CLIENT ALERT: ACCESS TO CARE/NETWORK ADEQUACY

CMS Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-F)

On May 10, 2024, the Centers for Medicare and Medicaid Services (CMS) published a final rule titled: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-F) in the Federal Register. Myers and Stauffer is providing this alert to states to make them aware of several notable provisions related to network adequacy and access and to help inform each state's evaluation of the final rule language and potential concerns.

For the full final rule text, see: https://www.federalregister.gov/public-inspection/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and

The final rule, aimed to strengthen the standards and monitoring applicable to access to care in the Medicaid managed care environment, will:

- Establish national maximum appointment wait time of 15 business days for routine primary care, obstetric/gynecological (OB/GYN), and 10 business days for routine outpatient behavioral health and substance use disorder (SUD) services.
- Require secret shopper surveys as part of monitoring activities, using independent entities.
- Require an annual enrollee experience survey.
- Require the performance of an annual payment analysis to compare managed care organization (MCO) payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate.
- For any MCO with access issue(s) that need improvement, require a remediation plan.
- Require reporting of assurances related to adequate capacity and services.
- Require public transparency.

Additional discussion for each of these elements is included below:

1. Establish maximum appointment wait-time standards for routine primary care, OB/GYN, outpatient behavioral health and SUD services and a state-selected service. (§§ 438.68(e), 457.1218).
2. Require secret-shopper surveys as part of monitoring activities and use independent entities (§§ 438.68(f), 457.1207, 457.1218).

3. Conduct an annual enrollee experience survey (§§ 438.66(b) and (c), 457.1230(b)).
4. Conduct annual payment analysis to compare MCO payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate (§§ 438.207(b), 457.1230(b)).
5. Implement a remedy plan for any MCO with access issue(s) that need improvement (§ 438.207(f)).
6. Provide assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b)) CMS' rule would include the provision of additional assurances and reporting of capacity and services.
7. Ensure transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285).

1. Establish maximum appointment wait-time standards for routine primary care, OB/GYN, outpatient behavioral health and SUD services and a state-selected service. (§§ 438.68(e), 457.1218).

CMS is scheduled to finalize in the rule the following national wait-time standards:

- No longer than 10 business days for routine outpatient mental health and SUD services
- No longer than 15 business days for routine primary care and OB/GYN services.

In addition to the service types listed above, states must select at least one additional type of service and establish corresponding wait times, using an evidence-based approach for Medicaid. It is understood that some services may not be covered by all health plans. The state will be required indicate the additional provider type(s) in the Managed Care Program Annual Report, per § 438.66(e), and the Network Adequacy and Access Assurances Report, per § 438.207(d). CMS revised the final rule to apply the wait time standards based on the service type rather than the provider type to allow for instances such as primary care physicians performing OB/GYN care in response to comments received on the proposed rule. Appointment wait time access will have a compliance expectation of 90 percent.

The standards are based on the Affordable Care Act (ACA) marketplace standards, which will become effective in 2024. The final rule allows States the authority to vary the wait times for the same service type — for example, adult or pediatric; in person or telehealth. It is important to note that CMS is not defining "routine" and is expecting the states to work with the health plans to determine the definition for their state. States can take the initiative to set appointment wait times for urgent appointments, too.

The standards would be a requirement in the health plan contract. CMS is also revising § 438.206(c)(1)(i), which will require including the appointment wait time standards as a required provision in the managed care plan Medicaid contract.

CMS encourages telehealth and suggests that States may wish to consider telehealth appointment wait times, in addition to the in-person requirements. Utilizing encounter data to measure telehealth use is a monitoring tool available for State managed care programs.

Finally, the final rule contains a new provision in §438.214(d)(2) to ensure health plan contracts contain a requirement that terminated providers cannot participate as a provider in an Medicaid managed care network. This provision is effective no later than July 9, 2024, the effective date of the final rule.

Applicability date: No later than the first rating period beginning on or after three years after the effective date of the final rule.

