremy Silanskis. I'm a Deputy Group Director with the Financial Management Group in Medicaid. So, I'm going to start with some basic facts. Under Medicaid, each state sets their own rates. So, we have the unique state Medicaid programs, and for the vast majority of Medicaid services, the states are setting individual rates. And then, from the CMS perspective, we review state plan methodologies for fee-for-service, and we approve methods, but we don't look at individual rates, and there's still a tremendous amount of spending in Medicaid. We're over $800 billion annually in expenditures. But what the dynamic sets up is that we don't have great insight into how Medicaid payment rates compare. And so, you know, we had fee-for-service provisions in regulation already, and what the final rule that we issued recently does is it replaces those regulatory requirements which required that states document access through a document that was called an Access Monitoring Review Plan (AMRP). States and other stakeholders found that plan process to be very burdensome and ineffective, and they've repeatedly asked CMS to consider changing the requirements. So, the new regulatory fee-for-service procedures address the stakeholder concerns by focusing on transparency and payment rates, stakeholder engagement, and a targeted approach to documenting access when states propose to reduce or restructure their fee-for-service rates through that state plan amendment process that I talked about earlier, where we look at their methodologies.

So, under the rule, states are required to publish and keep current their fee-for-service rates on a state website that's accessible to the public. And a lot of states already did that, but there were a variety of ways that they did it. Sometimes, you needed special access to go in to see certain rates, but the new rule sets a standard so everyone in the public can go in and take a look at a particular code associated with a service associated with qualified providers.

In addition, states are required to compare their fee-for-service payment rates for primary care, obstetrical and gynecological, and outpatient mental health and substance use disorder services to Medicare rates and publish the comparative analysis every two years. That comparative payment rate analysis compares the state agency's Medicaid fee-for-service fee schedule payment rates to the most recently published Medicare payment rates effective for the same time period for the E&M (Evaluation and Management) codes applicable to the category of service. So, an apples to apples comparison between what Medicare pays and what Medicaid pays. It's conducted at the CPT (Current Procedural Terminology) or HCPC (Healthcare Common Procedure Coding System) code level as applicable for the service using the most current set of codes published by CMS.

And so similarly, states are required to publish an average hourly rate paid for personal care, home health aide, homemaker, and habilitation services and publish that disclosure every two years. Those home- and community-based services do not have an equivalent Medicare payment rate to make a comparison, and so the disclosure of those rates presented as an hourly amount will allow the public to see how the service rates compare across the Medicaid program. So again, those are transparency provisions, right? We will have all the rates out there, we'll have some level of information to compare to Medicare, and for some services where there isn't a

Medicare analog, we'll have rates that are scaled at a specific unit that people can compare across states.

In addition to that, in an effort to better engage the home community-based service stakeholder community, the rule requires states to establish an advisory group for direct care workers, beneficiaries, beneficiary authorized representatives, and other interested parties to meet at least every two years and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services. That group will present findings and recommendations to state Medicaid agencies on HCBS (Home- and Community-Based Services) payment rates and access to care. And then finally, the rule requires states to demonstrate access sufficiency through an initial analysis when submitting a state plan amendment. That's again a document that we look at and approve to ensure that states' rates meet federal requirements. With each rate reduction that they submit to us, we're restructuring circumstances that could reduce access for all services. They're required to pass this initial analysis to us. The level of analysis to demonstrate sufficient access required for the state's proposed rate change is dependent on how Medicaid payment rates compare to Medicare. So, if they're at or above 80%, that's one threshold—the proposed decrease amount. If the decrease is less than 4% of spending for a service category, and whether access concerns have been raised through the public process. If they pass all of those threshold questions, then they still need to submit information to us to say, "Hey, this rate reduction or restructuring is consistent with our statutory requirement," but it's not a standardized process. The states will have some discretion on the types of information that they send into us. If they don't need any of those threshold questions, then we have specific data and information that is prescribed in the rule that they'll need to send into us through a template format, and we'll evaluate that information to ensure that access to care is sufficient. We're working on issuing a template to states to make that process easier for them. We're hoping to get that out soon. It goes through a full OMB (Office of Management and Budget) approval process, and we're in the stages of getting that out. So, that covers the fee-for-service provisions for the Access Rule. I'm going to turn it over to John Giles to talk about the Managed Care Access Finance and Quality Rule. Thanks.

