Sellers Dorsey Summary

CMS-2442 Proposed Ensuring Access to Medicaid Services

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Executive Summary

On April 27, 2023, the Centers for Medicare & Medicaid Services (CMS) released for public inspection a notice of proposed rulemaking, "Medicaid Program; Ensuring Access to Medicaid Services." The proposed rule was published in the Federal Register on May 3, 2023. The rule expands on CMS' previous rulemaking around access to care, transparency, and HCBS quality of care. Also of note, CMS simultaneously released a companion proposed rule, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," addressing topics specific to managed care delivery systems, including new requirements around medical loss ratio, state-directed payments, and rate transparency; for more information, please see Sellers Dorsey's summary of the managed care rule.

Key provisions in the proposed rule include:

Medicaid Advisory Committee and Beneficiary Advisory Group

- Re-names the Medical Care Advisory Committee (MCAC) to the Medicaid Advisory Committee (MAC) and proposes additional procedural and operational requirements including the establishment and operations of a Beneficiary Advisory Group (BAG)
- Requires the MAC membership to include at least 25% BAG members with lived experiences.
- Requires the state to establish and publish MAC and BAG bylaws, memberships, meeting schedules and minutes.
- Requires the MAC to create an annual report for the state.

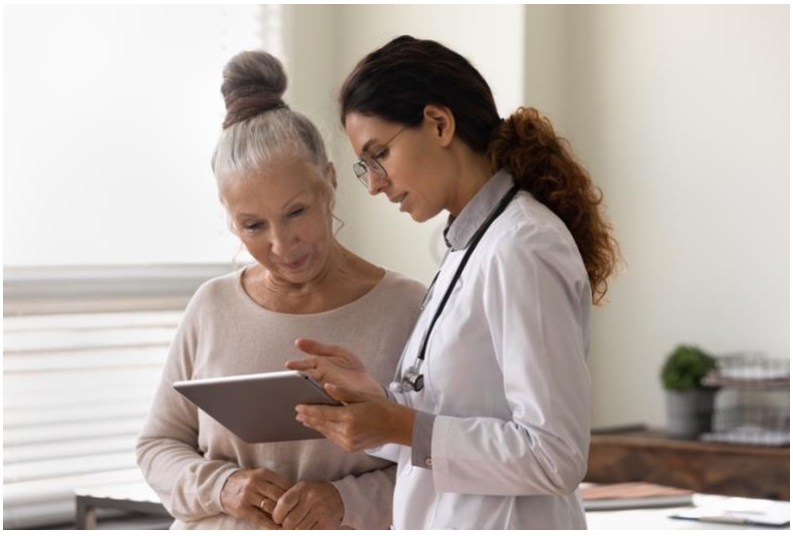
Home and Community-Based Services (HCBS)

- Requires states to annually reassess the functional need of the person-centered service plans of at least 90% of individuals continuously enrolled in the waiver for at least 365 days. Applies to both fee-for-service (FFS) and managed care delivery systems.
- Implements new grievance standards for 1915(c) waivers.
- Requires states to maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.
- Requires states to report every other year on measures in the mandatory measures of the HCBS Quality Measure Set or those identified by the Secretary and stratify specified measures, in addition to establishing performance targets. Requires use of this measure set in 1915(c) waiver programs and establishes a process for removing or adding measures.
- Requires states that limit the size of their section 1915(c) waiver program and maintain a wait list of individuals seeking to enroll to provide a description annually on how they maintain the waitlist.
- Requires states to annually report on the percent of payments for homemaker, home health aide, and personal care services that are spent on compensation for direct care workers.
- Establishes new requirements for Website Transparency to provide information on HCBS access, quality, and outcomes across states.

Documentation of Access to Care and Service Payment Rates

- Repeals and replaces CMS' existing AMRP framework.
- Requires states to publicly post their FFS fee schedule.
- Requires states to develop and publish an analysis comparing Medicaid to Medicare rates for primary care, OB/GYN services, and outpatient behavioral health services.
- Requires states to develop and publish a rate disclosure showing the average hourly payment rate for home health aide services, homemaker services, and personal care services.
- Requires states to establish an advisory committee for direct care worker payment rates.
- 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.
- Requires states to conduct a more extensive access analysis 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 three criteria are not met.
- Provides mechanisms for ensuring compliance with requirements for state analysis for rate reduction or restructuring.

