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Coordinator: Welcome, and thank you for standing by. I would like to inform all participants that your lines have been placed on a listen-only mode until the question-and-answer session of today's call. Today's call is being recorded. If anyone has any objections, you may disconnect at this time. I would now like to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you, and good afternoon, and welcome everyone to today's All-State Call and Webinar. I'll now turn to Dan Tsai, our Center Director for opening remarks. Dan?

Dan Tsai: Thanks. Greetings, everybody. Thanks for joining. For those of you that were on with us, hopefully many folks last week, we went through the recently finalized and released Access Rule, and today the team is going to go through the managed care rule.

As I said last week, our team and hopefully many of you all are both very excited about these rules and how we think about strengthening things that really matter in the program, both in how we work with and oversee collectively managed care plans and how we think about what access means.

And you'll hear in the managed care rule today some very concrete things that

I know. The states have been aware of and waited in on substantially around wait times and things of that sort, but I also acknowledge last time, and I want to do that again today, that there is a lot of work, a lot to do from an implementation standpoint, both for outlining some of the nitty-gritty and very important operational details on each of these rules and provisions, but also the whether it be a systems or an operational or a contract or a rate implication - rate setting implication for managed care in this case, and what that means.

And so the timing of provisions across these rules, including the managed care rule today really span out. I think some of them go out, I can't remember offhand, up through seven years, et cetera, from where we are today, really to provide runway and a sense of direction of where we're all trying to head.

So, I want to thank folks in advance, our state and other colleagues, and also our team for collectively over the long run just thinking about how we continue to build on and strengthen the program. So, you'll hear from the team today on a range of provisions.

So, John, I believe, John Giles, who's the Group Director for Managed Care Group; and then Laura Snyder, also in that group; and Rory Howe, who's the Group Director for the - our Financial Management Group. Amanda Paige Burns will talk about a lot of the really exciting quality and quality rating system provisions that really are quite exciting when you think about what that means over the long-term. And so that - I'll leave it to the team to go through things there.

Before we get into that, Cathy from our pharmacy team is going to quickly go through some brief updates on Medicaid drug rebates. And so, lastly, I think folks know, if you are - you should log in, if you haven't already to the webinar platform, there will be slides, you can put in questions there, and

there's going to be Q&A time. So, with that, I'm going to first turn it to Cathy on drugs, and then, Cathy, you can turn it to the team on the managed care rule. Thanks. Cathy?

Cathy Traugott: Thank you, Dan. As Dan mentioned, I am Cathy Traugott, I'm with the Division of Pharmacy here at CMS. And as he mentioned, we just want to cover two topics very quickly that have been coming up a lot lately. The first one relates to coverage standards under the drug benefits.

We can go to the next slide, please. With this, generally, if a manufacturer participates in the rebate program, states must cover that manufacturer's drugs when they meet the definition of a covered outpatient drug. And unless there's a limited exception that applies, states may - basically must cover those covered outpatient drugs for all of the medically accepted indications.

And the medically accepted indications or any FDA-approved indications and any indications that are supported by compendia that are outlined in the statute. There are a few exceptions to this. There are a few indications, for example, agents used for anorexia, weight loss, or weight gain, they do not have to cover products for these specific indications.

The question that has come up is, what does that mean for a product that has both an FDA-approved indication for which the drug must be covered, and it has one of these excluded indications? Well, what it means is you do need to cover the drug for that FDA, any FDA-approved indication, except for the one that is excluded.

And we can use Wegovy, which is a product that has recently been approved that I'm sure a lot of you are very familiar with, as an example. When it was first approved, it was approved for chronic weight management only. That

really falls under that exception where your state did not have to cover it because it couldn't be used for weight loss.

However, recently the FDA added another indication that relates to cardiovascular events. That does fall under the coverage standards. So, what this really means is that states must cover Wegovy for those cardiovascular events, but still do not have to cover it for the weight loss.

Now states can cover products for weight loss if they want, and it needs to be a part of their state plan and done in accordance with their state plan. So, if states have any questions about coverage related to weight loss, please reach out to someone here in the Division of Pharmacy, and we'd be happy to talk through it with you.

Next slide, please. The other topic we wanted to cover very quickly are drug shortages, because many of you are also aware, there have been drug shortages over the years, and in particular recently there have been a number that have definitely affected Medicaid - the Medicaid population. This includes Extencilline has been very much a topic of conversation.