John Giles: Thanks, Jeremy. Hi, everyone. My name is John Giles. I'm the Director of our Managed Care Group here in the Center for Medicaid and CHIP Services, and I'm going to provide a high-level overview of the recent Managed Care Final Rule, which was displayed on the same day as the Access Rule that you just heard about. So maybe just a couple of background pieces on why the Managed Care Rule is so significant. More than 80% of Medicaid beneficiaries are enrolled in a managed care plan or a managed care delivery system, and more than half of Medicaid's expenditures, approximately $450 billion, are spent on managed care services. So, I'm going to quickly highlight some of the policies that we finalized as part of the recent Managed Care Rule. So first, we finalized policies for Medicaid and CHIP managed care to strengthen our existing rules on network adequacy and access to care. This included setting a national standard for appointment wait times in Medicaid and CHIP managed care for key provider types for both the adult and pediatric Medicaid and CHIP populations. This included setting appointment wait times for primary care and OBGYN services at 15 business days and

mental health and substance use disorder services at 10 business days. The rule requires that managed care plans would be required to achieve those appointment wait time standards 90% of the time. Additionally, the rule allows states to select an additional provider type under their managed care contract for which they will set the appointment wait time standard. The Managed Care Rule also finalizes several other important tools to help strengthen and focus on access to care issues in Medicaid and CHIP managed care. This includes requiring an annual independent secret shopper survey that will be used to validate appointment wait times and provider directory accuracy information in Medicaid and CHIP managed care. The rule also requires states to implement annual enrollee experience surveys with managed care enrollees. You just heard Jeremy talk about the payment analysis that is required in the fee-for-service rule. The Managed Care Rule requires a similar analysis and requires states to collect and submit annual payment data that will compare managed care provider rates to Medicare or Medicaid fee-for-service rates for specific HCBS services, and that includes homemaker, home health aide, personal care, and habilitation. The rule also requires that states develop remedy plans to address any known or emerging access issues or deficiencies that are found in any of the access policies that I just covered.

The Managed Care Rule also includes provisions to finalize in regulation provisions around what we call in Medicaid managed care "in lieu of services or settings" (ILOSs). So, an "in lieu of service or setting" is something that a managed care plan—a state authorizes with their managed care plan that allows their managed care plan to offer a substitute service for a covered service in a Medicaid state plan. So, in this rule, we finalized regulations that clarified that in lieu of services or settings can be used as both immediate or longer-term substitutes for covered Medicaid services and benefits and that those services can focus on prevention that could reduce costs over a longer time horizon and address underlying health-related social needs. This would include things such as housing instability, nutritional insecurity, or environmental modifications.

The Managed Care Rule also includes important updates to some of our payment policies, specifically related to state-directed payments. In Medicaid managed care, states can contractually require their managed care plans to pay providers in specific ways. And they do that through a process with CMS to seek prior approval of that payment arrangement and then they implement contractual provisions with their managed care plan to pay providers in those specific ways. So, our final rule includes updates to those policies that reflect important tools to strengthen program and fiscal integrity to eliminate unnecessary regulatory barriers for states and plans developing and implementing value-based payment structures with their providers and ensure that payments made to providers are based on the delivery of services to managed care enrollees and that payments reflect improvements in quality of care provided to managed care enrollees and that states and CMS are both appropriately evaluating provider payment mechanisms to ensure that those payments are aligned with program goals and objectives. Notably, in this rule, we finalized an average commercial rate for inpatient and outpatient hospital services, nursing facility services, as well as the professional services at an academic medical center. And no additional expenditure limits were finalized for state directed payments.