CMS will accept public comment on the proposed rulemaking through July 3, 2023.



Medicaid Advisory Committee and Beneficiary Advisory Group
(§ 431.12)

Regulatory Background

Section 431.12 required States to have a MCAC to advise the State Medicaid agency about health and medical care services. This regulation was intended to ensure that State Medicaid agencies have a way to receive feedback from interested parties, however, the current regulations lack specificity related to how these committees can be used to ensure efficient administration of the Medicaid program. In this rule, CMS proposes to revise § 431.12 to require States to establish both a Medicaid Advisory Committee (MAC) and a new Beneficiary Advisory Group (BAG). These changes would be effective 60 days after the effectiveness of the final rule with a one-year compliance timeline.

Summary of New or Amended Provisions

- Amends § 431.12 to replace the current MCAC requirements with a new committee framework, States would be required to establish and operate the newly named Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG):
    - Amends § 431.12(a) to update the name of the existing MCAC to the MAC, and to add the requirement for States to establish and operate a dedicated beneficiary advisory group comprised of Medicaid beneficiaries, the BAG.
    - Amends § 431.12(b) regarding the State plan requirements, to reflect the proposed MAC and BAG and the expanded mandate proposed in this proposed rule.
    - Amends § 431.12(c) to specify that committee members of the MAC and BAG be appointed by the agency director or higher State authority on a rotating, continuous basis and serve for a specific amount of time, the length of which to be determined by each State and documented in its bylaws.
        - Requires States to make their process and bylaws for recruitment and appointment of members of the MAC and BAG public and post the list of both sets of members easily accessible on the State's website.

- Amends § 431.12(d) to account for both committee membership and composition, and to require the MAC membership to 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.

  - New § 431.12(d)(1) requires that at least 25% of the MAC must be individuals with lived Medicaid beneficiary experience from the BAG. BAG would be comprised of people who: (1) are currently or have been Medicaid beneficiaries and (2) individuals with direct experience supporting Medicaid beneficiaries (family members or caregivers of those enrolled in Medicaid).

Note on request for public comment

- CMS seeks comment on the 25% requirement.
- CMS seeks comment on the minimum percentage requirement for MAC members composition to include those who are current or past Medicaid beneficiaries or individuals with direct experience supporting Medicaid beneficiaries such as family members or those providing care to Medicaid beneficiaries.

- Replaces the language in § 431.12(e) with new requirements for States to create a dedicated BAG, that will meet separately from the MAC.

  - New § 431.12(e) (1) requires that the MAC members described in paragraph § 431.12 (d)(1) must also be members of the BAG.

  - New § 431.12 (e) (2) requires that BAG meetings occur in advance of each MAC meeting to ensure BAG member preparation for each MAC discussion.

- Amends § 431.12(f) to create 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:

  - New § 431.12(f)(1) requires State agencies to develop and post publicly on their website bylaws for the governance of the MAC and BAG, current lists of MAC and BAG memberships, and past meeting minutes for both the committee and group.

  - New § 431.12(f)(2) requires State agencies to develop and post publicly a process for MAC and BAG member recruitment and appointment, and for selection of MAC and BAG leadership.

  - New § 431.12(f)(3) requires State agencies to develop, publicly post, and implement a regular meeting schedule for the MAC and BAG.

- New § 431.12(f)(4) requires that at least two MAC meetings per year must be opened to the public. For the MAC meetings that are open to the public, the meeting agenda must include a dedicated time for public comment to be heard by the MAC. The State must also adequately notify the public of the date, location, and time of public MAC meetings at least 30 calendar days in advance. The same requirements would apply to States whose BAG meetings were determined, by its membership, to be open to the public.

Note on request for public comment
CMS seeks comment on this approach.

- New § 431.12(f)(5) requires that States offer in-person and virtual attendance options to maximize member participation at MAC and BAG meetings.