So, we wanted to just clarify, how things work when there's a drug shortage. And the FDA has allowed temporary importation of a non-FDA approved drug from another country to mitigate the effects of that drug shortage until the drug shortage can be addressed. So, because these are non-FDA approved drugs that are coming from another country, they do not meet the definition of a covered outpatient drug and, therefore, are not eligible for rebates under the Medicaid program.

However, states are eligible for FFP if they want to cover these drugs. So, we wanted to clarify that these drugs can be covered, and you can receive FFP for

these products. You do need to have in your state plan that you will want to cover these products for this particular reason. So, if states do not already have that language in their state plan, you can have that added through state plan amendments.

We have some suggested language here on the slide, but we're also willing to talk through it with you and your particular state situation and see what language might work for your state for this specific coverage if you want to cover it. So, please feel free to reach out to anyone in the Division of Pharmacy to help you with that.

And again, we can always answer any questions about either of these topics later in this presentation or at another time. But in the meantime, I will turn it over to John Giles to continue his presentation.

John Giles: Thanks, Cathy. Hi, everyone. I'm going to start walking us through a deep dive on the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule. Next slide please.

Before we get into the deep dive, and I know you are - you have seen these slides last week when the Access Rule did their deep dive, but just once again to provide sort of an overarching view for the policies across both the Access and the managed care rule.

CMS did release two final rules, ensuring access to Medicaid Services and the Managed Care Access, Finance, and Quality Final Rule. These final rules really support the Biden-Harris Administration's efforts to advance groundbreaking and high-impact solutions to ensure greater access to Medicaid and CHIP services for all eligible individuals.

In combination, these rules establish historic national standards for access to care regardless of whether that care is provided through a managed care plan or directly by a state through fee-for-service. These rules do include staggered applicability dates to allow states and managed care plans adequate time to implement changes, some of which will require some significant process and system updates.

Next slide. So, just a few key provisions that cut across both of these rules before we do the deep dive on managed care. These rules establish national maximum standards for certain appointment wait times for Medicaid and CHIP managed care enrollees and require stronger state monitoring and reporting requirements related to access and network adequacy for Medicaid and CHIP managed care plans, which now cover the majority of Medicaid and CHIP beneficiaries in Medicaid.

These rules require states to conduct independent secret shopper surveys of Medicaid and CHIP managed care plans, to assess compliance with appointment wait time standards, and to identify inaccurate information in provider directories.

The rules create new payment transparency requirements for states by requiring the disclosure of provider payment rates in fee-for-service and a comparison to Medicare rates for certain services in fee-for-service and managed care with the overarching goal of greater insight into how Medicaid payment levels affect access to care.

The rules also establish additional transparency and interested party engagement requirements for setting Medicaid payment rates for home and community-based services, as well as the requirement that at least 80% of Medicaid payments for personal care, homemaker and home health aide

services be spent on compensation for direct care workers. Next slide.

The rules also create timeliness of access measures for HCBS services, strengthening necessary safeguards to ensure beneficiary health and welfare, and promoting quality of care and health equity in HCBS. The rules strengthen how states use their state Medicaid advisory committees through which various interested parties can advise Medicaid agencies about health and medical care services to ensure that all states are using these committees optimally to realize a more effective and efficient Medicaid program that is informed by the experiences of Medicaid beneficiaries, caretakers, and other interested parties.

The rules require states to conduct enrollee experience surveys annually for each managed care plan to gather input directly from enrollees. And the rules establish a framework for states to implement the Medicaid and CHIP quality rating system as a one-stop shop for enrollees to compare Medicaid and CHIP managed care plans based on quality of care, access to providers, covered benefits, drugs, costs, and other plan performance indicators.

Next slide, please. So, now, we're going to do the deep dive on the Medicaid Managed Care Access, Finance, and Quality Final Rule. So, next slide. So, just a little bit of background on managed care. I know many of you are familiar with these statistics, 85% of Medicaid beneficiaries, 83% for CHIP are now enrolled in a managed care plan, which now accounts for more than $450 billion in total Medicaid and CHIP spending, and oversight of managed care is a key priority for CMS.

There is significant variation among Medicaid and CHIP managed care programs, both within and across states. This variation can result in measurable difference in access and quality, as well as the fiscal sustainability

and program integrity of the program.

Unlike in Medicare in the marketplace, Medicaid and CHIP beneficiaries in some states do not have a way to compare their managed care plans based on quality or that meets a minimum Federal standard. And to advance our ability to monitor the effectiveness of states' managed care programs and promote the Biden-Harris Administration's priorities, we have finalized a managed care rule that will enable CMS and states to strengthen its oversight of Medicaid or CHIP programs.

