CMS Proposed Rule on Ensuring Access to Medicaid Services

On May 3rd, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule titled *Ensuring Access to Medicaid Services*. These proposed improvements seek to increase transparency and accountability, standardize data and monitoring, and create opportunities for States to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care. A substantive component of this proposed rule focuses on improving access to and the quality of home and community-based services (HCBS). Comments are due by July 3rd, 2023.

NOTE: Page numbers refer to the pdf page numbers in the unofficial published inspection document made available on the federal register prior to the official publication of the rule.

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I. Medicaid Advisory Committee and Beneficiary Advisory Group (pgs. 24-38)

Proposed Changes

CMS proposes to update § 431.12 to require states to establish and operate the newly named Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG). The MAC and its corresponding BAG would serve as vehicles for bi-directional feedback between interested parties and the State on matters related to the effective administration of the Medicaid program. With this proposal, FFP, or Federal match, for Medicaid administrative activities would remain available to States for expenditures related to MAC and BAG activities in the same manner as the former MCAC.

CMS proposes to amend the title and paragraph (a) of § 43.12 to update the name of the existing MCAC to the MAC and to add the requirement for States to establish and operate the BAG, a dedicated advisory group comprised of Medicaid beneficiaries. Additionally, CMS proposes conforming updates to paragraph (b) regarding the State plan requirements to reflect the proposed MAC and BAG and the expanded mandate in the proposed rule.

CMS proposes updating paragraph (c) of § 431.12 regarding appointment of committee members to specify that the members of the MAC and BAG must be appointed by the agency director or higher State

authority on a rotating, continuous basis. Committee and advisory group members would serve a specific amount of time, determined by each State.

CMS proposes to amend paragraph (d) of § 431.12 regarding committee membership to account for both membership and composition and to require the MAC membership include members from the BAG, who are currently or have been Medicaid beneficiaries, and individuals with direct experience supporting Medicaid beneficiaries; as well as advocacy groups; providers or administrators of Medicaid services; representatives of managed care plans or State health plan associations representing such managed care plans; and representatives from other State agencies that serve Medicaid beneficiaries. Specifically, in paragraph (d)(1) of § 431.12, CMS proposes that at least 25% of the MAC must be individuals with lived Medicaid beneficiary experience from the BAG. The language in paragraph (d)(2)(D) broadens the type of representatives from other State agencies that are required to be on the committee from the similar MCAC requirement.

CMS proposes to replace paragraph (e) of § 431.12, to require that States create a BAG, a dedicated beneficiary advisory group that will meet separately from the MAC. Specifically, at paragraph (e)(1), CMS proposes that the MAC members described in proposed paragraph (d)(1) must also be members of the BAG. At subsection (f), they propose an administrative framework for the MAC and BAG to ensure transparency and a meaningful feedback loop to the public and among the members of the committee and group.

CMS proposes to revise paragraph (g) to detail an expansion of the topics on which the MAC and BAG should provide feedback to the Medicaid agency from the prior MCAC requirements.

CMS proposes to create a new paragraph (h) to expand on existing State responsibilities for managing the MAC and BAG regarding staff assistance, participation, and financial support.

CMS proposes to create a new paragraph (i) to require that the MAC, with support from the State and in accordance with the requirements proposed at this section, submit an annual report to the State. The BAG perspective and feedback will be embedded in the report, since the Group is represented on the MAC. The State, in turn, would be required to review the report and include responses to recommendations in the report.

CMS proposes to maintain the current regulatory language on FFP from current paragraph (g) to support committee and group administration and continue that language in new paragraph (j) with conforming edits for new committee and group names.

This requirement, if finalized, would be effective 60 days after the effective date of the final rule, which would provide States with 1 year to implement these requirements.

Background/Rationale

Pertaining to § 431.12, the current regulations lack specificity related to how these committees can be used to ensure the proper and efficient administration of the Medicaid program more expressly by more fully promoting beneficiary perspectives. The proposed framework would be designed to ensure the proper and efficient administration of the Medicaid program and to better ensure that care and services under the will be provided in a with the best interests of the beneficiaries.

Paragraph (a) changes would see that the committee and its corresponding advisory group would advise the State not only on issues related to health and medical services, as the MCAC did, but also on matters related to policy development and to the effective administration of the Medicaid program consistent with the language of section1902(a)(4)(B) of the Act, which requires a State plan to meaningfully engage Medicaid beneficiaries and other low-income people in the administration of the plan. Expanding the scope of the current committee is necessary to align the actions of the committee with the expanding scope of the Medicaid program, consistent with section 1902(a)(4)(B) of the Act, because the MAC creates a formalized way for interested parties and beneficiary representatives to provide feedback to the State about issues related to the Medicaid program and the services it covers and to help ensure that the program operates efficiently and as it was designed to operate.

Paragraph (c) changes would facilitate transparency and improve the current regulations, which do not mention nor promote transparency of information related the MCAC with the public. CMS believes that transparency of information can lead to enhanced accountability on the part of the State to making its MAC and BAG as effective as possible.

Advisory committees and groups can be most effective when they represent a wide range of perspectives and experiences. The current MAC regulations only provide high level descriptions of types of members that should be selected. Since each State environment is different, in the proposed rule, CMS continues to provide the State with discretion on how large the MAC and BAG should be, but they outline in more detail the types of categories of members that can best reflect the needs of a Medicaid program. CMS believes that diversely populated MACs and BAGs can provide States with access to a broad range of perspectives, and importantly, beneficiaries' perspective, which can positively impact the administration of the Medicaid program.

CMS's aim is to support several of the priorities for operationalizing health equity across CMS programs as outlined in the CMS Framework for Health Equity (2022-2032) and the HHS Equity Action Plan which is consistent with EO 13985 which calls for advancing equity for underserved populations.

CMS identifies health plans as an important contributor to the MAC, but they acknowledge that not all States that have managed care delivery systems. CMS understands that many Medicaid health plans administer similar committees and thus allow for States to tailor health plan representation based on its managed care market. For example, States can fulfil this category with only one or with multiple plans operating in the State. In addition, CMS also gives States the flexibility to meet the health plan representation requirements with either participating Medicaid managed care plans or the State health plan association representing such plans, as applicable.

CMS believes adding the creation of the BAG will result in providing the State with increased access to the beneficiary perspective. This proposal directly addresses and provides the mechanism (the BAG) through which States can meet the language of section 1902(a)(4)(B) of the Act, which requires a State plan to meaningfully engage Medicaid beneficiaries and other low-income people in the administration of the plan.

The creation of a separate beneficiary-only advisory group aligns with what CMS learned from multiple interviews with State Medicaid agencies and other Medicaid interested parties (for example, Medicaid researchers, former Medicaid officials) conducted over the course of 2022 on the effective operation of the existing MCACs. Interested parties described the importance of having a comfortable, supportive, and

trusting environment that facilitates beneficiaries' ability to speak freely on matters most important to them. It is equally important that the BAG have a subset of its members that also sit on the State's MAC to ensure that the beneficiary perspective and experience are heard directly.

The proposed changes aim to strike a balance that reflects some States' current practices without putting strict limitations on specific topics for discussion to all States. Broadening the scope of the topics that the MAC and BAG discuss will benefit the State by giving greater insight into how it is currently delivering care for its beneficiaries and thereby assist in identifying ways to improve the way the Medicaid program is administered.

CMS believes that when States provide their MACs and BAGs with additional staffing support that can explain, provide background materials, and meet with the members in preparation for the larger discussions, the members have a greater chance to provide more meaningful feedback and ensure that members are adequately prepared to engage in these discussions. The proposed changes to the requirements seek to create environments that support meaningful engagement by the members of these groups whose feedback can then be used by States to support the efficient administration of their Medicaid program.

Comments

CMS invites comments on additional ways to ensure that the State can create a feedback loop with the MAC and BAG.

CMS seeks comment on whether 1 year is too much or not enough time for States to implement the updates in this regulation in an effective manner. They understand that States may need to modify their current MCACs to reflect the updated requirements and may also need to create the BAG and recruit members to participate if they do not already have a similar entity already in place.

II. Home and Community-Based Services (pgs. 38-118)

A. Person-Centered Service Plans (Section B.1 pgs. 39-49)

Proposed Changes

CMS proposes to establish § 441.301(c)(3)(ii)(A) which would require States to demonstrate that a reassessment of functional need was conducted at least annually for at least 90% of individuals enrolled in the 1915(c) waiver for at least 365 days.

CMS proposes to establish § 441.301(c)(3)(ii)(B) to require States to demonstrate that they reviewed the person-centered service plan (PCP) and revised the PCP as appropriate based on the results of the required reassessment at least every 12 months for at least 90% of individuals continuously enrolled in the waiver for at least 365 days.

CMS proposes to begin a new paragraph under § 441.301(c)(3)(i) with the title *Requirement*. The sentence currently located at § 441.301(c)(3) beginning "The person-centered service plan must be reviewed…" would be moved to this new section and revised as follows: "The State must ensure that the person-centered service plan is reviewed, and revised, as appropriate, based upon the reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual."

CMS proposes to add the requirements at § 441.301(c)(3) to 42 CFR 438.208(c).

CMS proposes to revise § 441.301(c)(1) as follows: "The individual, or if applicable, the individual and the individual's authorized representative, will lead the person-centered planning process. When the term 'individual' is used throughout this section, it includes the individual's authorized representative if applicable. In addition, the person-centered planning process: . . ."

CMS proposes at § 441.301(c)(3)(iii) to make the requirements proposed under § 441.301(c)(3)(ii) effective 3 years after the effective date of the final rule for FFS systems, and effective for the first managed care contract rating period that begins on or after 3 years of the effective date of the rule for MCO, PIHP, or PAHP contracts.

CMS proposes to cross-reference the proposed requirements added to § 441.301(c)(3) at §§ 441.450(c), 441.540(c), and 441.725(c) for application among 1915(j), (k), and (i) State plan services, respectively.

Background/Rationale

In 2014 CMS released guidance for 1915(c) HCBS waiver programs that established the expectation that states would develop and report on performance measures related to compliance with the regulatory requirements, including person-centered planning requirements. Under this guidance, states that scored below 86% of the performance threshold for a measure were required to implement a Quality Improvement Project. Additionally, under 1902(a)(19) of the Act, States are required to provide safeguards to assure that eligibility for services will be determined and provided in an administratively simplified manner, and in the best interest of the beneficiaries. HCBS beneficiaries may experience changes in functional needs or circumstances that need to result in changes to their person-centered plan (PCP). Finally, section 2402(a) of the Affordable Care Act (ACA) requires HHS to ensure states that receive federal funds for HCBS develop systems that are responsive to beneficiaries' changing needs and choices, maximize independence and self-direction, and provide support and coordination to facilitate full community engagement. CMS believes that each element of the PCP process is essential to ensuring States' compliance with section 2402(a) of the ACA.

CMS received feedback from stakeholders in response to the Access to Coverage and Care in Medicaid & CHIP RFI and other engagement activities that HCBS need standardized reporting and minimum standards. CMS believes that the proposed standards establish a new strategy for oversight, monitoring, quality assurance and quality improvement for HCBS programs, based on the priorities identified by States, oversight entities, consumer advocates, and other stakeholders. Stakeholders also emphasized the importance of PCP for the delivery of care and assurance of health and welfare for participants. By failing to complete reassessments and updates to PCPs, Stats risk harming beneficiaries by failing to identify and mitigate risk factors, and not ensuring that interventions and supports cause no harm.

CMS raised the performance level threshold from the 86% established in the 2014 guidance to 90% based on concerns raised by interested parties that the lower thresholds provide too much latitude for unexpected delays. CMS also referenced media reports and anecdotal data that illustrated examples where reassessments were delayed without valid reasons, suggesting States may need to be held to higher standards. CMS also considered but chose not to include good cause exceptions in the event of natural disasters, public health emergency, or other event that would impact States' compliance, as States' can utilize existing disaster authority waiver requests in these circumstances.

CMS proposes to revise the regulatory text under § 441.301(c)(3)(i) to clarify that the State is the required actor, and that changes to the PCP are not required if the reassessment doesn't indicate a need for changes.

Section 240(a)(3)(A) of the ACA requires States to improve coordination and regulation of all HCBS programs to achieve a more consistent administration of policies and procedures across HCBS programs. CMS believes that in the context of Medicaid-funded HCBS, this indicates a need for consistency across fee-for-service (FFS) and managed care service delivery systems. Thus, CMS proposes to include the new regulatory requirements for both systems. This reasoning is used throughout the HCBS proposals that apply to both FFS and managed care authorities.