- New § 431.12(f)(6) requires that States ensure meeting times and locations for MAC and BAG meetings are selected to maximize participant attendance, which may vary by meeting.

- New § 431.12(f)(7) requires State agencies to facilitate participation of beneficiaries by ensuring that meetings are accessible to people with disabilities, that reasonable modifications are provided when necessary to ensure access and enable meaningful participation, that communication with individuals with disabilities is as effective as with others, that reasonable steps are taken to provide meaningful access to individuals with Limited English Proficiency, and that meetings comply with the requirements at § 435.905(b) and applicable regulations implementing the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Affordable Care Act at 28 CFR part 35 and 45 CFR parts 84 and 92.

- Amends § 431.12(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 and be based on state needs and matters of policy and program development.

- New § 431.12(h) expands on existing State responsibilities for managing the MAC and BAG regarding staff assistance, participation, and financial support to create meaningful beneficiary engagement and participation.

- New § 431.12(i) requires that the MAC, with support from the State and in accordance with the requirements proposed in this section, submit an annual report to the State and that the State post the published report on its website.

Effective Date

Effective 60 days after the effective date of the final rule, which would provide States with one year to implement these requirements.

Note on request for public comment: CMS seeks comment on whether one year is too much or not enough time for States to implement the updates in this regulation in an effective manner.

Home and Community-Based Services (HCBS)

Regulatory Background

In 2014, CMS released guidance for section 1915(c) waiver programs that included expectations for State reporting of State-developed performance measures to demonstrate both compliance with section 1915(c) of the Social Security Act and implementing regulations through six assurances (level of care, service plan, qualified providers, health and welfare, financial accountability, and administrative authority). CMS also issued State Medicaid Director Letter #22-003 that outlined the first official version of the HCBS Quality Measure Set.

The following proposed HCBS requirements in this rulemaking are intended to establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for section 1915(c) waiver programs. The approach focuses on priority areas that have been identified by States, oversight entities, consumer advocacy organizations, and other interested parties and include person-centered planning, health and welfare, access, beneficiary protections, and quality improvement. CMS proposes new state assurance requirements, minimum performance requirements, and new reporting requirements for section 1915(c) waiver programs that are intended to supersede and fully replace the reporting requirements and the 86% performance level threshold for performance measures described in the 2014 guidance for section 1915(c) waiver programs. Additionally, most new requirements are proposed to apply similarly to section 1915(i), (j), and (k) State plan services and managed care delivery systems under sections 1915(a), 1915(b), 1932(a), and 1115(a) to the extent they include HCBS services.

Summary of New or Amended Provisions

Person-Centered Service Plans

(§§ 42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c))

- New § 441.301(c)(3)(ii)(A) requires that States demonstrate that a reassessment of functional need was conducted at least annually for at least 90% of individuals continuously enrolled in the waiver for at least 365 days.
- New § 441.301(c)(3)(ii)(B) requires that States demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of the required reassessment of functional need at least every 12 months for at least 90% of individuals continuously enrolled in the waiver for at least 365 days.
- Amends § 441.301(c)(3) to specify that a State must ensure that the person-centered service plan is reviewed at least every 12 months, when the individual's circumstances or needs change, or at the request of the individuals.
    - To ensure consistency in the administration of policies and procedures across HCBS programs, CMS proposes to apply the requirements at §441.302(c)(3) to 1915(i), (j), and (k) State plan services via cross-reference.
    - To ensure consistency in person-centered service plan requirements between FFS and managed care delivery systems, CMS proposes to add the requirements at § 441.301(c)(3) to 42 CFR 438.208(c).

Note on request for public comment

CMS seeks public comment on whether they should establish similar person-centered planning and service plan requirements for section 1905 (a) State plan personal care, home health, and case management services.

Grievance System

(§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii))

- New § 441.301(c)(7) requires that States establish grievance procedures for Medicaid beneficiaries receiving section 1915(c) waiver program services through an FFS delivery system.
    - States must establish a procedure under which a beneficiary can file a grievance related to the State's or a provider's compliance with the person-centered planning and service plan requirements at §§ 441.301(c)(1) through (3) and the HCBS settings requirements at §§ 441.301(c)(4) through (6).

