



Ensuring Access to Medicaid Services Final Rule 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule 2024

In April 2024, the Centers for Medicare & Medicaid Services (CMS) issued two new sets of rules to advance the agency’s efforts to improve access to care, quality and health outcomes, and better address health equity issues in Medicaid. The [Ensuring Access to Medicaid Services final rule](#) (“Medicaid Access Rule”) applies to Medicaid enrollees in a fee-for-service (FFS) delivery system, and the [Medicaid and Children’s Health Insurance Program \(CHIP\) Managed Care Access, Finance, and Quality final rule](#) (“Managed Care Access Rule”) applies to Medicaid and CHIP enrollees in a managed care delivery system.

When CMS initially proposed these changes in 2023, the Legal Action Center (LAC) submitted comments on a number of the provisions that would improve access to substance use disorder (SUD) and mental health (MH) care for Medicaid enrollees ([Medicaid Access Rule comments](#); [Managed Care Access Rule comments](#)). We commend CMS for its commitment to improving health outcomes and equity for this population and for prioritizing patient experiences, timely access to care, adequate reimbursement rates, transparency, and clear terminology. The following chart summarizes the proposed rules, LAC’s comments, and the final rules. Finally, we have identified additional next steps and clarifications that we urge CMS to consider in future rulemaking and sub-regulatory guidance to ensure adequate access to SUD and MH care for all Medicaid enrollees.

Managed Care Access Rule

Proposed Rule	LAC Comments	Final Rule
<p>Enrollee Experience Surveys: Require States to conduct an annual enrollee survey of individuals in managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) and publish the results online. Also require states to evaluate CAHPS survey results for CHIP enrollees.</p>	<p>LAC supported this proposal and recommended CMS adopt a standardized survey tool for all States and assure that enrollees with SUD and MH are included in the survey and that there are specific questions about the enrollees’ experience of accessing SUD and MH care.</p>	<p>CMS finalized the rule as proposed, but with an amended implementation date and an exemption for plans in which all enrollees are also enrolled in a Medicare Advantage dual eligible special needs plan (D-SNP), which uses a different survey. 42 C.F.R. §§ 438.66(b) and (c), 457.1230(b), 457.1207. Enrollee experience survey applicable July 9, 2027. CHIP survey analysis applicable July 9, 2026.</p>

<p>Appointment Wait Time Standards: Require States to establish and enforce wait time standards for the following services, when delivered under a MCO, PIHP, or PAHP – routine outpatient SUD and MH (adult and pediatric): 10 business days; primary care (adult and pediatric): 15 business days; OB/GYN: 15 business days; and a fourth service type selected by the State. These standards must be met 90% of the time.</p>	<p>LAC supported this proposal and recommended CMS adopt a uniform definition of “routine” and ensure it applies to both initial and follow up appointments. LAC also recommended wait times for MH and SUD be tracked and reported separately, and ensure that the appointments include community-based treatment settings as well as intermediate levels of care.</p>	<p>CMS finalized the rule as proposed with minor wording changes. While CMS did not define routine, it stated that at a minimum, this would include well-child visits, annual gynecological exams, and medication management. CMS clarified that the appointment wait times only apply to enrollees in D-SNPs if Medicaid is the primary payer. §§ 438.68(e), 457.1218. Applicable for the first rating period on/after July 9, 2027.</p>
<p>Secret Shopper Surveys: Require States to use independent entities to conduct annual secret shopper surveys of managed care plan compliance with routine appointment wait time standards and provider directory accuracy for primary care, OB/GYN, outpatient SUD and MH, and one service type selected by the State; publish the results online, and send provider directory data errors to managed care entity within 3 business days of receipt. Telehealth appointments may only be counted if the provider also offers in-person appointments and identified separately in the survey results.</p>	<p>LAC supported this proposal and recommended SUD and MH be verified separately and that CMS set a minimum threshold at which the agency or State must take enforcement action. LAC also recommended the independent entity also verify the provider’s cultural and linguistic capabilities, forward incorrect information to the managed care plan, and contact the managed care plan’s enrollee helpline to seek help making an appointment.</p>	<p>CMS finalized the rule as proposed. §§ 438.68(f), 457.1207, 457.1218. Applicable for the first rating period on/after July 10, 2028.</p>
<p>Assurances of Adequate Capacity and Services – Provider Payment Analysis: Require managed care plans to submit a payment</p>	<p>LAC supported this proposal and recommended additional methodologies for analyzing SUD and MH services.</p>	<p>CMS finalized the rule as proposed with minor wording changes. §§ 438.207(b), 457.1230(b).</p>