Also related to state-directed payments, CMS released a CMCS informational bulletin that coincides with the Managed Care Final Rule. This CIB (CMCS Informational Bulletin) addresses CMS' exercise of enforcement discretion until January 1, 2028, for existing health care related tax programs to withhold harmless arrangements that involved the redistribution of Medicaid payments in order to give states and providers a clear timeline to transition away from potentially impermissible arrangements and to come into compliance with federal law. This step ensures compliance while preserving stability for health care providers, particularly safety net providers, as well as for Medicaid-eligible individuals. It is important to reiterate that the CIB's non-enforcement policy applies only to existing health care related tax programs and withhold harmless arrangements involving the redistribution of Medicaid payments. We expect states that have existing hold harmless arrangements to undertake changes necessary so that the state is compliant with all non-federal share financing requirements by no later than January 1, 2028.

Finally, I wanted to highlight that through this final rule, we are establishing the CMS framework for the Medicaid and CHIP Quality Rating System (QRS). We first articulated our intention to establish a quality rating system for Medicaid and CHIP in the 2016 Managed Care Rule, and the intent of this QRS is to provide beneficiaries with meaningful information to support plan selection and to improve transparency. The framework we are finalizing in this rule was based on many years of engagement with beneficiaries as well as with state partners and aims to provide a one-stop shop by including elements in the QRS such as linking to the plan's provider directories and prescription drug coverage information. The framework includes a list of mandatory quality measures selected through extensive engagement and consideration of alignment with other QRSs and CMS measurement programs. The framework also includes methodology requirements for calculating quality ratings as well as website design requirements to ensure that beneficiary-facing information in each state's QRS really meets the needs that we heard from enrollees. And at the same time, we're giving states the flexibility to customize their QRS to their state context, for instance, by allowing states to incorporate additional quality measurement.

One last note to mention on the Managed Care Final Rule is that CHIP generally is aligning with all of Medicaid on all of the policies that I just covered, with the exception of state-directed payments, which do not exist in CHIP, as well as for how the Enrollee Experience Surveys will ultimately be reported to CMS via CHIP in the existing CAHPS (Consumer Assessment of Healthcare Providers & Systems) Survey. And with that, I will turn the call back over to, I think, maybe we're going into Q&A.

Jill Darling: Yes, thanks, John. And thank you to Karen and Jeremy. We will be going into Q&A, so if you have a question, please use the raise hand feature at the bottom of your screen. Please have one question and one follow-up question, and we'll give it a moment to see if we get any hands.

OK, I am not seeing any hands, so that could be good news. I am going to provide the Rural Health Open Door Forum email for everyone in case you want to send a comment or question. I will pass it to John Hammarlund for closing remarks.

John Hammarlund: Thanks a lot, Jill. Well, thanks, CMS colleagues, for presenting today. This is really useful information. I hope all of you out there in telephone and Zoom land find that it was useful for you as well. We look forward to talking to you in approximately six weeks from now for our next call, something like that. And as I always like to remind folks, you have a chance to craft the agendas for these meetings. You have a chance to let us know what you would like to hear from us about. So, that box that Jill just sent you, the RuralHealthODF@cms.hhs.gov, is the way for you to reach out to us and let us know what you'd like to hear about the next time we meet in about six weeks.

So, I really do encourage you to stay in touch with us and help craft the agendas moving forward because we want to make sure that they are as responsive to your needs as possible. Thanks again for joining us today. We really appreciate it. Thanks to my Co-Chair, Heather, for leading us off, and thanks again to the presenters. We'll be talking to you in about six or so weeks. With that, I'll hand it back to you, Jill.

Jill Darling: Great. Thank you, John. Thank you, everyone, for joining us. This concludes today's call. Have a great day.