- New § 441.301(c)(7)(iii)(A) through (C) provide general requirements for States' grievance procedures:
    - New § 441.301(c)(7)(iii)(A) requires that a beneficiary or authorized representative be permitted to file a grievance. Under the proposal, another individual or entity may file a grievance on a beneficiary's behalf, so long as the beneficiary or authorized representative provides written consent. All references to beneficiary in the regulatory text of this section include the beneficiary's representative, if applicable.
- New § 441.301(c)(7)(iii)(B)(1) through (7) require States to:
    - Have written policies and procedures for their grievance processes that at a minimum meet the requirements of this proposed section and serve as the basis for the State's grievance process;
    - Provide beneficiaries with reasonable assistance in completing the forms and procedural steps related to grievances and to ensure that the grievance system is consistent with the availability and accessibility requirements at § 435.905(b);
    - Ensure that punitive action is not threatened or taken against an individual filing a grievance;
    - Accept grievances, requests for expedited resolution of grievances, and requests for extensions of timeframes from beneficiaries;
    - Provide beneficiaries with notices and other information related to the grievance system, including information on their rights under the grievance system and on how to file a grievance, and ensure that such information is accessible for individuals with disabilities and individuals who are limited English proficient in accordance with § 435.905(b);
    - Review grievance resolutions with which beneficiaries are dissatisfied; and
    - Provide information on the grievance system to providers and subcontractors approved to deliver services under section 1915 (c) of the Act.
- New § 441.301©(7)(iii)(c)(1) through (5) require that the processes for handling grievances must:
    - Allow beneficiaries to file a grievance either orally or in writing;
    - Acknowledge receipt of each grievance;
    - Ensure that decisions on grievances are not made by anyone previously involved in the review or decision-making related to the problem or issue for which the beneficiary has filed a grievance or a subordinate of such an individual, are made by individuals with appropriate expertise, and are made by individuals who consider all the information submitted by the beneficiary related to the grievance;

- Provide beneficiaries with a reasonable opportunity, face-to-face (including through the use of audio or video technology) and in writing, to present evidence and testimony and make legal and factual arguments related to their grievance;

- Provide beneficiaries, free of charge and in advance of resolution timeframes, with their own case files and any new or additional evidence used or generated by the State related to the grievance; and

- Provide beneficiaries, free of charge, with language services, including written translation and interpreter services in accordance with § 435.905(b), to support their participation in grievance processes and their use of the grievance system.

- New § 441.301(c)(7)(iv)(A) requires that the beneficiary be able to file a grievance at any time.

  - New § 441.301(c)(7)(iv)(B) requires that beneficiaries be permitted to request expedited resolution of a grievance, whenever there is a substantial risk that resolution within standard timeframes will adversely affect the beneficiary's health, safety, or welfare.

  - New § 441.301(c)(7)(v) provides resolution and notification requirements for grievances.

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

  - New § 441.301(c)(7)(v)(B)(1) requires that standard resolution of a grievance and notice to affected parties must occur within 90 calendar days of receipt of the grievance.

  - New § 441.301(c)(7)(v)(B)(2) requires that expedited resolution of a grievance and notice must occur within 14 calendar days of receipt of the grievance.

  - New § 441.301(c)(7)(v)(C) permits States to extend the timeframes for the standard resolution and expedited resolution of grievances by up to 14 calendar days if the beneficiary requests the extension, or the State documents that there is need for additional information and how the delay is in the beneficiary's interest.

  - New § 441.301(c)(7)(v)(D) requires that States make reasonable efforts to give the beneficiary prompt oral notice of the delay, give the beneficiary written notice within two calendar days of determining a need for a delay but no later than the timeframes in paragraph (c)(7)(v)(B) of the reason for the decision to extend the timeframe, and resolve the grievance as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires if the State extends the timeframe for a standard resolution or an expedited resolution.

Note on request for public comment

Current grievance system requirements for Medicaid managed care plans at part 438, subpart F do not include specific requirements for an expedited resolution of a grievance. CMS invites comment on whether part 438, subpart F should be amended to include the proposed requirements at § 441.301(c)(7)(iv)(B) and at § 441.301(c)(7)(v)(B)(2).