<p>analysis of the total amount paid for evaluation and management (E/M) codes for primary care, OB/GYN, and MH and SUD services, and percentage of Medicare reimbursement, and for States to review these analyses and submit to CMS.</p>		<p>Applicable for the first rating period on/after July 9, 2026.</p>
<p>Assurances of Adequate Capacity and Services Reporting: Require States to report the results of the secret shopper survey and payment analysis to CMS.</p>	<p>LAC supported this proposal.</p>	<p>CMS finalized the rule as proposed with a revision to the submission time. §§ 438.207(d), 457.1230(b). Applicable for the first rating period on/after the secret shopper survey and payment analysis go into effect.</p>
<p>Remedy Plans to Improve Access: Require States to submit a plan to remedy care access issues (such as network adequacy standards and availability of services), within 90 days of identifying access issues, with specific recommendations of approaches.</p>	<p>LAC supported this proposal and recommended CMS clarify that access issues include payment rates and compliance with the Mental Health Parity and Addiction Equity Act. LAC also recommended CMS identify a threshold for additional enforcement and consider other policies that would improve access to covered services, such as adopting stronger prior authorization and medical necessity standard protections.</p>	<p>CMS finalized the rule as proposed. § 438.207(f). Applicable for the first rating period on/after July 9, 2028.</p>
<p>Transparency: Require States to publish additional information on their websites on one page that is clear and easy to understand, including the assurances of adequate capacity and services report, the secret shopper survey results, State directed payment evaluation reports, and documentation of</p>	<p>LAC supported this proposal and recommended CMS clarify that the documentation of Parity Act compliance be updated prior to any contract modification or change in benefits, consistent with existing requirements. LAC also recommended CMS review States' documentation of Parity compliance more frequently; develop guidance, FAQs, self-</p>	<p>CMS finalized the rule as proposed. §§ 438.10(c), 438.602(g), 457.1207, 457.1285. Applicable for the first rating period on/after July 9, 2026.</p>

<p>compliance with the Mental Health Parity and Addiction Equity Act (Parity Act).</p>	<p>compliance tools, and standardized templates for documenting Parity compliance; and recommend that States contract with independent external entities to do a Parity compliance review.</p>	
<p>Terminology: Change the language throughout 42 CFR Part 438 to use “mental health” and “substance use disorder,” rather than “behavioral health.”</p>	<p>LAC supported this proposal.</p>	<p>CMS finalized the rule as proposed. §§ 438.2, 438.3(e), 438.10(h), 438.68(b), 438.214(b).</p>
<p>In Lieu of Services and Settings (ILOS): Define ILOS as a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State plan and adopted analysis and documentation requirements for using this flexibility, with an exception for short-term inpatient MH or SUD treatment provided in an institution for mental disease (IMD) due to the statutory IMD exclusion. Examples of possible ILOSs include sobering centers and services addressing social determinants of health.</p>	<p>N/A</p>	<p>CMS finalized the rule as proposed with minor changes for clarity. CMS notes that these new rules do not change States’ current flexibilities to cover short-term stays in IMDs. §§ 438.2, 438.3, 438.7, 438.16, 436.66, 457.1201, 457.1207.</p>
<p>Medicaid Managed Care Quality Rating System: Adopt new regulations governing the rating system with minimum mandatory measures, a rating methodology, and a mandatory website display format. The mandatory measures include: use of first-line psychosocial care</p>	<p>N/A</p>	<p>CMS finalized the rule as proposed with minor modifications for clarity, and excluding two proposed measures related to long term services and supports. §§ 438.334, 457.1240.</p>

for children and adolescents on antipsychotics, initiation and engagement of SUD treatment, screening for depression and follow-up plan, follow-up after hospitalization for MH, and several consumer survey measures on access to care.		
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Medicaid Access Rule