CMS also uses this rationale to support their cross-referencing the proposal across 1915(j), (k), and (i) State plan service authorities. In addition, CMS considered also incorporating 1905(a) "medical assistance" State plan HCBS services in the proposal. However, they ultimately chose not to incorporate 1905(a) authorities into the proposal due to State feedback that these programs have substantially different PCP requirements, data collection and reporting capabilities than other HCBS authorities, and only encompass a small minority of HCBS delivered nationally. This reasoning is used throughout the HCBS proposals that apply to multiple HCBS waiver and state plan authorities.

CMS believes the revisions to § 441.301(c)(1) align the PCP process language in 1915(c) waiver regulations with the language included in 1915(j) and (k) State plan options.

CMS proposed a time period based on feedback from States and other stakeholders that 2-3 years could be needed to amend State regulations, legislation, policy, procedures, systems, and contracts to support implementation of the proposal. CMS also considered the timeline in the context of the HCBS proposals as a whole.

Comments

CMS is generally seeking comments on these proposals. CMS is specifically requesting feedback on the whether the implementation timeframe is sufficient, or if alternatives (2 or 4 years) should be considered and the rationale for doing so, and whether these proposals should apply to 1915(j), (k), (i) and 1905(a) authorities.

B. Grievance System (Section B.2 pgs. 49-59)

Proposed Changes

CMS proposes at new § 441.301(c)(7) that States establish grievance procedures for Medicaid beneficiaries receiving section 1915(c) waiver program services through an FFS delivery system. The procedures must allow beneficiaries to file grievances related to State's or providers' compliance with PCP requirements at §§ 441.301(c)(1) through (3) and the HCBS final rule settings requirements at §§ 441.301(c)(4) through (6).

CMS proposes at § 441.301(c)(7)(ii)(A) to define "grievance" as an expression of dissatisfaction or complaint related to the State's or a provider's compliance with the PCP requirements at § 441.301(c)(1) through (3) and the HCBS settings requirements at § 441.301(c)(4) through (6), regardless of whether the beneficiary requests that remedial action be taken to address the area of dissatisfaction or complaint.

CMS proposes at § 441.301(a)(7)(ii)(B) to define "grievance system" as the processes the State implements to handle grievances, as well as the processes to collect and track information about them.

CMS proposes at § 441.301(c)(7)(iii)(A) to require that a beneficiary or authorized representative be permitted to file a grievance. Other individuals or entities, excluding providers, would also be permitted to file a grievance on a beneficiary's behalf, with the written consent of the beneficiary or their representative.

CMS proposes at § 441.301(c)(7)(iii)(B)(1) through (7) to require states to have written policies and procedures for the grievance process. States would need to provide beneficiaries with reasonable assistance in completing grievance forms and steps in accordance with § 435.905(b), ensure punitive action is not threated or taken against individuals filing a grievance, accept grievances, expedited resolution requests and timeline extension requests. States would also be responsible for providing notices and other information on rights to beneficiaries in accessible manner for individuals with disabilities and Limited English Proficiency according to § 435.905(b), reviewing grievance resolutions with dissatisfied beneficiaries, and provide information on the grievance system to provider and subcontractors approved to deliver HCBS services.

CMS proposes at § 441.301(c)(7)(iii)(C)(1) through (5) to require that States' processes for handling grievances must allow beneficiaries to file orally or in writing and acknowledge receipt of each grievance. Additionally, states would need to ensure decisions are not made by individuals involved in reviewing or decision-making related to the issue for which the beneficiary has filed a grievance, a subordinate of such an individual, and decisions are made by individuals with appropriate expertise who have considered all of the information submitted by the beneficiary related to the grievance. States would also be required to provide beneficiaries with reasonable opportunity, face-to-face, in person or through audio/video technology, and in writing, to present evidence, testimony, and make legal arguments related to their grievance. Finally, States would be required to provide beneficiaries, free of charge, and before resolution their own case files, evidence used or generated by the State, and language services including written translation and oral interpretation in accordance with 435.905(b).

CMS proposes at § 441.301(c)(7)(iv)(A) to allow beneficiaries to file a grievance at any time.

CMS proposes at § 441.301(c)(7)(iv)(B) to allow beneficiaries to request expedited resolution of a grievance when there is substantial risk that adherence to standard timeframes would adversely affect the beneficiary's health, safety, or welfare.

CMS proposes at § 441.301(c)(7)(v)(A) to require States resolve and provide notice of resolution for each grievance as quickly as the beneficiary's safety requires and within State-established timeframes that do not exceed the standard and expedited timeframes proposed in § 441.301(c)(7)(v)(B).

CMS proposes at § 441.301(c)(7)(v)(B)(1) to require standard resolution and notice to parties within 90 calendar days of receipt of the grievance. At § 441.301(c)(7)(v)(B)(2), CMS proposes to require expedited resolution and notice within 14 calendar days of receipt of the grievance.

CMS proposes at § 441.301(c)(7)(v)(C) to permit States to extend the timeframes for resolving standard and expedited grievances by up to 14 calendar days upon beneficiary request or if the State documents a need for additional information and how the delay is in the beneficiary's best interest. At § 441.301(c)(7)(v)(D) CMS proposes to require States to make reasonable efforts to give the beneficiary prompt oral notice, and written notice within 2 calendar days of the reason for extending the timeframe.

CMS proposes at § 441.301(c)(7)(vi)(A) to require that States establish an accessible method of written notice to beneficiaries that meets the requirements of § 435.905(b). At § 441.301(c)(7)(vi)(B), CMS proposes to require States to make reasonable efforts to provide oral notice for expedited resolutions.

CMS proposes at § 441.301(c)(7)(vii)(A) to require States maintain records of grievances and incorporate them into ongoing monitoring processes. At § 441.301(c)(7)(vii)(B)(1) through (6), CMS proposes the following minimum record requirements: a general description of reason for grievance, date received, date of reach review or meeting, resolution and date of resolution, name of beneficiary for whom the grievance was filed. At § 441.301(c)(7)(vii)(C), CMS proposes to require that grievance records be accurately maintained and be made available upon their request.

CMS proposes at § 441.301(c)(7)(viii) that these requirements be effective 2 years after the effective date of the final rule.

CMS proposes to cross-reference these requirements at §§ 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii) for s 1915(j), (k), and (i) State plan services, respectively.

Background/Rationale

Section 2402(a)(3)(B)(ii) of the ACA requires the development and monitoring of an HCBS complaint system, and again section 1902(a)(19) of the Act requires States to provide safeguards to assure that eligibility for services will be determined and provided in an administratively simplified manner, and in the best interest of the beneficiaries.

42 CFR part 431, subpart E require States to provide Medicaid applicants and beneficiaries with opportunities for fair hearing in certain circumstances related to eligibility, or reduction of benefits or services. Additionally, beneficiaries receiving HCBS under managed care systems have access to appeal and grievance systems under 42 CFR part 438, subpart F. However, beneficiaries in FFS HCBS do not have a venue to raise concerns about issues not currently subject to fair hearing process, creating a disparity.

CMS has received feedback from stakeholders about the need to establish FFS beneficiary grievance processes. CMS proposes to apply these processes to HCBS settings and PCP compliance due to their importance to ensuring beneficiaries have fully access to the benefits of community living, are able to

receive services in the most integrated setting, and so the new requirements do not conflict with existing fair hearing requirements.

The proposals only include FFS systems to avoid duplication with the similar requirements for managed care systems under 438, subpart F. The new definitions at § 441.301(c)(7)(ii) are modeled on existing managed care definitions.

Comments

CMS is seeking comments on additional changes to consider for this proposal.

CMS invites comment on whether part 438, subpart F (Managed Care requirements) should be amended to include the proposed requirements at § 441.301(c)(7)(iv)(B) and at § 441.301(c)(7)(v)(B)(2) for expedited review requests.

CMS also invites comments on overall burden for States to meet the requirements of this section, whether this timeframe is sufficient, or if shorter (1 year to 18 months) or longer timeframe (3 to 4 years) should be considered, with rationale.

CMS invites comments on whether these proposals should apply to 1915(j), (k), (i) and 1905(a) authorities.

C. Incident Management System (Section B.3 pgs. 59-71)

Proposed Changes

CMS proposes at § 441.302(a)(6) to require that States provide an assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

CMS proposes at § 441.302(a)(6)(i)(A) to establish a minimum standard definition of a critical incident to include, at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

CMS proposes at § 441.302(a)(6)(i)(B) to require that States have electronic critical incident systems that, at a minimum, enable electronic collection, tracking (including of the status and resolution of investigations), and trending of data on critical incidents.

CMS proposes at § 441.302(a)(6)(i)(C) to require providers to report to States and critical incidents that occur during service delivery or because of the failure to deliver authorized services.

CMS proposes at § 441.302(a)(6)(i)(D) to require States to use claims data, Medicaid Fraud Control Unit data, and date from other State agencies (e.g. adult/child protective services) to the extent allowed under State law to identify critical incidents that are unreported by providers.

CMS proposes at § 441.302(a)(6)(i)(E) to require that States share information, consistent with 42 CFR part 431, subpart F, on the status and resolution of investigations. CMS notes that this may be accomplished with information sharing agreements with other state agencies, if the State refers critical incidents to other investigative agencies. CMS is also proposing at § 441.302(a)(6)(i)(F) to require States to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within the State-specified timeframes.

CMS proposes at § 441.302(a)(6)(i)(G) to require States meet the reporting requirements at § 441.311(b)(1) for the performance of their incident management systems. Further, at § 441.302(a)(6)(ii)(A) through (C) CMS proposes the following minimum performance standards: initiate investigations for 90% of critical incidents within State timeframes; complete investigation and determine resolution for 90% of critical incidents within State timeframes; complete corrective action plan for 90% of critical incidents that required corrective action within State timeframes.

CMS proposes at § 441.302(a)(6)(iii) to apply these requirements to services delivered under FFS or managed care delivery systems. States would have three years following the effective date of the final rule to implement the requirements in FFS delivery system, and until the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule for managed care delivery systems.

CMS proposes to cross-reference these requirements at §§ 441.570(e), 441.464(e), and 441.745(a)(1)(v) for 1915(j), (k), and (i) State plan services, respectively, and renumber existing § 441.464(e) as § 441.464(g) and existing § 441.464(f) as § 441.464(h).

Background/Rationale

Section 1902(a)(19) of the Act requires States to provide safeguards to assure that eligibility for services will be determined and provided in an administratively simplified manner, and in the best interest of the beneficiaries. Similarly, Section 1915(c)(2)(A) of the Act and current Federal regulations at § 441.302(a) require that States have in place necessary safeguards to protect the health and welfare of individuals receiving section 1915(c) waiver program services. Section 2402(a) of the ACA requires HHS to ensure states that receive federal funds for HCBS develop systems that are responsive to beneficiaries' changing needs and choices, maximize independence and self-direction, and provide support and coordination to facilitate full community engagement. Among other requirements, section 2402(a)(3)(B)(ii) of the ACA requires the development and oversight of a system to qualify and monitor providers.

In 2014, CMS published guidance for States' performance measures related to health and welfare assurances including. In that guidance States were directed to demonstrate that they identify, address, and seek to prevent abuse, neglect, exploitation, and unexplained death; that they have an incident management system in place to resolve and prevent incidents; State policies and procedures related to restrictive interventions are followed; and that the State establishes, and monitors health care standards based on their approved waiver. States were responsible for scoring at least 86% performance level on the measures they set for themselves.

However, despite these long-standing requirements, CMS notes there have been high-profile instances of abuse and neglect recently due to poor quality care and inadequate oversight of HCBS. CMS cites the 2018 joint report group home safety, as well as findings from several other Office of the Inspector

General reports, a 2018 Government Accountability Office report, CMS' own audit and survey findings, and feedback received during stakeholder engagement.

There is currently no national standard definition for critical incidents that must be reported by providers and investigated by states. CMS created the proposed definition based on the commonalities and gaps found in their 2019 survey of States' incident management systems. CMS also notes that they are proposing to explicitly require providers to report on the failure to provide services, based on the findings of the OIG and other reports mentioned previously. CMS wants to ensure that the failure to share information between agencies or others who investigate incidents does not impede the State's ability to investigate, resolve, and track critical incidents.