- New § 441.301(c)(7)(vi) describes proposed requirements related to the notice of resolution for beneficiaries.
  - New § 441.301(c)(7)(vi)(A) requires that States establish a method for written notice to beneficiaries and that the method meet the availability and accessibility requirements at § 435.905(b).
  - New § 441.301(c)(7)(vi)(B) requires that States make reasonable efforts to provide oral notice of resolution for expedited resolutions.
- New § 441.301(c)(7)(vii) lists proposed recordkeeping requirements related to grievances.
  - New § 441.301(c)(7)(vii)(A) requires that States maintain records of grievances and review the information as part of their ongoing monitoring procedures.
  - New § 441.301(c)(7)(vii)(B)(1) through (6), require that the record of each grievance must contain the following information at a minimum: a general description of the reason for the grievance, the date received, the date of each review or review meeting (if applicable), resolution and date of the resolution of the grievance (if applicable), and the name of the beneficiary for whom the grievance was filed.
  - New § 441.301(c)(7)(vii)(C) requires that grievance records be accurately maintained and in a manner that would be available upon CMS request.
- To ensure consistency in the administration of policies and procedures across HCBS programs, CMS proposes to apply the requirements at §441.302(c)(7) to 1915(i), (j), and (k) State plan services via cross-reference.

Note on request for public comment

CMS requests comment on whether they should establish grievance requirements for section 1905(a) State plan personal care, home health, and case management services.

Incident Management System

(§§ 441.302(a)(6), 441.464I, 441.570I, and 441.745(a)(1)(v))

- New § 441.302(a)(6) requires 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.

- New § 441.302(a)(6)(i)(A) through (G) establish requirements for States' incident management systems:

  - New § 441.302(a)(6)(i)(A) establishes 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.

- Note on request for public comment: CMS requests comment on whether there are specific types of events or instances of serious harm to section 1915I waiver participants, such as identity theft or fraud, that would not be captured by the proposed definition and that should be included, and whether the inclusion of any specific types of events or instances of harm in the proposed definition would lead to the overidentification of critical incidents.

  - New § 441.302(a)(6)(i)(B) requires 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.

Note on request for public comment

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.

  - New § 441.302(a)(6)(i)(C) requires States to require providers to report to States any critical incidents that occur during the delivery of section 1915(c) waiver program services as specified in a waiver participant's person-centered service plan, or any critical incidents that are a result of the failure to deliver authorized services.

  - New § 441.302(a)(6)(i)(D) requires that States use claims data, Medicaid Fraud Control Unit data, and data from other State agencies such as Adult Protective Services or Child Protective Services to the extent permissible under applicable State law to identify critical incidents that are unreported by providers and occur during the delivery of section 1915(c) waiver program services, or as a result of the failure to deliver authorized services.

- New § 441.302(a)(6)(i)(E) requires that States share information, consistent with the regulations in 42 CFR part 431, subpart F, on the status and resolution of investigations.

- New § 441.302(a)(6)(i)(F) requires States to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within State-specified timeframes.

- New § 441.302(a)(6)(i)(G) requires that States meet the reporting requirements at § 441.311(b)(1) related to the performance of their incident management systems.

- New § 441.302(a)(6)(ii)(A) through (C) require that States demonstrate that an investigation was initiated, within State-specified timeframes, for no less than 90% of critical incidents; an investigation was completed and the resolution of the investigation was determined, within State-specified timeframes, for no less than 90% of critical incidents; and corrective action was completed, within State-specified timeframes, for no less than 90% of critical incidents that require corrective action.

- To ensure consistency in the administration of policies and procedures across HCBS programs, CMS proposes to apply the requirements at §441.302(a)(6) to 1915(i), (j), and (k) State plan services via cross-reference. Additionally, CMS proposes to apply these requirements to services delivered under FFS and managed care delivery systems.

Reporting

(§ 441.302(h))

- Amends § 441.302(h) to consolidate reporting expectations in one new section at proposed § 441.311, described in the Reporting Requirements section below. This reporting will supersede existing reporting for section 1915(c) waivers and standardize reporting across section 1915 HCBS authorities.