Next slide. Today, we're going to do an overview of the final rule, the Managed Care Access, Finance, and Quality Final Rule displayed in the Federal Register on the same day as the Access Rule on April 22, 2024. It will be published in the Federal Register on May 10 and will have an effective date of July 9, 2024.

Applicability dates, as Dan noted at the top of the call, will really vary by provision. CMS tried to be very thoughtful as we thought through the applicability dates, in both in terms of implementation and process changes that states and plans would need to make.

In the forthcoming slides, we will summarize some of the notable provisions in the final rule, as well as any prior regulatory requirements, major changes from the proposed rule, and the applicability date for each provision. We will note any differences between provisions that apply to Medicaid and separate CHIP and proposed provisions that were not finalized. Next slide.

So, these are the topics we're going to cover today that are included in the managed care rule. We will be covering access in-lieu-of services, state-directed payments, medical loss ratio with program integrity, the quality rating

system, and then covering those provisions related to CHIP. Next slide.

So, as we noted, the way that the slides are set up is to really highlight for you the prior requirement, the final rule requirement, any major changes from the NPRM, as well as the applicability date for each section that we're going to highlight today. I'm going to primarily focus on the final rule provisions, but just note that that's how the slide is laid out.

So, on this first slide, we're covering the appointment wait time standards that will expand oversight of network adequacy in managed care. In the final rule, we are finalizing to require states to develop and enforce appointment wait time standards in addition to their other network adequacy standards that would include appointment wait times for primary care services, both adults and pediatrics, within 15 business days.

Mental health and substance use disorder services for adults and pediatrics within ten business days. Ob-Gyn services within 15 business days, as well as a state-selected service within a state-established timeframe. In the final rule, managed care plans must achieve compliance with these appointment wait time standards 90% of the time, and CMS may select additional types of services after consultation in public comment. Next slide.

Also, related to access to care, we have proposals that will increase state oversight of managed care plan performance, as well as enrollee experience. So, a couple of the final rule provisions will require an annual independent secret shopper survey that will assess managed care plan performance with the appointment wait time standards, as well as provider directory accuracy. The rule will require states to conduct an enrollee experience survey annually, that would be posted on the state's public website and reported to CMS as part of an existing reporting vehicle, which is the

MCPAR.

And we will require states to submit remedy plans to address areas in which managed care plans' access to care could be improved. And the remedy plan would include specific steps, timeframes, and responsible parties to achieve improvement within a 12-month period. Next slide.

And then finally, related to access to care, the rule will require states to submit an annual payment analysis that will compare certain managed care provider payments to Medicare or Medicaid fee-for-service. This analysis would include a separate reporting for primary care, Ob-Gyn, mental health, substance use disorder services, and personal care, homemaker, home health aide, and habilitation services. Next slide.

Now, we're going to change gears and tackle the health-related social needs with in-lieu-of-services or ILOS. So, again, in line with the Biden-Harris Administration's priorities, CMS has developed several opportunities for states to cover services that address the social determinants of health or more specifically the health-related social needs such as nutrition and housing supports.

An innovative opportunity to cover these services is as in-lieu-of-services or settings which allow managed care plans to substitute innovative and cost-effective and medically appropriate alternatives for state plan services or settings. CMS previously approved this flexibility for California in December of 2021, and we published significant sub-regulatory guidance on in-lieu-of-services in January of 2023. In our proposed rule and now in this final rule, we're codifying many of those policies. Next slide.

So, related to in-lieu-of-services, we want to expand opportunities for states to

utilize in-lieu-of-services to address both SDOH and HRSN and align opportunities across the Medicaid authorities. So, specifically, we are requiring in the rule that ILOSs can be immediate or longer term substitutes for covered state plan services or settings or when the in-lieu-of-service can be expected to reduce or prevent the future need for such state plan services or setting. The final rule also aligns in-lieu-of-services with the approvable services or settings under the state plan or a Section 1915(c) waiver. Next slide.

The rule reinforces existing enrollee protections related to in-lieu-of-services, including that the services must be optional for enrollees and that the provision or offer the in-lieu-of-service does not absolve the managed care plan from providing other medically necessary state plan services.