Proposed Rule	LAC Comments	Final Rule
<p>Medicaid Advisory Committee and Beneficiary Advisory Group: Require States to replace their existing Medical Care Advisory Committee with a broader Medicaid Advisory Committee (MAC) to align with the expanding scope of the Medicaid program and to establish a Beneficiary Advisory Group (BAG), for which the State Medicaid Director appoints members with 25% crossover membership to the MAC.</p>	<p>LAC supported this proposal and recommended CMS require a greater number of members from the BAG (50%) to participate on the MAC, ensure membership on both committees to represent diverse population demographics and a cross-section of service categories including SUD and MH services, and identify several additional topics for consultation for the committees.</p>	<p>CMS finalized the rule with several language modifications, including renaming the BAG to the Beneficiary Advisory Council (BAC). States will have two years to achieve the 25% crossover membership from the BAC, and States may choose to select a higher percentage. 42 C.F.R. § 431.12. MAC and BAC applicable July 9, 2025. Full cross-over applicable July 9, 2026.</p>
<p>Timeliness Standards in Fully Fee-For-Service States: Solicited comments on mirroring appointment wait time standards, secret shopper survey requirements, and publication requirements in the Managed Care Access Rule to States that deliver care through a fully FFS model (i.e. no services through managed care).</p>	<p>LAC recommended CMS adopt the standards proposed in the Managed Care Access Rule in fully FFS States, with the same suggestions for improvement.</p>	<p>CMS is not adopting these standards in fully FFS States at this time and will study implementation in managed care system for future proposals.</p>

<p>Service Payment Rates, Transparency, and Comparative Payment Rate Analysis: In addition to requiring the publication of all Medicaid FFS fee schedule rates by population, provider and geographical location, require States to conduct a standardized comparative payment rate analysis biennially between Medicaid payment rates and Medicare rates of Evaluation and Management (E/M) codes for certain services – primary care, OB/GYN, and outpatient behavioral health – to document and ensure FFS Medicaid payment rate adequacy, and publish their State’s FFS rates in a clearly accessible, public location on the State’s website.</p>	<p>LAC supported this proposed rule and recommended CMS require States to provide an assessment of whether the payment rates for MH and SUD services comply with the Parity Act (which applies to the Medicaid expansion population, even in fully FFS), as well as separately identify and report comparative rates for MH and SUD services. LAC also recommended rate comparisons for non-office-based outpatient services to fully capture SUD treatment and offered additional payment analyses that States should use for MH and SUD services beyond the Medicare comparisons. LAC recommended CMS replace the term “behavioral health” with mental health and substance use disorder to conform to the Medicaid managed care rule.</p>	<p>CMS finalized the rule largely as proposed with some clarifying language, including updating the name of “outpatient behavioral health services” to “outpatient mental health and substance use disorder services.” § 447.203(b). Applicable July 1, 2026.</p>
<p>State Analysis Procedures for Rate Reduction or Restructuring: Require States to conduct a standardized access analysis when it submits a state plan amendment proposing to reduce or restructure provider payment rates.</p>	<p>LAC supported this proposal and recommended CMS require States to demonstrate compliance with the Parity Act for any proposed rate reduction or restructuring for FFS in expansion states and provide technical guidance to States on compliance with this provision on how to conduct a Parity Act analysis, both as written and in operation.</p>	<p>CMS finalized the rule as proposed. It acknowledged that Congress has not extended Parity Act requirements to FFS Medicaid but CMS encourages states to ensure that these benefits comply with parity. CMS also asserts that its review of rate reductions or restructuring includes the fundamental objective of the Parity Act – to ensure access to MH and SUD treatment. § 447.203(c). Applicable July 9, 2024.</p>

Recommendations

CMS has adopted strong new rules that will help measure and improve access to substance use disorder and mental health services in both fee-for-service Medicaid and managed care. In addition, we offer the following recommendations for CMS to consider in future rulemaking and sub-regulatory guidance to address outstanding concerns.