HCBS Payment Adequacy

(§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

- New § 441.302(k)(3)(i) requires that at least 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to homemaker services, home health aide services, and personal care services, be spent on compensation to direct care workers.

Note on request for minimum public comment

CMS is requesting comment on the following options for the percentage of payments that must be spent on compensation to direct care workers for these services: (1) 75%; (2) 85%; and (3) 90%.

- For other HCBS services at §440.180(b), CMS is requesting comment on whether a required percent of payments going to the direct care workforce should apply and if so, on the following options for the minimum percentage of payments that must be spent on compensation to direct care workers: (1) 65%; (2) 70%; (3) 75%; and (4) 80%.

- New § 441.302(k)(1)(i) defines 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), as well as the employer shared of the payroll taxes for direct care workers delivering services under section 1915(c) waivers.

- New § 441.302(k)(1)(ii) defines direct care workers to include workers who provide nursing services, assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), and provide behavioral supports, employment supports, or other services to promote community integration. Direct care workers include individuals employed/contracted by a Medicaid provider, State agency, or third party or delivering services under self-directed delivery models. Specifically, direct care workers include:

  - Nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists) who provide nursing services to Medicaid-eligible individuals receiving HCBS,

  - Licensed or certified nursing assistants,

  - Direct support professionals,

  - Personal care attendants,

  - Home health aides, and

  - Other individuals who are paid to directly provide services to Medicaid beneficiaries receiving HCBS to address ADLs, IADLs, behavioral supports, employment supports, or other services to promote community integration.

- New § 441.302(k)(2) requires that States demonstrate that they meet the minimum performance level at § 441.302(k)(3)(i) through new Federal reporting requirements at § 441.311(e).

- New § 441.302(k)(4) applies these requirements to services delivered under FFS or managed care delivery systems.

- Cross reference at §§ 441.464(f), 441.570(f), and 441.745(a)(1)(vi) to apply these requirements to section 1915(j), (k), and (i) State plan services.

  - ***Note on request for public comment*** CMS is requesting comment on whether these requirements should apply to section 1905(a) State plan personal care and home health services.

Supporting Documentation Required

(§ 441.303(f)(6))

- Amends § 441.303(f)(6) to require States to meet the reporting requirements at § 441.311(d)(1), specifically requiring information from States on waiting lists and processes related to HCBS waiting lists to ensure that CMS can adequately oversee and monitor States' use of waiting lists in their section 1915(c) waiver programs.

Reporting Requirements

(§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

A. Compliance Reporting

1. Incident Management System Assessment

- New § 441.302(a)(6) establishes new requirements for states' incident management systems:
- New § 441.311(b)(1)(i) requires states to report every 24 months the results of an incident management system assessment to demonstrate they meet requirements at § 441.302(a)(6).
- New § 441.311(b)(1)(ii) permits CMS to reduce the frequency of required reporting to once every 60 months.
- ***Note on request for public comment*** CMS requests comments on the timeframes for reporting across incident management systems and results.

2. Critical Incidents

- New § 441.311(b)(2) requires states report annually on the:
  - Number and percent of critical incidents for which an investigation was initiated within State-specified timeframes,
  - Number and percent of critical incidents that are investigated and for which the state determines the resolution within state-specified timeframes; and
  - Number and percent of critical incidents requiring corrective action, as determined by the State, for which the required corrective action has been completed within State-specified timeframes.
- ***Note on request for public comment*** CMS requests comments on the frequency to report on critical incidents, and the rationale for an alternative timeframe if recommended.

3. Person-Centered Planning

- New § 441.311(b)(3)(i) requires states to report on the percent of beneficiaries continuously enrolled for at least 365 days for whom a reassessment of functional need was completed within the past 12 months.

- New § 441.311(b)(3)(ii) requires states to report on the percent of beneficiaries continuously enrolled for at least 365 days who had a service plan updated as a result of a reassessment of functional need within the past 12 months.

- For both reporting requirements related to person-centered planning, CMS will allow states to report these metrics for a statistically valid random sample of beneficiaries.