The rule also requires that contract requirements, including documenting in-lieu-of-service definitions. Linking each in-lieu-of-service with the services and settings for which they may substitute, identifying clinically-defined target populations, and specifying the billing codes for identifying in-lieu-of-services in the encounter data. And the rule does limit total in-lieu-of-service spending to no more than 5% of the total managed care capitation payments as certified by the state's actuary for each applicable managed care program. Next slide.

The rule also requires appropriate monitoring and oversight of in-lieu-of-services. Specifically, the rule does require a retrospective evaluation for states with in-lieu-of-service spending above 1.5% of total capitation payments, and the rule requires states to conduct ongoing monitoring of in-lieu-of-services and to develop a transition of care policy whenever an in-lieu-of service is terminated. Next slide.

Now, we're going to cover the state-directed payment provisions of the managed care rule. A little bit of background on state-directed payments. State-directed payments are contractual obligations that enable states to direct Medicaid managed care expenditures for services covered under the managed care contract. State-directed payments have become a significant payment method for states accounting for more than $52 billion annually across 39 states.

State-directed payments allow states to take a more proactive role in directing managed care plans toward key policy and delivery system investments. However, some state-directed payments are also correlated with financing challenges. Next slide.

So, the first area here on state-directed payments is really a goal to reduce state burden by implementing appropriate flexibilities for certain SDPs. So, the rule eliminates the need for CMS approval of a pre-print for state-directed payments that are minimum fee schedules at 100% of the published Medicare rate.

The rule eliminates unnecessary regulatory limitations on value-based purchasing arrangements to enable states to more easily link state-directed payments to quality metrics and other performance-based data while ensuring payments are tied to actual performance and not to reporting. And the rule allows states to utilize state-directed payments for non-network providers to ensure access to care that is often provided by non-network providers such as for family planning services. Next slide. I'm now going to hand the presentation to Rory Howe, the Director of the Financial Management Group.

Rory Howe: Thanks, John, and good afternoon, everyone. I'm covering two provisions of the managed care rule that relate to fiscal integrity and the non-Federal share.

The first provision affirms that states are required to follow existing statutory and regulatory requirements regarding non-Federal share sources of state-directed payments. It also affirms that CMS may disapprove proposed state-directed payments that do not comply with Federal, non-Federal - with non-Federal share requirements. This provision reflects existing standards and statute and is effective on July 9.

The second provision establishes a requirement that providers receiving an SDP must attest that they do not participate in any hold-harmless arrangements prohibited by existing healthcare-related tax statute and regulations. The attestation requirement is not applicable until January 1, 2028. It's important to note that CMS released an informational bulletin to coincide with the managed care final rule.

The bulletin indicates that CMS will exercise enforcement discretion until January 1, 2028, for existing healthcare-related tax programs with hold-harmless arrangements involving the redistribution of Medicaid payments to give states and providers a clear timeline to transition away from potentially impermissible arrangements and to come into compliance with Federal law.

The step will ensure compliance while preserving stability for healthcare providers, particularly safety net providers, as well as for Medicaid-eligible individuals. It's important to reiterate that the bulletin's non-enforcement policy only applies to existing healthcare-related tax programs with the specific type of hold harmless arrangement that I mentioned.

And we do expect states that have those arrangements in place to begin to come into compliance as soon as possible, but no later than January 1, 2028. And during the non-enforcement period, CMS does intend to continue to identify and track redistribution arrangements through reviews of state-

directed payments and other oversight activities that CMS conducts.

And even though we won't be taking enforcement actions for the specified time period for existing arrangements. New arrangements that come in that do not meet Federal requirements could result in a disapproval of state-directed payments or a disallowance of FFP.

And just a final reminder on the informational bulletin, we are always available to provide technical assistance to states to assist with this transition and on this issue. And with that, I will turn it over to Laura Snyder.

Laura Snyder: Thank you, Rory. If we can go to the next slide. Oh, there we are. Okay. Continuing with the theme of strengthening fiscal and program integrity for SDPs, the final rule does establish a payment rate ceiling at the average commercial rate for hospital services, nursing facility services, and qualified practitioner services furnished at academic medical centers, as proposed.

The rule also does require states to condition fee schedule-based SDPs on actual utilization during the rating period and prohibit post-payment reconciliation processes that initially condition payment on historical utilization outside of the rating period. I will note that we did revise the applicability date for this provision, giving states an additional year. So, the applicability dates the first rating period for this provision beginning on or after July 9 of 2027.