CMS raised the performance level threshold from the 86% established in the 2014 guidance to 90% based on concerns raised by interested parties that the lower thresholds provide too much latitude for unexpected delays. CMS also referenced the harms documented in the audits, reports, and stakeholder feedback, as justification for more stringent compliance with health and welfare reporting requirements. CMS also considered but chose not to include good cause exceptions in the event of natural disasters, public health emergency, or other event that would impact States' compliance, as States' can utilize existing disaster authority waiver requests in these circumstances.

Comments

CMS requests comment on whether there are other events or instances of serious harm, such as identity theft or fraud, that are not captured by the proposed definition that should be included, and whether any of the included elements would lead to the overidentification of critical incidents.

CMS requests comment on the burden associated with requiring States to have electronic critical incident systems and whether there is specific functionality, such as unique identifiers, that should be required or encouraged for such systems.

CMS requests comment on whether States should be required to use these or other State data sources to identify unreported critical incidents.

CMS invites comments on whether these proposals should apply to 1915(j), (k), (i) and 1905(a) authorities.

D. Reporting (Section B.4 pgs. 71-72)

Proposed Changes

CMS proposes to amend § 441.302(h) by removing the following: "annually"; "The information must be consistent with data collection plan designed by CMS and must address the waiver's impact on-"' and by removing paragraphs (1) and (2) under the section. Additionally, CMS proposes to add ", including the data and information as required in § 441.311" at the end of the amended text, "Assurance that the agency will provide CMS with information on the waiver's impact."

Background/Rationale

Section 2402(a)(3)(A) of the ACA requires HHS to issue regulations that improve coordination among and regulation of all providers of HCBS programs to achieve a more consistent administration of policies and procedure across HCBS programs. Elsewhere in the proposed rule, CMS proposes establishing a new reporting requirements section. CMS believes these proposed changes remove duplicative or conflicting reporting requirements with the newly proposed requirements and will create more standardized and streamlined reporting for providers.

E. HCBS Payment Adequacy (Section B.5 pgs. 72-83)

Proposed Changes

CMS proposes at § 441.302(k)(3)(i) to require that at least 80% of all Medicaid payments for homemaker, home health aide and personal care services be spent on compensation to direct care workers.

CMS proposes at § 441.302(k)(1)(i) to define "compensation" to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations and benefits (such as health and dental benefits, sick leave, and tuition reimbursement). Additionally, under 1915(c) waivers, compensation would include the employer share of payroll taxes for direct care workers delivering services.

CMS proposes at § 441.302(k)(1)(ii) to define "direct care worker" to include workers who provide nursing services, assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), and provide other supports to promote community integrations. CMS' proposed definition includes nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists), licensed or certified nursing assistants, direct support professionals, personal care attendants, home health aides, and others who provide ADL/IADL, or community integration services to beneficiaries. CMS proposes to exclude nurses in supervisory or administrative roles who do not provide direct nursing services to beneficiaries. Finally, the definition includes workers employed by or contracted with a Medicaid provider, State agency, or third party; or delivering services under a self-directed model.

CMS proposes at § 441.302(k)(3)(i) to require States to demonstrate that they meet the minimum performance level through the reporting requirements proposed at § 441.311(e).

CMS proposes at § 441.302(k)(4) to apply these requirements to services delivered under FFS or managed care delivery systems. States would have 4 years from the effective date of the final rule to implement these requirements in the FFS delivery system, and until the first managed care plan contract rating period that begins on or after 4 years after the effective date of the final rule to implement these requirements.

CMS proposes to cross-reference these requirements at §§ 441.464(f), 441.570(f), and 441.745(a)(1)(vi) for section 1915 (j), (k), and (i) State plan services, and proposing to renumber existing § 441.464(e) as § 441.464(g) and existing § 441.464(f) as § 441.464(h).

Background/Rationale

Section 1902(a)(30)(A) of the Act requires State Medicaid programs to ensure that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist providers so there are no disparities in access to services among Medicaid beneficiaries in a geographic area. For many HCBS, hands-on and in-person services are delivered by direct care workers who typically earn low wages and limited benefits. Consequently, direct care workers have high turnover rates, increasing overtime and temporary staffing, and insufficient workforce may prevent individuals from transitioning to the community. Insufficient staffing may also lead to poorer quality outcomes and lower continuity of care. CMS also notes that while these challenges are longstanding, the COVID-19 pandemic significantly worsened workforce shortages, while demand for HCBS continues to rise.

Section 2402(a)(1) of the ACA requires States to allocate resources for services in a way that is responsive to beneficiaries' changing needs. Section 2402(a)(3)(B)(iii) of the ACA requires States to monitor the HCBS system functions to assure that a sufficient number of qualified direct care workers to provide self-directed personal assistance services. CMS asserts that to comply with these requirements, States must have enough qualified direct care workers available.

CMS believes that requiring States to ensure a portion of the payment for HCBS goes towards direct care workforce compensation supports the economy, efficiency, and quality of HCBS authorized under section 1915(c) of the Act. By providing sufficient payment rates, States can ensure they have an adequate workforce to meet the service needs of beneficiaries, and ultimately higher quality HCBS services. CMS believes that by stabilizing the direct care workforce, beneficiaries will benefit from better qualified employees, lower turnover, and higher quality of care.

CMS based this proposal on feedback from States that implemented similar payment requirements, which had the intended impact of ensuring a sufficient portion of the payment goes toward direct care workers. States indicated that they believed the 80% threshold was appropriate, given the expected administrative and other costs for providers.

CMS chose to propose this requirement for the three listed services based on the expectation that the vast majority of their payments should be comprised of direct care worker compensation, as these services have low facility or indirect costs. CMS considered applying the requirement to other services at § 440.180(b), but concluded they did not have adequate information about the facility or indirect costs to establish a payment threshold at this time.

CMS considered incorporating training or other costs in their proposed compensation definition, but were unsure if training or workforce activities were appropriate measures of financial benefit for workers.

Comments

CMS invites comment on the following options for the minimum percentage of payments that must be spent on compensation to direct care workers for homemaker services, home health aide services, and personal care services: (1) 75 percent; (2) 85 percent; and (3) 90 percent. If an alternative is recommended, please provide CMS with the rationale.

CMS invites comments on whether the proposal should apply to other services listed at § 440.180(b), particularly residential, day, and home-based habilitation services. Additionally, CMS requests comment on the following options for the minimum thresholds for direct care worker compensation for the specific

additional services this provision should apply to: (1) 65 percent; (2) 70 percent; (3) 75 percent; and (4) 80 percent. CMS requests that commenters respond separately for services delivered in community-based facilities and for residential facilities, from other service types due to their higher indirect facility costs and room and board fees, respectively.

CMS requests comment on whether the definition of compensation should include other specific financial and non-financial forms of compensation for direct care workers.

CMS invites comments on whether there are other types of direct care workers that should be included in the proposed definition, and whether any should be excluded.

CMS requests comment on the application of payment adequacy provisions across section 1915(i), (j), and (k) authorities, 1905(a) State plan authorities, and whether self-directed service delivery models should be exempted from these models across all Medicaid authorities.

CMS invites comments on the overall burden associated with implementing this section, whether the timeframe is sufficient, and whether they should require a shorter (i.e. 3 year) or longer (i.e. 5 year) timeframe.

F. Supporting Documentation Required (Section B.6 pgs. 83-85)

Proposed Changes

CMS proposes at § 441.303(f)(6) to add the following sentence to the end of the text: If the State has a limit on the size of the waiver program and maintains a list of individuals who are waiting to enroll in the waiver program, the State must meet the reporting requirements at § 441.311(d)(1).

Background/Rationale

Section 1915(c) of the Act authorizes States to limit the number of individuals served by a waiver. Consequently, many States choose to operate waiting lists of individuals interested in receiving waiver services, though States vary in how they operate and maintain those lists. CMS has not required States to submit information on the existence or composition of their waiting lists, which has led to information gaps on the accessibility of HCBS services. CMS has also learned of some states operating waiting lists despite not fully serving their waiver enrollment cap, but CMS is unable to determine the extent of this problem without additional data. Additionally, under section 1902(a)(6) of the Act CMS may require State Medicaid agencies to submit reports from time to time to comply with provisions and verification.

G. Reporting Requirements (Section B.7 pgs. 85-103)

1. **Compliance Reporting (pgs. 86-92)**

Proposed Changes

CMS proposes at § 441.311(b)(1)(i) to require States to report on the results of an incident management system assessment every 24 months. The assessment demonstrate that States' systems meet the requirements proposed at § 441.302(a)(6), including the standard definitions, minimum functional requirements, data reporting and sharing requirements, and investigative requirements.

CMS proposes at § 441.311(b)(1)(ii) to allow States to reduce the frequency of reporting up to once every 60 months once the incident management system has been determined to meet the requirements.

CMS proposes at § 441.311(b)(2) to require States to report annually on the number and percent of critical incidents for which an investigation was initiated, investigated and resolved, and corrective actions completed within state-specified timeframes.

CMS proposes at § 441.311(b)(3)(i) to require States to report the percent of beneficiaries continuously enrolled for at least 365 days that had a reassessment of functional need completed within the past 12 months. This report would be based on a statistically valid random sample of beneficiaries, rather than all eligible beneficiaries.

CMS proposes at § 441.311(b)(3)(ii) to require States to report the percent of beneficiaries continuously enrolled for at least 365 days who had their service plan updated as a result of their reassessment within the past 12 months. This report would be based on a statistically valid random sample of beneficiaries, rather than all eligible beneficiaries.

CMS proposes at § 441.311(b)(4) to add the regulatory language previously included at § 441.302(h)(1).

Background/Rationale

As mentioned in previous sections, CMS found through audits, surveys, and stakeholder engagement that States use varying definitions of critical incidents, some use non-standardized forms to collect critical incident information, and some lack updated, integrated electronic incident management systems. Additionally, CMS based the person-centered planning reporting requirements on the feedback received during stakeholder engagement activities over several years and the RFI previously discussed.

CMS believes that requiring States to report on the incident management system assessments every other year appropriately balances the burden to States, the frequency of change to State policy and systems, and the potential risk to beneficiaries. CMS also anticipates providing States with technical assistance on how to meet the proposed requirements.

Comments

CMS invites comment on whether the timeframe for State reporting the incident management system assessment is sufficient, if alternatives (annual or every 3 years) should be required, whether reporting for compliant systems should be more frequent (every 3 or 4 years), and the rationale for alternative timeframes.

CMS invites comments on the timeframe for reporting critical incidents, whether reporting should be required less frequently (every 2 years), and the rationale for alternative timeframes.

CMS invites comments on other person-centered planning compliance metrics to require in place of or in addition to those proposed, whether states should be required to report less frequently (every 2 years), and the rationale for alternative timeframes.

2. Reporting on the Home and Community-Based Services (pgs. 92-93)

Proposed Changes

CMS proposes at § 441.311(c)(1)(i) to require that States report every other year, in the format and schedule required by the agency, on the mandatory measures of the HCBS Quality Measure Set.

CMS proposes at § 441.311(c)(1)(ii) to allow states to voluntarily report on other (non-mandatory) measures in the HCBS Quality Measure Set.

CMS proposes at § 441.311(c)(1)(iii) to require States to establish performance targets, subject to CMS approval, for each mandatory measure and measure CMS will report on the States' behalf and describe the quality improvement strategies they will employ to meet those targets.

CMS proposes at § 441.311(c)(1)(iv) to allow States to establish performance targets and quality improvement strategies for the voluntary measures.

CMS proposes at § 441.311(c)(2) to report on a subset of measures on States' behalf. Additionally, at § 441.311(c)(3) CMS proposes to allow States to report on not-yet required measures and not-yet required populations.

Background/Rationale

CMS believes that reporting every other year effectively balances the reporting burden of the voluntary measures, many of which are survey-based, and allows states to implement quality improvement interventions between reporting periods.

Comments

CMS invites comment on whether they should establish a compliance threshold that would exempt States from developing improvement strategies, and if so recommendations for that threshold.

CMS invites comments on whether the timeframe for States to report on the measures in the HCBS Quality Measure Set is sufficient, whether it should be more or less frequent (1 or 3 years), the rationale for any alternative timeframes, and any additional changes CMS should consider in this section.