Ensuring Access to Mental Health and Substance Use Disorder Services in “Carve Out” States: A number of states cover mental health and substance use disorder benefits through financing models that differ from their coverage of other medical benefits. For example, states that use managed care for most medical benefits may “carve out” some or all substance use disorder and/or mental health benefits and provide them under a FFS delivery system. For those states, the final rules provide limited tools to ensure adequate access to these benefits. That is, the FFS payment rate transparency and comparative analysis requirements will apply to all state Medicaid programs regardless of financing model (managed care and FFS), but, in states with carved-out mental health and/or substance use disorder benefits, the appointment wait time standards and secret shopper survey from the Managed Care Access Rule would not apply. We recommend CMS provide guidance on how States with mixed delivery systems should ensure equitable and meaningful access to substance use disorder and mental health care.

Compliance with the Parity Act: Medicaid managed care plans, alternative benefit plans (the Medicaid expansion population) and CHIP are required to comply with the Mental Health Parity and Addiction Equity Act (Parity Act). In circumstances where some benefits are offered through managed care, States are required to ensure that their benefits comply with the Parity Act, and CHIP and ABPs are subject to the Parity Act regardless of the financing structure (FFS or capitated managed care). While CMS has stated that it works closely with state Medicaid offices to ensure compliance with the Parity Act, a recent Department of Health and Human Services Office of Inspector General [report](#) identified substantial limitations in both CMS and State Medicaid parity compliance efforts. LAC urges CMS to ensure that the various analyses comply with the Parity Act and to provide additional resources to States on how to do so. LAC provided additional [comments](#) in response to a 2023 CMS [request](#) for guidance on steps to improve Parity Act enforcement in Medicaid and CHIP. We continue to recommend CMS promptly adopt additional Parity Act compliance requirements and state oversight practices and align Medicaid/CHIP parity standards with those in the private insurance market.

Payment Analyses: With respect to the payment analyses for both FFS Medicaid and managed care, LAC remains concerned that Medicare is not an appropriate benchmark of the reimbursement rate adequacy and the analysis – with its focus on a narrow set of codes that cannot be billed by most mental health and substance use disorder practitioners – will not capture the true level of disparate reimbursement that undermines provider participation. CMS asserts in the Medicaid Access Rule that the low Medicare opt-out rate for physicians – that is, the fact that most physicians accept Medicare – suggests that Medicare’s payment rates are sufficient. While this may be true for many categories of providers, the final rule acknowledges that only 60% of psychiatrists accepted new patients in Medicare in 2019 compared to 81% of general practice/family medicine physicians, 81% of physicians specializing in internal medicine, and 93% of physicians specializing in OB-GYN. Mental health and

substance use disorder providers have among the [highest opt-out rates](#) from Medicare, with psychiatrists accounting for [42%](#) of physicians who opted out of Medicare in 2022. A recent [report](#) from the Department of Health and Human Services Office of the Inspector General found that, on average, there were actually fewer mental health and substance use disorder providers who were actively participating in traditional Medicare than Medicaid. Among practicing providers, only 29% of substance use disorder and mental health providers served traditional Medicare beneficiaries, while 38% served Medicaid enrollees. In recent Medicare rulemaking, CMS has acknowledged that Medicare has long [undervalued](#) substance use disorder and mental health services. While the agency has made some adjustments to a number of these services to improve the rates in recent years, the outstanding disparities continue to prevent Medicare beneficiaries from having meaningful access to the treatment they need for these conditions.

A recent [report](#) by RTI International offers a preview of the reimbursement disparities that we would expect to see in the Medicaid program. Examining disparities in commercial insurance, RTI found, on average, reimbursement for medical/surgical clinician office visits was 22% higher than for mental health and substance use disorder clinicians (125% of Medicare compared to 103% of Medicare). The average reimbursement rate for medical/surgical specialist physician office visits (135% of Medicare) was 25% higher than for psychiatrist office visits (108% of Medicare) and 29% higher than for psychologist office visits (105% of Medicare). While these payment analyses will provide a helpful start – and we suspect will identify disparate reimbursement rates for psychiatrists compared to primary care practitioners when benchmarked to Medicare – we are concerned that limited focus on E/M codes in the Managed Care Access Rule will fail to capture the full range of disparities, especially since many MH and SUD clinicians are unable to bill these codes. We recommend CMS engage with the substance use disorder and mental health provider community to continue to identify additional ways to analyze payment disparities, as well as meaningful ways to attract practitioners and improve access to these services, in both Medicaid and Medicare.