2. **Require secret-shopper surveys as part of monitoring activities and use independent entities (§§ 438.68(f), 457.1207, 457.1218).**

   To more effectively monitor access and identify any gaps, the final rule will require states to perform annual secret-shopper surveys and report the results. To ensure unbiased results, CMS' final rule also requires States to use an independent entity to perform this activity. For an entity to be considered independent, it cannot be part of any state governmental agency and cannot be owned or controlled by any of the health plans.

   The accuracy of four data elements must be verified: active network status with the MCO; street address (§ 438.10(h)(1)(ii)); telephone number (§ 438.10(h)(1)(iii)); and whether provider is accepting new enrollees (§ 438.10(h)(1)(vi)).

   The survey process also includes a review of electronic provider directories (no paper) (§ 438.10(h)(1)), for primary care providers, OB/GYN, outpatient mental health and SUD providers, and the state-chosen provider type.

   The final rule requires the secret-shopper survey be completed with a statistically valid sample of providers, using a random sample and including all areas of the state covered by the managed care contracts (§ 438.68(f)(4)).

   For health plans to be considered compliant, the independent results from a statistically valid sample need to show that the appointment availability standards were met at least 90 percent of the time. Offered telehealth appointments may only be counted for compliance purposes if in-person appointments are available, and telehealth appointment should be identified separately in the survey results.

   In § 438.68(f)(1)(iii) and (iv) respectively, to maximize the value, identified errors from the secret-shopper survey must be communicated by the entity conducting the secret shopper survey to states no later than three business days, and states must send those errors to the applicable health plan within three days of receipt. The error information must be sufficient to facilitate correction. Health plans must update the provider directory within the time frames specified in § 438.10(h)(3)(i) and (ii).

Applicability date: No later than the first rating period beginning on or after four years after the effective date of the final rule.

3. **Conduct an annual enrollee experience survey (§§ 438.66(b), 438.66(c), 457.1230(b) and 457.1207).**

   The final rule adds the requirement that states conduct an annual survey of its enrollees to solicit comment and to better understand the challenges that those individuals might face in obtaining timely and quality care to meet their needs. The disparities in access to care may be a function of the availability of providers who are willing to provide care to the medically underserved populations, and this could provide a means for states to address that issue.

These surveys should focus on matters important to enrollees, as well as on the perceived experience from the enrollees who participate in the survey. Some states are using this type of survey, like the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the National Core Indicators-Aging and Disabilities (NCI-AD®) Adult Consumer Survey.™ These surveys should support other network adequacy activities.

Most states are using a CAHPS® survey as part of the external quality review voluntary protocols, which provides for and includes an enhanced federal match up to 75 percent; however, for those states who are not or only periodically using the CAHPS® survey, this change may impact the scope of work for the external quality review organization, if contracted to perform, or the health plans, when the requirement is added to the health plan contract. The frequency of the annual survey, while important to know how policies implemented are changing the managed care program, may impact the results received from the survey.

CMS has updated § 438.66(c)(5) to require that States conduct an annual enrollee experience survey and to be explicit that use of provider survey results alone would not be sufficient to comply with § 438.66(c)(5). Also, CMS is not requiring provider surveys at this time; however, it is indicated in the final rule that the results of these surveys and the secret-shopper results may impact decisions at a later date.

The final rule requires posting the results of the survey on the state's website within 30 calendar days of submitting the report to CMS. The surveys must meet the interpretation, translation, and tagline criteria in § 438.10(d)(2).

Applicability date §§ 438.66(b) and (c): No later than on or three years after the effective date of the final rule.
Applicability date § 457.1230(b): The first rating period beginning on or two years after the effective date of the rule.

4. Annual payment analysis to compare MCO payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate (§§ 438.207(b), 457.1230(b)).

In its efforts to improve enrollee safety and quality of care, CMS has encouraged states to link Medicaid payments to quality measures. CMS believes that payment rates are linked to provider network sufficiency and that greater transparency of the rates is needed to determine if those rates are impacting enrollee access to care.