- Note on request for public comment: CMS welcomes comment on whether there are other specific compliance metrics related to person-centered planning that states should be required to report on and the timeframe for reporting, and the rationale for an alternative timeframe if recommended.

4. Type, Amount, and Cost of Services

- New § 441.311(b)(4) contains language previously at § 441.302(h)(1), requiring state reporting of the type, amount and cost of services provided.

B. Reporting on Home and Community-Based Services (HCBS) Quality Measure Set

- New § 441.311I(1)(i) requires states to report every other year on measures identified in the HCBS Quality Measure Set as mandatory measures for states to report or are identified as measures for which the Secretary will report on behalf of states, according to the form and scheduled prescribed by the Secretary.

- New § 441.311(c)(1)(ii) allows states to report on measures in the HCBS Quality Measure Set that are not identified as mandatory.

- New § 441.311(c)(1)(iii) requires states to establish performance targets (subject to CMS review and approval) for each of the measures in the HCBS Quality Measure Set identified as mandatory or measures CMS will report on behalf of states, in addition to describing the quality improvement strategies that will be undertaken to achieve the established performance targets.

  Note on request for public comment CMS invites comment on if there should be a threshold of compliance that would permit states be exempt from developing improvement strategies and, if so, what that threshold should be.

- New § 441.311(c)(1)(iv) allows states to establish performance targets for non-mandatory measures in the HCBS Quality Measure Set or measures the Secretary will report on behalf of states as well as to describe the quality improvement strategies that they will pursue to achieve the performance targets for those targets.

- New § 441.311(c)(2) obligates CMS to report, on behalf of states, on a subset of measures in the HCBS Quality Measure Set that are identified as measures for which they will report on behalf of states.

- New § 441.311 (c)(3) permits states, without requiring, to report on measures that are not yet required but will be, and on populations for whom reporting is not yet required but will be phased-in in the future.

- Note on request for public comment: CMS seeks input on if the timeframe for state reporting on the measures in the HCBS Quality Measures is sufficient, if reporting should be required more or less frequently, and the rationale for an alternative timeframe if recommended.

C. Access Reporting

- New § 441.311(d)(1)(i) requires states provide a description annually on how they maintain the list of individuals who are waiting to enroll in a section 1915© waiver program, if they have a limit on the size of the waiver program and maintain a list of individuals who are waiting to enroll in the waiver program, as described in § 441.303(f)(6). Additionally, the information must include, but not be limited to, information on whether the state screens individuals on the waiting list for eligibility in the waiver program, whether the state periodically re-screens individuals on the list, and the frequency of any re-screening.

- New § 441.311(d)(1)(ii) requires states annually report the number of people on the waiting list, if applicable.

- New § 441.311(d)(1)(iii) requires states annually report 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.

  Note on request for public comment CMS invites comment on whether there are other specific metrics or reporting requirements related to waiting lists that states should be required to report on additions or replacement for what is proposed. CMS also welcomes comment on if the timeframe for state reporting on their waiting lists is sufficient, if reporting should be required more or less frequently, and the rationale for an alternative timeframe if recommended.

- New § 441.311(d)(2)(i) requires states report annually on the average amount of time from when homemaker services, home health aide services, or personal care services, as listed in § 440.180(b)(2) through (4), are initially approved to when services began,

for individuals newly approved to begin receiving services within the past 12 months. CMS proposes to allow states to use a statistically valid random sample of beneficiaries.

> ***Note on request for public comment*** CMS seeks comment on whether this requirement should be applied to additional services. CMS also seeks comment on whether reporting should be required more or less frequently, and the rationale for an alternative timeframe if recommended. Additionally, CMS invites comment on other specific metrics related to the amount of time it takes for eligible individuals to receive these services, as additions or replacements for what is proposed.

- New § 441.311(d)(2)(ii), requires states to report annually on the percent of authorized hours for homemaker services, home health aide services, or personal care services, as listed in § 440.180(b)(2) through (4), that are provided within the past 12 months. CMS proposes to allow states to use a statistically valid random sample of beneficiaries.