3. Access Reporting (pgs. 94-96)

Proposed Changes

CMS proposes at § 441.311(d)(1)(i) to require States to annually provide a description of how they maintain the list of individuals who are waiting to enroll in an HCBS program, if they maintain one. The description would include, but not be limited to: whether the State screens individuals for program eligibility, whether individuals are periodically re-screened, and the frequency of re-screening, if applicable.

CMS proposes at § 441.311(d)(1)(ii) to require States to report the number of individuals on the waiting list, if applicable.

CMS proposes at § 441.311(d)(1)(iii) to require States to report on the average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list, if applicable.

CMS proposes at § 441.311(d)(2)(i) to require States to report annually on the average amount of time from when homemaker, home health aide, or personal care services are initially approved to when those services began, for individuals newly approved to begin receiving services within the past 12 months. This report would be based on a statistically valid random sample of beneficiaries, rather than all eligible beneficiaries.

CMS proposes at § 441.311(d)(2)(ii) to require states to annually report on the percent of authorized hours for homemaker services, home health aide services, or personal care services that are provided within the past 12 months. This report would be based on a statistically valid random sample of beneficiaries, rather than all eligible beneficiaries.

Background/Rationale

CMS focused on homemaker, home health aide, and personal care service access for these reporting requirements based on stakeholder feedback that timely access to these services is especially challenging and the failure of States to ensure timely access provides substantial health, safety, and quality risks to beneficiaries.

Comments

CMS invites comments on whether there are other waiting list metrics or reporting requirements they should consider in place of or in addition to those proposed, the timeframe for State reporting, whether States should be required to report less frequently (ever 2 or 3 years), and the rationale for alternative timeframes.

CMS invites comments on whether the service initiation reporting requirement should apply to additional services authorized under section 1915(c) of the Act, the timeframe for reporting, whether States should be required to report less frequently (every 2 or 3 years), the rationale for alternative timeframes, and other metrics related to service initiation CMS should consider.

CMS invites comments on whether service provision percentage should be reported less frequently (every 2 or 3 years), the rationale for alternative timeframes, other metrics related to individuals use of authorized services CMS should consider, and whether this requirement should apply to additional services authorized under section 1915(c) of the Act.

4. **Payment Adequacy (pgs. 96-100)**

Proposed Changes

CMS proposes at § 441.311(e) to require States to report annually on the percent of payments for homemaker, home health aide, and personal care services, that are spend on compensation for direct care workers. States would separately report for each service type, and within each service separately report on agency and self-directed payments.

Background/Rationale

As discussed previously, CMS focused this requirement on these services based on their expectation that the majority of payments should be used for direct care worker compensation and that providers have low facility and other indirect costs. CMS considered but did not include in this proposal other HCBS services listed at § 440.180(b).

Comments

CMS invites comments on whether these requirements should apply to other services listed at § 440.180(b), particularly residential, day and home-based habilitation services, whether CMS should allow States to provide an assurance or attestation that they meet these requirements instead of reporting, and whether CMS should consider reducing reporting frequency to every other year.

CMS invites comment on whether they should require States to report at the delivery system, waiver program, or population; as well as the median and hourly wage and compensation by category.

CMS invites comment on whether they should allow States to exclude small provider agencies, as defined by those with low Medicaid revenues for a service, number of direct care workers serving beneficiaries, or the number of beneficiaries receiving the service, and what limit they should establish (5^{th}, 10^{th}, 15^{th}, 20^{th} percentile).

CMS invites comment on whether to allow States to exclude payments for self-directed services.

5. **Effective Date (pgs. 100-103)**

Proposed Changes

CMS proposes at § 441.311(f)(1) to provide States with 3 years following the effective date of the final rule to implement these reporting requirements, excluding the payment adequacy reports, in FFS systems, and until the contract rating period that begins on or after 3 years after the effective date of the final rule for managed care systems.

CMS proposes at § 441.311(f)(2) to provide States with 4 years following the effective date of the final rule to implement the payment adequacy reporting requirements in FFS systems, and until the contract

rating period that begins on or after 4 years after the effective date of the final rule for managed care systems.

CMS proposes at § 441.311(f) to apply all of the reporting requirements to services delivered under FFS and managed care systems.

CMS proposes to apply these requirements to section 1915(j), (k), and (i) State plan services by cross-referencing at §§ 441.474(c), 441.580(i), and 441.745(a)(1)(vii), respectively, and proposing to renumber existing § 441.580(i) as § 441.580(j).

Background/Rationale

CMS determined this implementation date based on feedback from stakeholders and considering the requirements of the proposed rule as a whole.

As previously discussed, section 2402(a)(3)(A) of the ACA requires consisted administration of policies and procedures across HCBS programs, which CMS interprets as consistency across FFS and managed care systems.

Comments

CMS invites comments on the timeframe, whether a shorter (2 & 3 years) or longer (4 & 5 years) timeframe should be required, and the rationale for alternative timeframes.

CMS invites comments on the application of these proposals on section 1915(i), (j), and (k), and 1905(a) authorities.

H. Home and Community-Based Services (Section B.8 pgs. 103-114)

Proposed Changes

CMS proposes a definition within § 441.312(b)(1) for "Attribution rules," meaning the process States use to assign beneficiaries to a specific health care program or delivery system for the purpose of calculating the measures on the "HCBS Quality Measure Set" as described in proposed § 441.312(d)(6), and at § 441.312(b)(2) for "Home and Community-Based Services Quality Measure Set" to mean the Home and Community-Based Measures for Medicaid established and updated at least every other year by the Secretary through a process that allows for input and comment.

CMS proposes at § 441.312(c)(1) a process for updating and maintaining the measure set at least every other year, in a process that allows for public comment.

CMS proposes at § 441.312(c)(2) that the Secretary solicit comment every other year with states and other interested parties to establish priorities, identify measures to address gaps, identify measures to remove, and ensure that all measures included are evidence-based, meaningful for states, and feasible for State and program-level reporting.

CMS proposes at § 441.312(d) a process for developing and updating the HCBS Quality Measure Set, specifically identifying all measures in the HCBS Quality Measure Set, including newly added measures, measures that have been removed, mandatory measures, measures that the Secretary will report on States' behalf, measures that States can elect to have the Secretary report on their behalf, as well as the measures that the Secretary will provide States with additional time to report and the amount of additional time. Additionally, the process would inform States on how to collect and calculate data, provide a standardized format and reporting schedule, provide reporting procedures for States to follow, and identify specific populations for which States must report the measures, including people enrolled in a specific delivery system type, people who are dually eligible for Medicare and Medicaid, older adults, people with physical disabilities, people with intellectual or developmental disabilities, people who have serious mental illness, and people who have other health conditions; and provide attribution rules for determining how States must report on measures for beneficiaries who are included in more than one population. Finally, the process would identify the subset of measures that must be stratified by race, ethnicity, Tribal status, sex, age, and other metrics specified by the Secretary.

CMS proposes at § 441.312(d)(6) to include quality reporting based on continuous enrollment in the Medicaid waiver. They anticipate setting attribution rules to address transitions in Medicaid eligibility, Medicare enrollment, transitions between different delivery systems or MLTSS plans within the reporting year.

CMS proposes at § 441.312(e) that the Secretary consider the complexity of State reporting and allow for the phase-in over a specified period of time of mandatory State reporting for some measures and of reporting for certain populations, such as older adults or people with intellectual and disabilities.

CMS proposes at § 441.312(f) that States be required to provide stratified data for 25% of measures by three years after the effective date of regulations, 50% of measures by five years, and 100% of measures by seven years.

CMS proposes at § 441.312(g) the list of interested parties with whom the Secretary must consult to specify and update the quality measures established in the HCBS Quality Measure Set. The list of proposed interested parties includes: State Medicaid Agencies and agencies that administer Medicaid-covered HCBS; health care and HCBS professionals who specialize in the care and treatment of older adults, children and adults with disabilities, and individuals with complex medical needs; health care and HCBS professionals, providers, and direct care workers who provide services to older adults, children and adults with disabilities and complex medical and behavioral health care needs who live in urban and rural areas or who are members of groups at increased risk for poor outcomes; HCBS providers; direct care workers and organizations representing direct care workers; consumers and national organizations representing consumers; organizations and individuals with expertise in HCBS quality measurement; voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care; measure development experts; and other interested parties the Secretary may determine appropriate.

CMS proposes that these quality measurement requirements be incorporated within the applicable regulatory sections for other HCBS authorities, including 1915(i), (j), and (k).

Background/Rationale

CMS believes that they can reduce the time and resources that States and other on identifying, assessing, and for use in HCBS programs. CMS believes that quality is a critical component of efficiency, and as such, having a standardized set of measures that is used to assess the quality of Medicaid HCBS programs supports the efficient operation of the Medicaid program. Further, they believe that, due to the constantly evolving field of HCBS quality measurement, the failure to establish such a process would result in ongoing reporting by States of measures that do not reflect the priorities of interested parties, measures that offer limited value compared to other measures, and measures that do not meet strong scientific and other standards.

CMS considered giving States the flexibility to choose which measures they would stratify and by what factors. However, as discussed in the Mandatory Medicaid and CHIP Core Set Reporting rule (87 FR 51313), consistent measurement of differences in health and quality of life outcomes between different groups of beneficiaries is essential to identifying areas for intervention and evaluation of those interventions. This consistency could not be achieved if each State made its own decisions about which data it would stratify and by what factors.

CMS determined that this proposed phased-in approach to data stratification would be reasonable and minimally burdensome, and thus consistent with EO 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, because they balance the importance of being able to identify differences in outcomes between populations under these measures with the potential operational challenges that States may face in implementing these proposed requirements.

Comments

CMS invites comments on whether the timeframes for updating the measures in the Set and conducting the process for developing and updating the HCBS Quality Measure Set is sufficient, whether they should conduct these activities more frequently (every year) or less frequently (every 3 years), and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

CMS also invites comment on other considerations to be addressed in the attribution rules or other topics they should address in the technical information, on the proposed schedule for phasing in reporting of HCBS Quality Measure Set data, on whether they should phase-in reporting on all of the measures in the HCBS Quality Measure Set, and on the application of these provisions across sections 1915(i), (j), and (k) authorities.

I. Website Transparency (Section B.9 pgs. 114-118)

Proposed Changes

CMS proposes the addition of a new section § 441.313, titled *Website transparency*, to promote public transparency related to the administration of Medicaid-covered HCBS.

CMS proposes at § 441.313(a) requiring States to operate a website that meets the availability and accessibility requirements at § 435.905(b) and that provides the results of the reporting requirements under newly proposed § 441.311 (specifically, incident management, critical incident, person centered

planning, and service provision compliance data; data on the HCBS Quality Measure Set; access data; and payment adequacy data).

CMS proposes at § 441.313(a)(1) requiring that the data and information that States are required to report under § 441.311 be provided on one web page, either directly or by linking to the web pages of the managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan, or primary care case management entity that is authorized to provide services.

CMS proposes at § 441.313(a)(2) a requirement that the web page include clear and easy to understand labels on documents and links.

CMS proposes at § 441.313(a)(3) requiring that States verify the accurate function of the website and the timeliness of the information and links at least quarterly.

CMS proposes at § 441.313(a)(4) to require that States include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost and include information on the availability of oral interpretation in all languages and written translation available in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number.

CMS proposes at § 441.313(b) and (c) that they must report on its website the information reported by States to us under § 441.311 and that they provide States with 3 years to implement these requirements following effective date of the final rule.

CMS proposes specifying that a State must ensure compliance with the requirements in § 441.313, with respect to HCBS delivered both under FFS and managed care delivery systems.

Finally, CMS proposes to apply the proposed requirements of § 441.313 to section 1915(j), (k), and (i) State plan services by cross-referencing at §§ 441.486, 441.595, and 441.750, respectively.

Background/Rationale

CMS believes that quality is a critical component of efficiency, as payments for services that are low quality do not produce their desired effects and, as such, are more wasteful than payments for services that are high quality. However, feedback from interested parties during various public engagement activities over the past several years have indicated that it is difficult to find information on HCBS access, quality, and outcomes in many States. They believe that the proposal supports the efficient administration of Medicaid-covered HCBS authorized under section 1915 (c) of the Act.