The provision in § 438.207(b)(3) requires the health plan to conduct a payment analysis and submit annual documentation to the state. The requirement includes the criteria for services to be included and the methodology for the comparison.

CMS indicates in the final rule that the payment analysis results would be in the aggregate and would include evaluation and management (E&M) codes only. Other types of services and alternative payment structures can be submitted in an additional field in the Network Adequacy and Access Report (NAAAR), but are not required at this time.

As states are implementing this requirement, considerations regarding the data integrity may be considered. In the past, the health plans have been reluctant to provide payment rates to states as the rates are seen as proprietary to the health plan and part of the negotiation strategy for provider contracting and business operations. The states are dependent on self-reported (health plan) data and would potentially need to evaluate the validation of the data to ensure the results are accurate.

Applicability date: No later than the first rating period beginning on or after two years after the effective date of the final rule.

5. **Implement a remedy plan for any MCO with access issue(s) that need improvement (§ 438.207(f)).**

   Under the final rule, if an issue is identified with a managed care plan's performance with regard to any state standard for access to care, the state must follow the paragraphs (i) through (iv).

   - Develop a remedy plan to address the identified issue that, if addressed, could improve access within 12 months and that identifies specific steps, timelines for implementation and completion, and responsible parties.
   - Some approaches to address the issues are located in § 438.207(f)(1)(ii) for states to consider.
   - Improvements in access to care need to be measurable and sustainable.
   - Submit remedy plan to CMS no later than 90 calendar days following the date the issue was identified.
   - States would submit quarterly progress updates to CMS after the remedy plan has been implemented.
   - If progress is not sufficient, state may be required to continue past the initial 12 months or revise the remedy plan.

Applicability date: No later than the first rating period beginning on or after four years after the effective date of the final rule.

6. **Provide assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b)) CMS' final rule includes the provision of additional assurances and reporting of capacity and services.**

   The final rule requires states to use a CMS-published template for reporting assurance of compliance. CMS published the "Network Adequacy and Access Assurances Report" template in a July 6, 2022, CMCS Informational Bulletin. The final rule requires the secret-shopper evaluation results as well as the payment analysis results as a component of the assurance report. The submission will be required at the time of a readiness review, on an annual basis no later than 180 days after the end of the contract year, or any time there is a significant change and with submission of an associated contract.

Applicability date: CMS requires states to include the results from the secret shopper surveys proposed in § 438.68(f) (see section I.B.1.c. of the final rule) no later than the first rating period beginning on or after one year after the effective date of the final rule. States must include the payment analysis proposed in § 438.207(b)(3) (see section I.B.1.d. of the final rule) to the NAAAR no later than the first rating period for contracts beginning on or after two years after the effective date of the rule.

7. **Transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285)**

Ensuring that enrollees can easily and efficiently locate the information needed for them to obtain timely, quality care is the focus of this section of the final rule. CMS is building upon the requirements that states must already adhere to in the information that must be made available on a single, public-facing website, by requiring a number of minimum qualities that each website must include, as well as information regarding the network adequacy standards that are required.

CMS also believes that states and MCOs should implement and use web analytics to monitor traffic on the website and inform needed changes in the design. States must check their websites quarterly to verify the website is functioning as expected and information is current. There are currently four types of information required to be posted; this final rule would add nine more items, including enrollee handbooks, provider directories, formularies, information on rate ranges, state-directed payment evaluation reports, network adequacy standards, documentation of compliance with Subpart K-Parity in Mental Health and Substance Use Disorders, reports required by §§ 438.66(g) and 438.207(d), and secret-shopper survey results.

Applicability date: No later than the first rating period beginning on or after two years the effective date of the final rule.

Next Steps:

- Assess your managed care health plans' reporting in network adequacy. Determine if required information needed to be in compliance with the requirements is currently being obtained.
- Assess other monitoring currently being performed to determine if these requirements are already in place.
- Consider performing an environmental scan related to network adequacy. This exercise will provide each state with the current status regarding what requirements are in place, identify gaps, and reveal opportunities to enhance current processes.

FOR MORE INFORMATION

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