If we can go to the next slide, please. Again, continuing the theme of strengthening fiscal and program integrity for SDPs, the final rule also does require SDPs to be included in actually sound capitation rates, in other words, prohibiting the use of separate payment terms. While this was not the regulatory language that was proposed in the NPRM, it was listed as an option

that CMS solicited public comment on, and it is what we are finalizing.

The applicability date for this provision and recognition of the work states will need to do to come into compliance will be the first rating period beginning on or after July 9 of 2027. Next, the final rule does establish submission timeframes for all SDP pre-prints to require submission before the start date of the SDP or the start date of the amendment.

Currently, states are required to submit pre-prints prior to the end of the rating period in which the SDP takes effect. We'll note that this was a change from the NPRM in that we simplified the submission timing requirements for this particular provision.

We also, in the final rule, did establish submission timeframes for documentation of SDPs in rate certifications and managed care plan contracts to require submission no later than 120 days after the start date of the SDP. Just to remind folks, the SDPs do have to be documented in rate certifications and managed plan contracts currently, but this provision, which will not take effect until the first training period beginning on or after July 10 of 2028, does put a timeframe around these submission - of these documentations.

Next slide, please. Third, we did finalize provisions that will enhance the evaluation and reporting of SDPs. First, we did strengthen evaluation requirements for SDPs requiring states with SDP spending above 1.5% of total capitation payments to submit evaluation results to CMS and to post these evaluations publicly. We also did require in the final rule that all states provide an evaluation report upon CMS request.

And finally, we will note that we did also finalize the provision to require provider-level reporting on actual SDP expenditures in CMS. We did change

this in the final rule to require the reporting one year rather than 180 days after each rating period to allow additional time for claims run out and data validation.

And with that, if we can turn to the next slide. We will be discussing also the medical loss ratio and program integrity provisions that we finalized in the rule. Just a little bit of background, as folks know, MLR is a common financial metric used to report and benchmark the financial performance of a managed care plan. In Medicaid and CHIP-managed care, the MLR represents the proportion of revenues used by the plan to fund claim expenses and quality improvement activities.

The specifications for managed care plans reporting to states were finalized in 438.8 and 457.1203 in the 2016 final rule, and states must submit summaries of these reports to CMS under 438.74 and 457.1203. The modifications to these regulations finalized in this final rule are based on reviews of plan and state summary reports, as well as alignment with recent MLR regulatory changes for marketplace plans.

Next slide, please. First, the MLR provisions that we finalized clarify and strengthen MLR requirements. Explicitly they require managed care plans to include actual expenditures and revenue for SDPs as part of their MLR reports to states. This is current policy, but this explicitly requires it in regulatory text.

Second, the regulations finalized improved consistency in MLR reporting, allowing CMS to better compare MLRs across plans and states through technical revisions for provider incentive arrangements, quality improvement expenditures, and expense allocation reporting to align with marketplace plan MLR calculations. There are also technical revisions that we finalized for state MLR summary report data requirements and the publication of credibility

adjustment factors.

Next slide, please. We also finalized provisions on MLR and program integrity to expand program integrity provisions for provider incentives and overpayments. Specifically, the final rule requires managed care plans, provider incentive arrangements to reflect bound contracting practices. It also requires managed care plans to report overpayments within 30 calendar days. I will note this is a change from the NPRM that proposed to require such reporting ten - within ten business days. We did extend that to 30 to allow sufficient investigation time for plans.

It will also require plans to report annually to states on all overpayments identified or recovered rather than just the recoveries of overpayments. I will also finally note that all of these provisions, the applicability date was extended it out a bit for an additional year to provide states more time to come into compliance and make operational changes. And with that, I will be turning it over to Amanda Paige Burns to discuss the quality provisions of this final rule.

Amanda Paige Burns: Thanks, Laura. Hey, everyone. I'm going to highlight two areas in the final rule related to managed care quality, starting with a little bit of background. Oh, I'm sorry, next slide. All right. So, as you know, states are required to carry out a set of managed care quality oversight activities, which include developing and maintaining the managed care state quality strategy and establishing the state's ongoing quality assessment and performance improvement programs or QAPIs.

Additionally, states must ensure that an external quality review, also called EQR, is performed for each contracted managed care plan, which must be done by a Qualified External Quality Review Organization, or EQRO. In this

rule, we are establishing several changes to increase transparency and the opportunity for meaningful, ongoing public engagement around managed care state quality strategies, as well as changes to reduce unnecessary burden for certain external quality reporting requirements.