Comments

CMS welcomes comment on whether the requirements at § 435.905(b) are sufficient to ensure the availability and the accessibility of the information for people receiving HCBS and other HCBS interested parties and for specific requirements to ensure the availability and accessibility of the information, on whether States should be permitted to link to web pages of these managed care entities. Additionally, CMS requests comment on whether their requirements are sufficient to ensure the accessibility of the information for people receiving HCBS and other interested parties, the length of the timeline for function verification and requirement implementation, and the application of provisions across section 1915(i), (j), and (k).

III. Documentation of Access to Care and Service Payment Rates (pgs. 118-246)

A. Fully Fee-For-Service States (Section C.1 pgs. 122-123)

Background/Rationale

The timeliness standards of the proposed Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality proposed rule (Managed Care proposed rule) at § 438.68 do not apply to any care delivery in the States, so CMS is considering a narrower application of timeliness standards to fully FFS States similar to the proposed appointment wait time standards, secret shopper survey requirements, and publication requirements (as applied to outpatient mental health and substance use disorder, adult and pediatric; primary care, adult and pediatric; obstetrics and gynecology; and an additional type of service determined by the State).

Comments

CMS is seeking comments on whether added access standards for States with a fully FFS delivery system are appropriate. CMS is also seeking comments on a potentially appropriate method to collect data demonstrating that States meet the established standards at least 90% of the time.

B. Payment Rate Transparency (Section C.2 pgs. 123-208)

1. Payment Rate Transparency § 447.203(b)(1) (pgs. 123-132)

Proposed Changes

CMS proposes to rescind § 447.203(b) in its entirety and replace it with new requirements to ensure FFS Medicaid payment rate adequacy, including a new process to promote payment rate transparency.

CMS proposes to require the State agency to publish all Medicaid FFS payment rates in effect on a website developed and maintained by the single State agency that is accessible to the general public no later than January 1, 2026. The published Medicaid FFS payment rates would include fee schedule payment rates made to providers delivering Medicaid FFS services to beneficiaries. The website would also be easily reached from a link on the State Medicaid agency's website.

CMS also proposes that the single State agency include the date the payment rates were last updated on the State Medicaid agency's website.

CMS proposes that FFS Medicaid payment rates must be organized in such a way that a member of the public can readily determine the amount that Medicaid would pay for the service and, in the case of a bundled or similar payment methodology, identify each constituent service included within the rate and how much of the bundled payment is allocated to each constituent service under the State's methodology. If the rates vary, the State must separately identify the Medicaid FFS payment rates by population (pediatric and adult), provider type, and geographical location, as applicable.

CMS proposes that States paying varying Medicaid FFS payment rates by population (pediatric and adult), provider type, and geographical location, as applicable need to separately identify their Medicaid FFS payment rates in the payment rate transparency publication by each grouping or multiple groupings, when applicable to a state's program.

CMS proposes an alternative date of July 1, 2026, for the initial publication of Medicaid FFS payment rates and for the initial publication to include approved Medicaid FFS payment rates if the proposal is not finalized at a time that does not allow for States to have a period of at least 2 years between the effective date of the final rule and the proposed January 1, 2026 to publish Medicaid FFS payment rates.

If further adjustment is necessary beyond the July 1, 2026, timeframe to allow adequate time for States to comply with the payment rate transparency requirements, then CMS would adjust date of the initial payment rate transparency publication in 6- month intervals, as appropriate, to allow for approximately 2 years between the effective date of the final rule and the initial required payment rate transparency publication.

CMS proposes that the single State agency ensure that Medicaid FFS payment rates are kept current where any necessary updates to the State fee schedules made no later than 1 month following the date of CMS approval of the SPA, section 1915(c) HCBS waiver, or similar amendment revising the provider payment rate or methodology.

In the event of a payment rate change that occurs in accordance with a previously approved rate methodology, the State would be required to update its payment rate transparency publication no later than 1 month after the effective date of the most recent update to the payment rate.

Background/Rationale

CMS proposes the timeframe to provide States with at least 2 years from the possible effective date of the final rule to comply with the payment rate transparency requirement. The initial publication due date would promote comparability between States' payment rate transparency publications. The transparency of a State's recent payment rates including the date the payment rates were last updated on the State Medicaid agency's website, and the ability to compare payment rates between States on accessible and easily reachable State-maintained websites, highlights how the proposed payment rate transparency would help to ensure that Medicaid payment rate information is available to beneficiaries, providers, CMS, and other interested parties for the purposes of assessing access to care issues.

CMS aims to ensure maximum transparency for bundled fee schedule payment rates or similar payment methodologies. Having states identify the portion of the bundled fee is allocable to each constituent service included in the bundled fee schedule payment rate would add an additional level of granularity to

the payment rate transparency publication that continues to enable a member of the public to readily be able to determine the payment amount that would be made for a service.

CMS intends for the public to be readily able to determine the payment amount that would be made for all relevant circumstances, especially since Medicaid FFS payment rates vary based on population, geography, and other factors.

The alternative date would allow more time for States to comply with the payment rate transparency requirements.

Regarding the proposal that a single State agency ensure the Medicaid FFS payments are kept current when any updates are made no later than 1 month following CMS approval, CMS proposes these requirements to best capture Medicaid FFS payment rate changes that occur because of previously approved SPAs containing payment rate methodologies. Currently, rate information is not easily obtained from each State's website in its current publication form, making it difficult to understand the amounts that States pay providers for items and services furnished to Medicaid beneficiaries and to compare Medicaid payment rates to other health care payer rates or across States.

However, these changes can ensure all States have data in a publicly accessible format where all Medicaid FFS payment rates can be easily located and understood. The new transparency requirements under this proposed rule would help to ensure that interested parties have access to updated payment rate schedules and could conduct analyses.

Comments

CMS is seeking comments on the proposed requirements for States to publish their Medicaid FFS payment rates for all services, the proposed structure for Medicaid FFS payment rate transparency publication on the State's website, and the timing of the publication of and updates to the State's Medicaid FFS payment rates for the proposed payment rate transparency requirements in § 447.203(b)(1).

2. Comparative Payment Rate Analysis and Payment Rate Disclosure § 447.203(b)(2) (pgs. 132-154)

Proposed Changes

CMS proposes to require States to develop and publish a comparative payment rate analysis of Medicaid payment rates for certain specified services, and a payment rate disclosure for certain HCBS.

- Each State agency would be required to develop and publish a comparative payment rate analysis of Medicaid payment rates as specified in proposed § 447.203(b)(3).
- CMS proposes States utilize the same website developed and maintained by the single State Agency to publish their Medicaid FFS payment rates and their comparative payment rate analysis and payment rate disclosure.

- For both the comparative payment rate analysis and payment rate disclosure that, if the rates vary, the State must separately identify the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable.
- The categories of services include: primary care services; obstetrical and gynecological services; outpatient behavioral health services; and personal care, home health aide, and homemaker services, as specified in § 440.180(b)(2) through (4), provided by individual providers and providers employed by an agency.
- CMS proposes to require these services be subject to a payment rate disclosure since the proposed rule aims to standardize data and monitoring across service delivery systems with the goal of improving access to care.
- CMS also proposes to narrow the scope of behavioral health services to just outpatient services to focus the comparative payment rate analysis on ambulatory care provided by practitioners in an office-based setting without duplicating existing requirements, or analysis that must be completed to satisfy existing requirements, for upper payment limits (UPL) and the supplemental payment reporting requirements.
- CMS proposes that the comparative payment rate analysis would be conducted on a CPT/HCPCS code level, focusing on E/M codes.

CMS proposes eliminating the following from the current access monitoring review plan (AMRP) process without replacement in the proposed comparative payment rate analysis requirement:

- § 447.203(b)(5)(ii)(F): Any additional types of services for which a review is required under current § 447.203(b)(6);
- § 447.203(b)(5)(ii)(G): Additional types of services for which the State or CMS has received a significantly higher than usual volume of beneficiary, provider or other interested party access complaints for a geographic area, including complaints received through the mechanisms for beneficiary input consistent with current § 447.203(b)(7);
- § 447.203(b)(5)(ii)(H): Additional types of services selected by the State.

Background/Rationale

CMS states that the provisions would align with and build on the payment rate transparency requirements, because States could source the codes and their corresponding Medicaid payment rates that the State already would publish to meet the payment rate transparency requirements.

The retrospective analysis ensures that CMS can publish the list of E/M CPT/HCPCS codes for the comparative payment rate analysis and that States have timely access to all information required to complete comparative payment rate analysis.

These particular services are also critical medical services and of great importance to overall beneficiary health.

CMS also intends to remain consistent with the proposed HCBS provisions where they propose to require annual State reporting on access and payment adequacy metrics for homemakers, home health aides, and personal care services.

CMS proposes to narrow the range of codes to analyze commonly provided services that fall into the different service categories proposed. By excluding facility-based services, particularly inpatient behavioral health services, CMS also intends to ensure the same E/M CPT/HCPCS code-level methodology could be used for all categories of services included in the proposed comparative payment rate analysis, including the use of E/M CPT/HCPCS codes used for outpatient behavioral health services.

CMS proposes to eliminate certain provisions from the current AMRP process because their implementation experience has shown that the majority of States did not select additional types of service to include in their AMRPs beyond the required services § 447.203(b)(5)(ii)(A) through (G). When assessing which services to include in this proposed rule, CMS determined that the absence of an open-ended type of service option, similar to § 447.203(b)(5)(ii)(H) is unlikely to affect the quality of the analysis proposed in this rule and therefore, CMS will not including it in the proposed set of services required for the comparative payment rate analysis.

Comments

CMS is seeking public comments on the proposal to require the comparative payment rate analysis includes, if the rates vary, separate identification of payment rates by population (pediatric and adult), provider type, and geographical location, as applicable, in the comparative payment rate analysis.

CMS is seeking public comment on the proposed required location for States to publish their comparative payment rate analysis and payment rate disclosure proposed in § 447.203(b)(4).

CMS is also seeking public comment on any additional types of payment adjustments or factors States make to their Medicaid payment rates as listed on their State fee schedules that should be identified in the comparative payment rate analysis that have not already discussed.

CMS is also seeking public comment on primary care services as one of the proposed categories of services subject to the comparative payment rate analysis requirements.

CMS is also seeking public comment on outpatient behavioral health services as one of the proposed categories of services subject to the comparative payment rate analysis requirements.

CMS is also seeking public comment on personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency as the proposed categories of services subject to the payment rate disclosure requirements.

3. Comparative Payment Rate Analysis for Primary Care, OBGYN, and Outpatient Behavioral Health § 447.203(b)(3)(i) (pgs. 154-186)

Proposed Changes

In paragraph (b)(3)(i), CMS proposes that for the categories of service described in paragraphs (b)(2)(i) through (iii), the State's analysis would compare the State's Medicaid FFS payment rates to the most recently published Medicare payment rates effective for the same time period for the E/M CPT/HCPCS

codes applicable to the category of service. The proposed comparative payment rate analysis of FFS Medicaid payment rates to FFS Medicare payment rates would be conducted on a code-by-code basis at the CPT/HCPCS code level using the most current set of published codes.

CMS proposes to identify E/M CPT/HCPCS codes to be included in the comparative payment rate analysis based on the following criteria: the code is effective for the same time period of the comparative payment rate analysis; the code is classified as an E/M CPT/HCPCS code by the American Medical Association (AMA) CPT Editorial Panel; the code is included on the Berenson-Eggers Type of Service (BETOS) code list effective for the same time period as the comparative payment rate analysis and falls into the E/M family grouping and families and subfamilies for primary care services, obstetrics and gynecological services, and outpatient behavioral services; and the code has an A (Active), N (Non-Covered), R (Restricted), or T (Injections) code status on the Medicare PFS with a Medicare established relative value unit (RVU) and payment amount for the same time period of the comparative payment rate analysis. The comparative payment rate analysis would be updated no less than every 2 years.

Paragraph (b)(3)(i)(A)

CMS proposes to require States to organize their comparative payment rate analysis by the service categories described in paragraphs (b)(2)(i) through (iii) of this section (primary care, OBGYN, and outpatient behavioral health).