And then the second topic we'll discuss today is the Medicaid and CHIP Quality Rating System or MAC QRS. Back in 2016 and 2020, CMS established our authority to require states to develop and operate a Medicaid and CHIP quality rating system, and also established that CMS would, in future rulemaking, to develop a MAC QRS framework that states would be required to adopt.

And so, in this final rule, we have finalized a MAC QRS framework consisting of three components, a set of mandatory measures, a methodology for calculating quality ratings for mandatory measures, and MAC QRS website display requirements.

Next slide, please. So, the final rule builds upon existing regulations requiring states to make their quality strategy available for public comment when it is adopted and when revisions are made. In this final rule, we have finalized changes that require states to make their quality strategy available for public comment every three years, regardless of whether the state intends to make significant changes, and also whenever significant changes are made.

The final rule also builds upon requirements for states to post the results of its three-year review on its website by clarifying that the evaluation of the effectiveness of the quality strategy must also be posted. In the 2016 final rule, we established that states must conduct an annual EQR of primary care case management entities, or PCCMs, operating under risk-bearing contract.

The final rule eliminates the mandatory EQR requirements for PCCMs, but maintains the optional EQR activities, which allow states to continue to monitor PCCMs at their discretion and access Federal financial participation at the 50% match rate if they choose.

Next slide, please. And then finally, to support states in their evaluations of quality outcomes and timeliness of an access to care and managed care plans and programs. The final rule establishes a new optional EQR activity to implement the evaluation requirements for quality strategies, state-directed payments, and in-lieu-of-services.

Next slide, please. And now we'll turn to the MAC QRS. In our previous rulemaking for the MAC QRS, we established that states would need to adopt a QRS within three years of a final rule. During our pre-rulemaking engagement, we heard a need to extend that timeline and propose giving states an additional year, so four years total, to implement a MAC QRS.

We have finalized the four-year implementation period and, in response to public comments identifying specific requirements that may be challenging for states to implement related to the methodology for calculating MAC QRS quality ratings, we have added an option for states to request a one-year, one-time extension to fully comply with the MAC QRS methodology requirements. We have also reduced the steps that states must take to implement an alternative MAC QRS methodology if a state chooses to do so.

Next slide, please. And then we have also finalized similar changes to the website display requirements. In the NPRM, we propose two phases of implementation for the MAC QRS website display requirements with more technologically intensive features reserved for a second phase. We propose the December 31, 2028, implementation date for the first phase and propose

that the second date would be no earlier than December 31, 2030.

In this final rule, we are finalizing the two-phase approach and implementation date and have added an option for states to request a one-year, one-time extension to fully comply with certain website requirements that states identified as challenging.

These include Phase 1 requirements to display mandatory measures stratified by sex, race and ethnicity, and dual eligibility status, as well as Phase 2 requirements to provide interactive tools that will allow beneficiaries to more efficiently identify plans that cover their providers and prescription drugs and use stratified mandatory measures.

We have also reduced the steps, states may take if they choose to implement additional website features as part of their MAC QRS. States can implement most additional website features without taking any additional steps. And finally, we have clarified in this final rule that states are not required to display all mandatory measures in their MAC QRS, only those that are applicable to their managed care program. Thank you for your time today, and with that, I'll pass it back to John.

John Giles: Thanks so much. Next slide, please. So, on this slide, we're just showing how CMS has aligned separate CHIP requirements with the Medicaid Managed Care Regulatory requirements with just a few exceptions as noted here on this slide.

So, for the access provision, so for the Enrollee Experience Survey, states will be required for separate CHIPs to post the Summary Comparative Consumer Assessment of Healthcare Provider and System, CAHPS, survey results on the state's website and review the CAHPS results in the state's annual analysis of

network adequacy rather than through the MCPAR with an applicability date of two years after the effective date of the final rule.

For in-lieu-of-services, the actuarial certification requirements and reporting for state-directed payments do not apply. The state-directed provisions do not apply to the CHIP program. For MLR, the provisions related to state-directed payments, as well as reporting for Medicare and Medicaid dually eligible enrollees are not applicable. And on the quality provisions, the provisions related to the Medicare and Medicaid dually eligible enrollees also do not apply.

Next slide. And finally, we wanted to have a slide that just gives a summary of the notable provisions from the proposed rule that are not being finalized in the final rule. So, for state-directed payments, no additional expenditure limit for state-directed payments has been finalized.

As represented during the state-directed payment portion of this presentation, the only expenditure limit is related to the payment ceiling at the average commercial rate, but no overall expenditure limit is being finalized in this rule. Additionally, there will be no separate state-directed payment line item for the plan MLR report or for the state's MLR summary reports, nor did we finalize the restriction on plans MLR resubmissions.

And then on the quality provisions, the revision to the date for the annual EQR technical report has not been finalized in this rule. Next slide. And with that, I believe we are turning back to Jackie Glaze and (Krista) for a Q&A session.

Jackie Glaze: Thank you, John. So yes, we're ready to take questions now. So, we'll begin by taking questions through the chat function, and we'll follow by taking

questions over the phone line. So, we'll ask that you begin submitting your questions at this time, and I'll turn to (Krista).

(Krista): Thanks so much, Jackie. Right now, I am seeing two questions that have already come through in the chat, so I'll just start with the first one, which is whether secret shopper requires dental services to be included?

John Giles: This is John. The secret shopper surveys will be used to validate the appointment wait times. So, they will not apply to dental services because this rule did not set an appointment wait time standard for dental providers. I will just note that if the state were to select dental as their state-specified provider type, they would be allowed to utilize their secret shopper surveys to validate those appointment wait times.

(Krista): Great, thank you so much, John. The next question here is, if the state receives the raw data from the EQRO after the study is completed, then the state sends the data to the MCOs. When does the three-day provider directory error begin? Do you folks need me to repeat the question? The question was, if the state receives the raw data from the EQRO after the study is completed, then the state sends the data to the MCOs, when does the three-day provider directory error begin?

John Giles: Is this related to the provider - the provider directory accuracy requirement for secret shopper?

(Krista): I did just receive a response in the chat that said, yes, this is about the secret shopper.

John Giles: I believe the requirement, and our managed care team should correct me if I'm wrong. I believe it's once the error has been identified, so if the state becomes

aware of it - if the state first becomes aware of it when the data is transferred to them, I believe that three-day clock would start then, but my team should confirm that. Okay. Then I think that's the answer to the question.

(Krista): Thanks so much, John. At this time, I'm not seeing any additional questions in the chat. So, Jackie, do we want to open the phone lines?

Jackie Glaze: Yes. Thank you, (Krista). So, (Amanda), I'll ask if you could please provide instructions for how to register their questions through the phone, and then if you can open the phone lines, please.

Coordinator: Thank you. We will now begin our question-and-answer session over the phone. If you would like to ask a question, please press Star 1. Please unmute your phone and record your name when prompted. Again, that is Star 1 if you would like to ask a question and Star 2 if you would like to withdraw your question. One moment, please. (Lauren Yates), your line is open.

(Lauren Yates): Thank you. I just had a quick question about the drug rebate program. Is this new guidance or clarification to the upcoming rule that's going to be coming out on drug manufacturing and pricing?

Cathy Traugott: So, this is Cathy. These two clarifications are really existing policy, and they are not a part of the final rule that is scheduled to be released soon.

(Lauren Yates): Today. Great. Thank you.

Coordinator: Thank you. As a reminder, if you'd like to ask a question, please press Star 1. Our next question comes from Arvind Goyal. Your line is open. Arvind, you might need to unmute your line.

Arvind Goyal: Yes. Can you hear me now?

Coordinator: Yes, we can.

Arvind Goyal: Thank you. So, my question is that a while ago, a couple months ago, CMS had issued some guidance on its work on cell and gene therapy. Guidance to be issued, I believe early part of 2025. And I just wanted to know if weight loss drugs and other high cost drugs guidance will also be included in that analysis and guidance.

Cathy Traugott: This is Cathy. I guess I'm not exactly sure which guidance you're talking about for cell and gene therapy that is coming out in 2025. I apologize. We do have a couple different initiatives going on within HHS related to cell and gene therapies that are in the works. There's nothing specifically tying these particular products specifically to those initiatives. That being said, if you do have any specific questions, I - you know, I'd be happy to answer them if you want to contact me directly.

Arvind Goyal: Yes, I will. Thank you very kindly.

Cathy Traugott: Okay.

Coordinator: Thank you. At this time, there are no further questions on the phone line.

Jackie Glaze: Thank you, (Amanda). Krista, I'll transition back to you. I believe you have a couple additional questions.

(Krista): Thank you. Yes, I do. One additional question here is with regard to the secret shopper regulation. Could you please speak a little more on CMS's view of the word independent and requirements?