Paragraph (b)(3)(i)(B)

CMS proposes to require States to clearly identify the Medicaid base payment rate for each code, including, if the rates vary, separate identification of the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable. They propose that the Medicaid base payment rate in the comparative payment rate analysis would only include the State's Medicaid fee schedule rate, that is, the State's Medicaid base rate for each E/M CPT/HCPCS code. Additionally, CMS proposes to require that States conduct the comparative payment rate analysis for only Medicaid base payment rates for selected E/M CPT/HCPCS codes. Additionally, CMS proposes that, if the States' payment rates vary, the Medicaid base payment rates must include a breakdown by payment rates paid to providers delivering services to pediatric and adult populations, by provider type, and geographical location, as applicable, to capture this potential variation in the State's payment rates.

Paragraph (b)(3)(i)(C)

CMS proposes in paragraph (b)(3)(i)(C) to require States to compare their Medicaid payment rates to the Medicare non-facility payment rates effective for the same time period as the same set of E/M CPT/HCPCS codes paid under Medicaid as specified under paragraph (b)(3)(i)(B) of this section, including, separate identification of the payment rates by provider type. Additionally, they propose to require States to compare their payment rates to the corresponding Medicare PFS non-facility rates because they are seeking a payment analysis that compares Medicaid payment rates to Medicare payment rates at comparable location of service delivery (that is, in a non-clinic, non-hospital, ambulatory setting such as a physician's office).

Additionally, in in paragraph (b)(3)(i)(C), CMS proposes that the Medicare non-facility payment rates as listed on the Medicare PFS used for the comparison must be for the same geographical location as the

Medicaid base payment rates. For States that pay Medicaid payment rates based on geographical location (for example, payment rates that vary by rural or non-rural location, by zip code, or by metropolitan statistical area), CMS proposes that States comparative payment rate analysis would need to utilize the Medicare non-facility payment rates as listed on the Medicare PFS for the same geographical location as the Medicaid base payment rates to achieve an equivalent comparison. For States that do not determine their payment rates by geographical location, CMS proposes that States would use the Statewide average of the Medicare Non-Facility Price(s) as listed on the PFS, as previously described, because it ensures consistency across all States' comparative payment rate analysis, aligns with the geographic area requirement of section 1902(a)(30)(A) of the Act, and ensures the Medicare non-facility payment rates as listed on the Medicare PFS that States use in their comparative payment rate analysis accurately reflect how Medicare pays for services. As proposed, States that do not determine their payment rates by geographical location would be required to consider Medicare's geographically determined payment rates by Statewide average of the Medicare non-facility payment rates.

Paragraph (b)(3)(i)(D)

CMS proposes in paragraph (b)(3)(i)(D) to require States to specify the Medicaid base payment rate identified under proposed § 447.203(b)(3)(i)(B) as a percentage of the Medicare non-facility payment rate identified under proposed § 447.203(b)(3)(i)(C) for each of the services for which the Medicaid base payment rate is published under proposed § 447.203(b)(3)(i)(B). For each E/M CPT/HCPCS code selected, they propose that States would calculate each Medicaid base payment rate as specified in paragraph (b)(3)(i)(B) as a percentage of the corresponding Medicare non-facility payment rate specified in paragraph (b)(3)(i)(C). Both rates would be required to be effective for the same time period of the comparative payment rate analysis. They propose that States would calculate the Medicaid base payment rate as a percentage of the Medicare non-facility payment rate in the comparative payment rate analysis to obtain an informative metric that can be used in the State's and CMS's assessment of whether the State's payment rates are compliant with section 1902(a)(30)(A) of the Act.

Paragraph (b)(3)(i)(E)

CMS proposes to require States to specify in their comparative payment rate analyses the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services for which the Medicaid base payment rate is published under paragraph (b)(3)(i)(B). This component examines the Medicaid-paid claims volume of each E/M CPT/HCPCS code included in the comparative payment rate analysis relative to the number of Medicaid enrolled beneficiaries receiving each service within a calendar year.

They propose to limit the claims volume data to Medicaid-paid claims, and the number of beneficiaries would be limited to Medicaid-enrolled beneficiaries who received a service in the calendar year of the comparative payment rate analysis, where the service would fall into the list of CMS-identified E/M CPT/HCPCS code(s). They propose to include beneficiary and claims information in the comparative payment rate analysis to contextualize the payment rates in the analysis, and to be able to identify longitudinal changes in Medicaid service volume in the context of the Medicaid beneficiary population receiving services, since utilization changes could be an indication of an access to care issue. Based on their implementation experience and concerns from States about the current requirement in §

447.203(b)(1)(v) to obtain private payer data, CMS proposes to require States only compare their Medicaid payment rates to Medicare's, for which payment data are readily and publicly available.

Background/Rationale

CMS reasons the (b)(3)(i) analysis is intended to provide an understanding of how Medicaid payment rates compare to the payment rates established and updated under the FFS Medicare program. CMS would expect to publish the E/M CPT/HCPCS codes to be used for the comparative payment rate analysis in sub regulatory guidance along with the final rule. CMS notes that E/M CPT/HCPCS codes are some of the most commonly billed codes and including them in the comparative payment rate analysis would allow us to uniformly compare Medicaid payment rates for these codes to Medicare PFS rates.

Paragraph (b)(3)(i)(A)

The proposed requirement at (b)(3)(i)(A) is included to ensure the analysis breaks out the payment rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health services separately for individual analyses of the payment rates for each CMS-selected E/M CPT/HCPCS code, grouped by category of service.

Paragraph (b)(3)(i)(B)

CMS believes that this approach represents the best way to create a consistent metric across States against which to evaluate access. It narrows the Medicaid base payment rates to the amount listed on the State's fee schedule in order for the comparative payment rate analysis to accurately and analogously compare Medicaid fee schedule rates to Medicare fee schedule rates as listed on the Medicare PFS. The proposed provision to breakdown the Medicaid payment rate is first stated in proposed paragraph (b)(2) and carried through in proposed paragraph (b)(3)(i)(B) provides clarity to States about how the Medicaid payment rate should be reported in the comparative payment rate analysis.

Paragraph (b)(3)(i)(C)

Benchmarking against FFS Medicare, another of the nation's large public health coverage programs, serves as an important data point in determining whether payment rates are likely to be sufficient to ensure access for Medicaid beneficiaries at least as great as for the general population in the geographic area, and whether any identified access concerns may be related to payment sufficiency. Similar to Medicaid, Medicare provides health coverage for a significant number of Americans across the country. Medicare also ensures that their payment rate data are publicly available in a format that can be analyzed. The accessibility and consistency of the Medicare non-facility payment rates as listed on the Medicare PFS, compared to negotiated private health insurance payment rates that typically are considered proprietary information and, therefore, not generally available to the public, makes Medicare non-facility payment rates as listed on the Medicare PFS an available and reliable comparison point for States to use in the comparative payment rate analysis.

Paragraph (b)(3)(i)(D)

Benchmarking against Medicare serves as an important data point in determining whether payment rates are likely to be sufficient to ensure access for Medicaid beneficiaries at least as great as for the general population in the geographic area, and whether any identified access concerns may be related to payment

sufficiency. Calculating Medicaid payment rates as a percentage of the Medicare non-facility payment rate is a common, simple, and informative statistic that can provide us with a gauge of how Medicaid payment rates compare to Medicare non-facility payment rates in the same geographic area. Initially and over time, States, CMS, and other interested parties would be able to compare the State's Medicaid payment rates as a percentage of Medicare's non-facility payment rates to identify how the percentage changes over time, in view of changes that may take place to the Medicaid and/or the Medicare payment rate. Being able to track and analyze the change in percentage over time would help States and CMS identify possible access concerns that may be related to payment insufficiency.

Paragraph (b)(3)(i)(E)

With this proposal, CMS seeks to ensure the comparative payment rate analysis reflects actual services received by beneficiaries and paid for by the State, or realized access.

CMS believes the comparative payment rate analysis proposed in paragraph (b)(3) is needed to best enable them to ensure State compliance with the requirement in section 1902(a)(30)(A) of the Act that payments are sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in the geographic area. By comparing FFS Medicaid payment rates to corresponding FFS Medicare non-facility payment rates, where Medicare is a public payer with large populations of beneficiaries and participating providers whose payment rates are readily available, CMS aims to establish a uniform benchmarking approach that allows for more meaningful oversight and transparency and reduces the burden on States and CMS relative to the current AMRP requirements that do not impose specific methodological standards for comparing payment rates and that contemplate the availability of private payer rate information that has proven difficult for States to obtain.

Comments

CMS seeks public comment on the proposed comparative payment rate analysis requirement in § 447.203(b)(3)(i), including the proposed requirement to conduct the analysis at the CPT/HCPCS code level, the proposed criteria that they would apply in selecting E/M CPT/HCPCS codes for inclusion in the required analysis, and the proposed requirement for States to compare Medicaid payment rates for the selected E/M CPT/HCPCS codes to the most recently published Medicare non-facility payment rate as listed on the Medicare PFS effective for the same time period which is discussed in more detail later in this rule when describing the proposed provisions of § 447.203(b)(3)(i)(C).

CMS invites public comment on the proposed requirements and content of the items in proposed § 447.203(b)(3)(i)(A) through (E).

Paragraph (b)(3)(i)(A)

CMS invites public comment on the proposed requirement for States to break out their payment rates at the CPT/HCPCS code level for primary care services, obstetrical and gynecological services, and outpatient behavioral health services, separately, in the comparative payment rate analysis.

Paragraph (b)(3)(i)(C)

CMS seeks public comment on the proposed use of Medicare non-facility payment rates as listed on the Medicare PFS as a benchmark for States to compare their Medicaid payment rates to in the comparative payment rate analysis requirements in proposed § 447.203(b)(3)(i) to help assess if Medicaid payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

CMS seeks comment on the proposed requirement for States to compare their Medicaid payment rates to the Medicare non-facility payment rate as listed on the Medicare PFS, effective for the same time period for the same set of E/M CPT/HCPCS codes, and for the same geographical location as the Medicaid base payment rates, that correspond to the Medicaid base payment rates identified under paragraph (b)(3)(i)(B) of this section, including, separate identification of the payment rates by provider type, as proposed in § 447.203(b)(3)(i)(C).

Paragraph (b)(3)(i)(D)

CMS seeks public comment on the proposed requirement for States to calculate their Medicaid payment rates as a percentage of the Medicare non-facility payment rate for each of the services for which the Medicaid base payment rate is published under proposed paragraph (b)(3)(i)(B), as described in proposed § 447.203(b)(3)(i)(D). They are also seeking public comment on any challenges States might encounter when comparing their Medicaid payment rates to Medicare non-facility payment rates under proposed § 447.203(b)(3)(i)(D), particularly for any of the proposed categories of service in paragraphs (b)(2)(i) through (iii), as well as suggestions for an alternative comparative analysis that might be more helpful, or less burdensome and equally helpful, for States, CMS, and other interested parties to assess whether a State's Medicaid payment rates are consistent with the access standard in section 1902(a)(30)(A) of the Act.

Paragraph (b)(3)(i)(E)

CMS invites public comment regarding their decision not to propose States identify the number of unique Medicaid- paid claims and the number of unique Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services for which the Medicaid base payment rate is published pursuant to paragraph (b)(3)(i)(B) in comparative payment rate analysis as proposed §447.203(b)(3)(i)(E).

They also seek comment regarding their decision to not propose States identify the total Medicaid-enrolled population who could receive a service within a calendar year for each of the services for each of the services for each of the services for which the Medicaid base payment rate is published pursuant to paragraph (b)(3)(i)(B) in the comparative payment rate analysis as proposed § 447.203(b)(3)(i)(E).

They seek public comment on the proposed requirement for States to include the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for which the Medicaid base payment rate is published under proposed paragraph (b)(3)(i)(B), as specified in proposed § 447.203(b)(3)(i)(E).

4. **Comparative Payment Rate Analysis for Personal Care, Home Health Aide, Homemaker Services § 447.203(b)(3)(ii) (pgs. 187-194)**

Proposed Changes

In paragraph (b)(3)(ii), CMS proposes that for each category of services described in proposed paragraph (b)(2)(iv), the State agency would be required to publish a payment rate disclosure that expresses the State's payment rates as the average hourly payment rates, separately identified for payments made to individual providers and to providers employed by an agency, if the rates differ.

In paragraph (b)(3)(ii)(A), CMS proposes to require States to organize their payment rate disclosures by each of the categories of services specified in proposed paragraph (b)(2)(iv), that is, to break out the payment rates for personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency, separately for individual analyses of the payment rates for each category of service and type of employment structure.