John Giles Hi, this is John. So, in the rule, we clarify, and I believe we define and lay out the requirements for independent. It must be independent of both the state and the managed care plan.

(Krista): Thank you so much, John. I do have another question here, which is whether SDPs can be applied to dentists.

Laura Snyder: I'm sorry, could you say that one more time, (Krista)?

(Krista): Can SDPs be applied to dentists?

Laura Snyder: So, yes. States have the ability to, as long as the - as dental is a part of the Medicaid managed care contract, to define the provider class for an SDP, so that could include dentists.

(Krista): Thank you so very much. Let me see here. I think those are the remainder of our questions in the chat at this time. I'm not sure if there are any other questions on the phone line at this moment.

Jackie Glaze: Thanks, (Krista). So, we'll transition back to the phone lines. So, (Amanda), if you could once again provide instructions for how to register questions and open the phone lines once again.

Coordinator: Thank you. As a reminder, please press Star 1 if you would like to ask a question. One moment, please. And at this time, we have no questions coming through.

Jackie Glaze: Thank you, (Amanda). Krista, any questions from you.

(Krista): Yes. A few new questions came through the chat. One is, for confirmation, independent of the state, does that include independent of the 1115 evaluator or state university?

John Giles: So, the independence requirement would apply on the state Medicaid agency, so it would need to be independent of the state Medicaid agency.

(Krista): Thank you, John. Another question here. Can states create new separate payment term SDPs prior to the period of prohibition? The preamble talks about transition periods, so just want to clarify, new ones are permissible.

Laura Snyder: So, this is Laura. I do think, you know, the final rule does not prohibit states from creating new separate payment terms, though I do think that states should be very mindful of the applicability date of the provision and the need to transition away from the use of separate payment terms by that date and time.

(Krista): Great. Thank you. This next question I think may be for the access team. I'm not sure if they are on the line. If not, we can take it back. But the question is, please clarify the requirements regarding percent of payment for Habilitation services spent on compensation to direct care workers delivering Habilitation services.

All right, well, I will take note of that question, and we can certainly take it back to our team and aim to provide a response offline. One other question here is related to the managed care rule. If there is a minimum SDP that is 100% of the Medicaid fee schedule, but not at the Medicare rate, is the pre-print required?

Laura Snyder: So, this was addressed in the final rule that we published in 2020. So, if the

SDP is a minimum schedule at 100% of the state plan-approved rate, it does not and has not required prior approval from CMS, which means that it does not require the submission of the pre-print for that SDP to CMS. It does still need to be documented, though, in rates and contracts as in SDP.

(Krista): Great. Thank you so much. I did get a few questions about the slides and whether they will be shared from today's presentation. So, I just wanted to remind folks that all slides from the Medicaid and CHIP All State Calls are posted on medicaid.gov on the dedicated All State Call page within one week of the presentation. And then one other question here related to the managed care final rule. Can you remind me of the new rule requirement for managed care provider directories online, including the implementation due date?

John Giles: Is this - (Krista) is this about the electronic provider directory requirements like the existing requirements?

(Krista): I'm not sure, but - yes, the person just actually did respond and say yes, that's correct.

John Giles: So, there are existing provider directory requirements that permit states to have an electronic provider directory. Those are specified in 438.10. I'm not sure exactly what requirement the commenter is trying to figure out as an existing requirement, but maybe we can get a copy of that question and respond offline.

(Krista): Sounds good, John, I will take note of the question. The person did just note now that it is related to wait times, but I think we can provide a response offline. All right. And one last question here that I see in the chat, can CMS clarify the in-lieu-of-services timeframes in the SMDL and the final rule?

Rebecca Burch Mack: Hi, this is Rebecca Burch Mack. I think we might need a little more context on this question, and we can take it offline. But I think, in general, as John pointed out, the requirements in the final rule are codifying the details in the state Medicaid director letter that they're referencing, and the applicability dates were outlined in the chart and do vary by provision, but generally are either the effective date or the first rating period following 60 days of the effective date. So, we can follow up more of that. Okay. Thanks.

(Krista): Sounds good, Rebecca. I will take note of that question and talk it along.

Jackie Glaze: Okay. Thank you. So, I would like to begin by thanking our team for their presentations today. If you do have questions that come up between our calls, please feel free to reach out to us, our state leads, or bring your questions to the next call. So, we do thank you again for joining us today, and we hope everyone has a great afternoon. Thank you.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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