In paragraph (b)(3)(ii)(B), CMS proposes to require States identify in their disclosure the Medicaid average hourly payment rates by applicable category of service, including, if the rates vary, separate identification of the average hourly payment rates for payments made to individual providers and to providers employed by an agency, as well as by population (pediatric and adult), provider type, and geographical location, as applicable. CMS proposes to require States calculate their Medicaid average hourly payment rates made to providers of personal care, home health aide, and homemaker services, separately, for each of these categories of services, by provider employment structures (individual providers and agency employed providers).

In paragraph (b)(3)(ii)(C) CMS proposes to require that the State disclosure must identify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services for which the Medicaid payment rate is published under proposed paragraph (b)(3)(ii)(B), so that States, CMS, and other interested parties would be able to contextualize the previously described payment rate information with information about the volume of paid claims and number of beneficiaries receiving personal care, home health aide, and homemaker services. Additionally, they propose that the number of Medicaid-paid claims and number of Medicaid enrolled beneficiaries who received a service be reported under the same breakdown as paragraph (b)(3)(ii), where the State provides the number of paid claims and number of beneficiaries receiving services from individual providers versus agency-employed providers of personal care, home health aide services, and homemaker services.

Background/Rationale

The reason for including this proposal builds on CMS's justification for including personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency in this proposed rule, which is to remain consistent with the proposed HCBS provisions at § 441.311(d)(2) and (e) and take specific action regarding direct care workers per Section 2402(a) of the Affordable Care Act. HCBS and direct care workers that deliver these services are unique to Medicaid and often not covered by other payers, which is why CMS proposes a different analysis of payment rates for providers of these services that does not involve a comparison to Medicare.

Comparing personal care and homemaker services to Medicare, as proposed in paragraph (b)(3)(i) for other specified categories of services, would not be feasible for States, and a comparison of Medicaid home health aide average hourly payment rates to analogous rates for Medicare would be of limited utility given the differences in circumstances when Medicaid and Medicare may pay for such services. Through the proposed payment rate disclosure, Medicaid payments rates would be transparent and comparable among States and would assist States to analyze if and how their payment rates are compliant with section 1902(a)(30)(A) of the Act.

CMS believes expressing the data in this manner would best account for variations in types and levels of payment that may occur in different settings and employment arrangements. Individual providers are often self-employed or contract directly with the State to deliver services as a Medicaid provider while providers employed by an agency are employed by the agency which works directly with the Medicaid agency to provide Medicaid services. These differences in employment arrangements often include differences in the hourly rate a provider would receive for services delivered, for example, providers employed by an agency typically receive benefits, such as health insurance, and the cost of those benefits are factored into the hourly rate that the State pays for the services delivered by providers employed by an agency (even though the employed provider does not retain the entire amount as direct monetary compensation). However, these benefits are not always available for individual providers who may need to separately purchase a marketplace health plan or be able to opt into the State-employee health plan, for example. Therefore, the provider employed by an agency potentially could receive a higher hourly rate because benefits are factored into the hourly rate they receive for delivering services, whereas the individual provider might be paid a rate that does not reflect employment benefits.

Regarding (b)(3)(ii)(B), a more granular analysis may show that within personal care providers receiving a payment rate of $10.50, an individual personal care provider is paid an average hourly payment rate of $9.00, while a personal care provider employed by an agency is paid an average hourly payment rate of $12.00 for the same type of service. Similarly for home health aides, a more granular analysis may show that within home health aides receiving a payment rate of $15.00, an individual home health aide is paid an average hourly payment rate of $13.00, while a home health aide employed by an agency is paid an average hourly payment rate of $17.00. However, they understand that States may set payment rates for personal care, home health aide, and homemaker services based on a particular unit of time for delivering the service, and that time may not be in hourly increments.

Regarding (b)(3)(ii)(C), they want to ensure the payment rate disclosure reflects actual services received by beneficiaries and paid for by the State, or realized access. CMS acknowledges that one limitation of using the average hourly payment rate is that the statistic is sensitive to highs and lows so one provider receiving an increase in their average hourly payment rate would bring up the average overall while other providers may not see an improvement. As these are only correlating trends, CMS also acknowledges that there may be other contextualizing factors outside of the payment rate disclosure that may affect changes in service volume and utilization.

Comments

CMS invites public comment on the proposed requirements and content of the items in proposed § 447.203(b)(3)(ii)(A) through (C).

CMS seeks public comment on the proposed requirement for States to break out their payment rates for personal care, home health aide, and homemaker services separately for individual analyses of the payment rates for each category of service in the comparative payment rate analysis, as described in proposed § 447.203(b)(3)(ii)(A).

They seek public comments on the proposed requirement for States to include the number of Medicaid-paid claims and number of Medicaid enrolled beneficiaries who received a service within a calendar year for which the Medicaid payment rate is published under paragraph (b)(3)(ii)(B), as specified in proposed § 447.203(b)(3)(ii)(C). Additionally, they request comment on whether they should propose a similar provision that would require at least 80 percent of all Medicaid FFS payments with respect to personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency must be spent on compensation for direct care workers.

5. Comparative Payment Rate Analysis Timeframe, Compliance, and Advisory Group § 447.203(b)(4) to (b)(6) (pgs. 195-208)

Proposed Changes

Paragraph § 447.203(b)(4)

In paragraph (b)(4), CMS proposes to require the State agency to publish the initial comparative payment rate analysis and payment rate disclosure of its Medicaid payments in effect as of January 1, 2025, as required under § 447.203(b)(2) and (b)(3), by no later than January 1, 2026. Thereafter, the State agency would be required to update the comparative payment rate analysis and payment rate disclosure no less than every 2 years, by no later than January 1 of the second year following the most recent update.

CMS proposes in paragraph (b)(4) to require States to publish the comparative payment rate analysis and payment rate disclosure consistent with the publication requirements described in proposed paragraph (b)(1) for payment rate transparency data. Paragraph (b)(1) would require the website developed and maintained by the single State Agency to be accessible to the general public.

CMS also proposes in paragraph (b)(4) to require States to publish the comparative payment rate analysis and payment rate disclosure consistent with the publication requirements described in proposed paragraph (b)(1) for payment rate transparency data. CMS proposes States utilize the same website developed and maintained by the single State Agency to publish their Medicaid FFS payment rates and their comparative payment rate analysis and payment rate disclosure.

Paragraph § 447.203(b)(5)

In § 447.203(b)(5), CMS proposes a mechanism to ensure compliance with paragraphs (b)(1) through (b)(4). Specifically, they propose that, if a State fails to comply with the payment rate transparency and comparative payment rate analysis and payment rate disclosure requirements in paragraphs (b)(1) through (b)(4) of proposed § 447.203, future grant awards may be reduced by the amount of FFP we estimate is attributable to the State's administrative expenditures relative to the total expenditures for the categories

of services specified in paragraph (b)(2) of proposed § 447.203 for which the State has failed to comply with applicable requirements, until such time as the State complies with the requirements.

CMS also proposes that unless otherwise prohibited by law, FFP for deferred expenditures would be released after the State has fully complied with all applicable requirements.

Paragraph § 447.203(b)(6)

CMS proposes that the State agency would be required to establish an advisory group for interested parties to advise and consult on provider rates with respect to service categories under the Medicaid State plan, section 1915(c) waiver and demonstration programs, as applicable, where payments are made to the direct care workers specified in § 441.302(k)(1)(ii) for the self-directed or agency-directed services found at § 440.180(b)(2) through (4).

The interested parties' advisory group would be required to include, at a minimum, direct care workers, beneficiaries and their authorized representatives, and other interested parties. "Authorized representatives" refers to individuals authorized to act on the behalf of the beneficiary, and other interested parties may include beneficiary family members and advocacy organizations. To the extent a State's MAC established under proposed § 431.12, if finalized, meets the requirements of this regulation, the State could utilize that committee for this purpose. However, they note the roles of the MAC under proposed § 431.12 and the interested party advisory group under proposed § 447.203(b)(6) would be distinct, and the existence or absence of one committee or group (for example, if one of these proposals is not finalized) would not affect the requirements with respect to the other as established in a final rule.

CMS further proposes that the interested parties' advisory group would advise and consult with the Medicaid agency on current and proposed payment rates, HCBS payment adequacy data as required at § 441.311(e), and access to care metrics described in § 441.311(d)(2), associated with services found at § 440.180(b)(2) through (4), to ensure the relevant Medicaid payment rates are sufficient to ensure access to homemaker services, home health aide services, and personal care services for Medicaid beneficiaries at least as great as available to the general population in the geographic area and to ensure an adequate number of qualified direct care workers to provide self-directed personal assistance services.

In § 447.203(b)(6)(iv), CMS proposes that the interested parties advisory group would meet at least every 2 years and make recommendations to the Medicaid agency on the sufficiency of State plan, 1915(c) waiver, and demonstration direct care worker payment rates, as applicable. The State agency would be required to ensure the group has access to current and proposed payment rates, HCBS provider payment adequacy minimum performance and reporting standards as described in § 441.311(e), and applicable access to care metrics for HCBS as described in § 441.311(d)(2) to produce these recommendations. These materials would be required to be made be available with sufficient time for the advisory group to consider them.

In § 447.203(b)(6)(v), CMS proposes that the Medicaid agency would be required to publish the recommendations of the interested parties' advisory group consistent with the publication requirements described in paragraph (b)(1) of this section for payment rate transparency data, within 1 month of when the group provides the recommendation to the agency. The work of the advisory group would be regarded as an element of the State's overall rate-setting process. Additionally, the feedback of this advisory group would not be required for rate changes.

Background/Rationale

Section 2402(a) of the Affordable Care Act directs the Secretary to promulgate regulations ensuring that all States develop service systems that, among other things, improve coordination and regulation of providers of HCBS to oversee and monitor functions, including a complaint system, and ensure that there are an adequate number of qualified direct care workers to provide self-directed services. This statutory mandate, coupled with the workforce shortages exacerbated by the COVID-19 pandemic, necessitates action specific to direct care workers. As such, CMS is proposing to require States to establish an interested parties' advisory group to advise and consult on FFS rates paid to direct care workers providing self-directed and agency directed HCBS, at a minimum for personal care, home health aide, and homemaker services as described in § 440.180(b)(2) through (4), and States may choose to include other HCBS.

Paragraph § 447.203(b)(4)

CMS expects the proposed initial publication timeframe to provide sufficient time for States to gather necessary data, perform, and publish the first required comparative payment rate analysis and payment rate disclosure. They determined this timeframe was sufficient based on implementation experience from the AMRP process.

CMS believes updating the comparative payment rate analysis and payment rate disclosure no less than every 2 years achieves an appropriate balance between administrative burden and our oversight responsibilities with regard to section 1902(a)(30)(A) of the Act.

Paragraph § 447.203(b)(5)

This proposed enforcement mechanism is similar in structure to the mechanism that applies with respect to the Medicaid Disproportionate Share Hospital (DSH) reporting requirements in § 447.299(e), which specifies that State failure to comply with reporting requirements will lead to future grant award reductions in the amount of FFP CMS estimates is attributable to expenditures made for payments to the DSH hospitals as to which the State has not reported properly. CMS is proposing this long-standing and effective enforcement mechanism in this proposed rule because we believe it is proportionate and clear, and to remain consistent with other compliance actions we take for State non-compliance with statutory and regulatory requirements.

Comments

Paragraph § 447.203(b)(4)

CMS seeks public comment on the proposed required location for States to publish their comparative payment rate analysis and payment rate disclosure proposed in § 447.203(b)(4).

Paragraph § 447.203(b)(5)

CMS seeks public comment on the proposed method for ensuring compliance with the payment rate transparency and comparative payment rate analysis and payment rate disclosure requirements, as specified in proposed § 447.203(b)(5).

Paragraph § 447.203(b)(6)

CMS seeks public comment on the proposed interested parties advisory group and about whether other categories of services should be included in the requirement for States to consult with the interested parties advisory group.

C. State Analysis Procedures for Rate Reduction or Restructuring (Section C.3 pgs. 208-245)

1. Overview (pgs. 208-212)

Proposed Changes

In § 447.203(c), CMS proposes a process for State access analyses that would be required whenever a State submits a SPA proposing to reduce provider payment rates or restructure provider payments. CMS proposes a two-tiered approach for determining the level of access analysis States would be required to conduct when proposing provider payment rate reductions or payment restructurings. The first tier of this approach, proposed at § 447.203(c)(1), sets out three criteria for States to meet when proposing payment rate reductions or payment restructurings in circumstances when the changes could result in diminished access that, if met, would not require a more detailed analysis to establish that the proposal meets the access requirement in section 1902(a)(30)(A) of the Act.

CMS notes that meeting the three criteria described in proposed § 447.203(c)(1) does not guarantee that the SPA would be approved, if other applicable Federal requirements are not met. Furthermore, if any criterion in the first tier is not met, they propose a second tier in § 447.203(c)(2), which would require the State to conduct a more extensive access analysis in addition to providing the results of the analysis in the first tier.

CMS proposes that an 80 percent Medicaid-to-Medicare fee ratio is a reasonable threshold and would hold across benefit categories, because they did not find any indication that a lower threshold would be adequate, or that a higher threshold would be strictly necessary, to support a level of access to covered services for Medicaid beneficiaries at least as great as for the general population in the geographic area.

Background/Rationale

This proposed rule seeks to achieve a more appropriate balance between reducing unnecessary burden for States and CMS, and ensuring that CMS has the information necessary to make appropriate determinations for whether a rate reduction or restructuring SPA might result in beneficiary access to covered services failing to meet the standard in section 1902(a)(30)(A) of the Act.

To improve the efficiency of their administrative procedures and better inform SPA approval decisions, this proposed rule would establish standard information that States would be required to submit with any proposed rate reductions or proposed payment restructurings in circumstances when the changes could result in diminished access, including a streamlined set of data when the reductions or restructurings are nominal, the State rates are above a certain percentage of Medicare payment rates, and there are no

evident access concerns raised through public processes; and an additional set of data elements that would be required when States propose FFS provider payment rate reductions or restructurings in circumstances when the changes could result in diminished access and these criteria are not met.

For both sets of required or potentially required elements, CMS proposes to standardize the data and information States would be required to submit with rate reduction or restructuring SPAs. Although the AMRP processes have helped to improve their administrative reviews and helped them make informed SPA approval determinations, the procedures within this proposed rule would provide similar information in a manner that reduces State burden. Additionally, the proposed procedures would provide States increased flexibility to make program changes with submission of streamlined supporting data to us when current Medicaid rates and proposed changes fall within specified criteria that create a reasonable presumption that proposed reductions or restructuring would not reduce beneficiary access to care in a manner inconsistent with section 1902(a)(30)(A) of the Act.

Comments

CMS is seeking public comment on their proposed procedures and requirements for State analysis for payment rate reduction or payment restructuring SPAs, including the qualification criteria for streamlined analysis proposed in § 447.203(c)(1), the proposed additional analysis elements in § 447.203(c)(2) for those proposed payment rate reductions or payment restructurings that do not meet the criteria in paragraph (c)(1), the proposed methods for ensuring compliance in § 447.203(c)(3), the proposed mechanisms for ongoing beneficiary and provider input in § 447.203(c)(4), the proposed methods to address access questions and remediation of inadequate access to care in § 447.203(c)(5), and the proposed compliance actions for access deficiencies in § 447.203(c)(6).

2. **Tier 1 (pgs. 212-231)**

Proposed Changes

Under proposed § 447.203(c)(1)(i), the State would be required to provide a supported assurance that Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring would be at or above 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services.

In § 447.203(c)(1)(ii), CMS proposes that the State would be required to provide a supported assurance that the proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the State fiscal year, would result in no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a single State fiscal year.

In § 447.203(c)(1)(iii), CMS proposes that the State would be required to provide a supported assurance that the public processes described in § 447.203(c)(4) yielded no significant access to care concerns or yielded concerns that the State can reasonably respond to or mitigate, as appropriate, as documented in

the analysis provided by the State under § 447.204(b)(3). The State's response to any access concern identified through the public processes, and any mitigation approach, as appropriate, would be expected to be fully described in the State's submission to CMS.

Background/Rationale

Together, CMS believes the proposed criteria of § 447.203(c)(1)(i) through (iii), where all are met, would establish that a State's proposed Medicaid payment rates and/or payment structure are consistent with the access requirement in section 1902(a)(30)(A) of the Act at the time the State proposes a payment rate reduction or payment restructuring in circumstances when the changes could result in diminished access. Importantly, proposed § 447.203(c)(4) would ensure that States have ongoing procedures for compliance monitoring independent of any approved Medicaid payment changes.

These criteria proposed in § 447.203(c)(1) represent thresholds CMS believes would likely assure that Medicaid payment rates would continue to be sufficient following the change to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Comments

CMS is requesting comment on the proposed § 447.203(c)(1)(i) supported assurance that Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring would be at or above 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services should include a weighted average of the payment rate analysis by service volume, number of beneficiaries receiving the service, and total amount paid by Medicaid for the code in a year using State's Medicaid utilization data from the MMIS claims system rather than using a straight code-by-code analysis.

As a possible addition to the proposed streamlined access analysis criteria in proposed § 447.203(c)(1), CMS is requesting comment on whether this list of circumstances discussed in SMDL #17-004 should be included in a new paragraph under proposed § 447.203(c)(1) and, if one or more of these circumstances were applicable, the State's proposal would be considered to qualify for the streamlined analysis process under proposed § 447.203(c)(1) notwithstanding the other proposed criteria in proposed paragraph(c)(1).

3. **Tier 2 (pgs. 232-243)**

Proposed Changes

In § 447.203(c)(2), CMS proposes that, for any SPA that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, where the requirements in paragraphs (c)(1)(i) through (iii) are not met, the State would be required to also provide specified information to us as part of the SPA submission as a condition of approval, in addition to the information required under paragraph (c)(1), in a format prescribed by CMS.

Specifically, in § 447.203(c)(2)(i), CMS proposes to require States to provide a summary of the proposed payment change, including the State's reason for the proposal and a description of any policy purpose for the proposed change, including the cumulative effect of all reductions or restructurings taken throughout the current State fiscal year in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a State fiscal year. They are proposing to collect this information for SPAs that require a § 447.203(c)(2) analysis, but for those that meet the criteria proposed under § 447.203(c)(1), they are not proposing to require a summary of the proposed payment change, including the State's reason for the proposal and a description of any policy purpose for the proposed change beyond that which is already provided as part of a normal State plan submission or as may be requested by CMS through the normal State plan review process.

In § 447.203(c)(2)(ii), CMS proposes to require the State to provide Medicaid payment rates in the aggregate (including base and supplemental payments) before and after the proposed reduction or restructuring for each benefit category affected by proposed reduction or restructuring, and a comparison of each (aggregate Medicaid payment before and after the reduction or restructuring) to the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services and, as reasonably feasible, to the most recently available payment rates of other health care payers in the State or the geographic area for the same or a comparable set of covered services.

In § 447.203(c)(2)(iii), CMS proposes to require States to provide information about the number of actively participating providers of services in each benefit category affected by the proposed reduction or restructuring.

In § 447.203(c)(2)(iv), CMS proposes to require States to provide information about the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring.

In § 447.203(c)(2)(v), CMS proposes to require information about the number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring.

Finally, in § 447.203(c)(2)(vi), CMS proposes to require a summary of, and the State's response to, any access to care concerns or complaints received from beneficiaries, providers, and other interested parties regarding the service(s) for which the payment rate reduction or restructuring is proposed as required under § 447.204(a)(2).

Background/Rationale

Proposed paragraph (c)(2) would require that States conduct and provide a rigorous analysis of a proposed payment rate reduction's or payment restructuring's potential to affect beneficiary access to care. However, by limiting these analyses to only those proposed payment rate reductions and payment restructurings in circumstances when the changes could result in diminished access that do not meet the criteria in proposed paragraph (c)(1), CMS believes that the requirements proposed in paragraph (c)(2) would help to enable CMS to determine whether the proposed State Medicaid payment rates and payment methodologies are consistent with section 1902(a)(30)(A) of the Act while minimizing State and Federal administrative burden, to the extent possible.

CMS would use this State-provided information and analysis to help understand the current levels of access to care in the State's program, and determine, considering the provider, beneficiary, and other interested party input collected through proposed § 447.203(c)(4), whether the proposed payment rate reduction or payment restructuring likely would reduce access to care for the particular service(s) consistent with the statutory standard in section 1902(a)(30)(A) of the Act. If CMS approves the State's proposal, the data provided would serve as a baseline for prospective monitoring of access to care within the State.

Comments

CMS is requesting comment whether these elements should apply to both proposed § 447.203(c)(1) and (c)(2) equally.

4. **Compliance and Other Changes (pgs. 243-246)**

Proposed Changes

In § 447.203(c)(3), CMS proposes mechanisms for ensuring compliance with requirements for State analysis for rate reduction or restructuring, as specified in proposed paragraphs (c)(1) and (c)(2), as applicable. They propose that a State that submits a SPA that proposes to reduce provider payments or restructure provider payments that fails to provide the required information and analysis to support approval as specified in proposed paragraphs (c)(1) and (2), as applicable, may be subject to SPA disapproval under § 430.15(c). Additionally, States that submit relevant information, but where there are unresolved access to care concerns related to the proposed SPA, including any raised by CMS in their review of the proposal and any raised through the public process as specified in proposed paragraph (c)(4) of this section, or under § 447.204(a)(2), may be subject to SPA disapproval under § 430.15(c).

Proposed paragraph (c)(3) would further provide that if, after approval of a proposed rate reduction or restructuring, State monitoring of beneficiary access shows a decrease in Medicaid access to care, such as a decrease in the provider-to-beneficiary ratio for any affected service, or the State or CMS experiences an increase in the number of beneficiary or provider complaints or concerns about access to care that suggests possible noncompliance with the access requirements in section 1902(a)(30)(A) of the Act, they may take a compliance action.

CMS proposes to move current § 447.203(b)(7) to proposed § 447.203(c)(4). They are not proposing any changes to the public process described in current paragraph (b)(7). If the other provisions of this proposed rule are finalized, they would redesignate paragraph (b)(7) as paragraph (c)(4).

CMS proposes to move current § 447.203(b)(8) to proposed § 447.203(c)(5) to better organize § 447.203 to reflect the policies in this proposed rule. They are not proposing any changes to the methods for addressing access questions and remediation of inadequate access to care, as described in current paragraph (b)(8). If the other provisions of this proposed rule are finalized, they would redesignate paragraph (b)(8) as paragraph (c)(5).

CMS proposes to move current § 447.204(d) to proposed § 447.203(c)(6).

Background/Rationale

Disapproving a SPA means that the State would not have authority to implement the proposed rate reduction or restructuring and would be required to continue to pay providers according to the rate methodology described in the approved State plan.

D. Medicaid Provider Participation and Public Process to Inform Access to Care (Section C.4 pgs. 245-246)

Proposed Changes

In § 447.204, CMS proposes conforming changes to reflect proposed changes in § 447.203, if finalized. Specifically, CMS proposes to update the language of § 447.204(a)(1), which currently references § 447.203, to reference § 447.203(c).

CMS proposes to remove this requirement to align with their proposal to rescind the AMRP requirements in current § 447.203(b).

With the removal of § 447.204(b)(1) through (b)(3), CMS proposes to revise § 447.204(b) to read, "[t]he State must submit to us with any such proposed State plan amendment affecting payment rates documentation of the information and analysis required under § 447.203(c) of this chapter."

CMS proposes to remove and relocate § 447.204(d), as they felt the nature of that provision is better suited to codification in § 447.203(c)(6).

Background/Rationale

These conforming edits are limited to § 447.204(a)(1) and (b) and are necessary for consistency with the newly proposed changes in § 447.203(b). The remaining paragraphs of § 447.204 would be unchanged.

Because they are proposing wholesale revisions to § 447.203(b) and the addition of § 447.203(c), the proposed data and analysis referenced in the current citation to § 447.203 would be located more precisely in § 447.203(c).

Current § 447.204(b)(1) refers to the State's most recent AMRP performed under current § 447.203(b)(6) for the services at issue in the State's payment rate reduction or payment restricting SPA. The objective processes proposed under § 447.203(c)(1) and (2), which would require States to submit quantitative and qualitative information with a proposed payment rate reduction or payment restructuring SPA, would be sufficient for them to obtain the information necessary to assess the State's proposal with the same or similar information as currently is required under § 447.204(b)(2) and (3).

Comments

CMS is seeking public comment on the proposed amendments to § 447.204.