  > ***Note on request for public comment*** CMS requests comment on whether this requirement should be applied to additional services. CMS also seeks comment on whether reporting should be required more or less frequently, and the rationale for an alternative timeframe if recommended. Additionally, CMS invites comment on other specific metrics related to the individuals' use of authorized services that should be reported, as additions or replacement for what is proposed.

D. Payment Adequacy

- New § 441.311(e) requires states annually report on the percent of payments for homemaker, home health aide, and personal care services (found at § 440.180(b) (2) through (4)) that are spent on compensation for direct care workers. Separate reporting would be required for each service subject to the reporting requirement, and, within each service, separately on payments for services that are self-directed.

  Note on request for public comment CMS requests comment on whether states should be allowed to provide an assurance or attestation, subject to audit, that they meet the requirement in place of reporting on the percent of payments, and whether the frequency for reporting should be reduced to every other year. Further requests for comment include whether states should be required to report on the percentage of payments for certain HCBS that are spent on compensation for direct care workers at the delivery system, HCBS waiver program, or population level. Relatedly, whether states should be required to report on median hourly wage and on compensation by category. Finally, CMS requests comment on whether the percent of payments going to the direct care workforce should apply to other services listed at §440.180(b).

  Note on request for public comment CMS also welcomes comment on whether reports to CMS should provide states the option to exclude payments to providers of agency-directed services that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, based on Medicaid revenues for the service, number of direct care workers serving Medicaid beneficiaries,

or the number of Medicaid beneficiaries receiving the service. Relatedly, on whether a specific limit on the exclusion should be established, and what that should be (i.e., the lowest percentile in terms of Medicaid revenue for the service, number of beneficiaries services, or number of direct care workers serving Medicaid enrollees). Lastly, CMS requests comments on whether states should be permitted to exclude payments for self-directed services from these reporting requirements.

5. Effective Date

- New § 441.311(f) applies all the reporting requirements described in § 441.311 to services delivered under FFS and managed care delivery systems.

- Applies requirements at § 441.311 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.

  Note on request for public comment CMS seeks input on the application of these provisions across section 1915(i), (j), and (k) authorities.

- Note on request for public comment: CMS welcomes input on whether we should establish similar reporting requirements for section 1905(a) "medical assistance" State plan personal care, home health, and case management services.

Home and Community-Based Services (HCBS) Quality Measure Set

(§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)

- New § 441.312 establishes requirements to use the Home and Community-Based Services Quality Measure Set in 1915(c) waiver programs and promote public transparency related to the administration of Medicaid-covered HCBS.

- New § 441.312(b)(1) defines "Attribution rules" as 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.

- New § 441.312(b)(2) defines "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 public input and comments, including through the Federal Register.

- New § 441.312(c)(1) obligates the Secretary to identify and update the measure set at least every other year, through a process that allows for public input and comment.

- New § 441.312(c)(2) requires the Secretary to solicit comment at least every other year with States and other interested parties to establish priorities, identify measures to remove or add, and ensure measures are meaningful and feasible for reporting.

- New § 441.312(c)(3) obligates the Secretary to, in consultation with States and other interested parties, develop and update the measures in the HCBS Quality Measure Set, at least every other year, through a process that allows for public input and comment.

- ***Request for public comment*** CMS seeks input on if the timeframe for measure updates and the process for developing and updating the HCBS Quality Measure Set is sufficient, whether these activities should occur more or less frequently, and the rationale for an alternative timeframe, if recommended.

- New § 441.312(d) defines the process for developing and updating the HCBS Quality Measure Set:
    - Identify all measures in the HCBS Quality Measure Set, including new, removed, mandatory, those reported on the behalf of states, measures that states can elect to have the Secretary report on their measure, and measures that the Secretary will allot additional time to report and the amount of additional time.
    - Inform states how to collect and calculate data.
    - Provide a standardized format and reporting schedule.
    - Provide procedures that states must follow in reporting the data.
    - Identify specific populations the states must report the measures.
    - Identify the subset of measures that must be stratified.
    - Describe how to establish state performance targets for each measure.

Note on forthcoming guidance
CMS intends to issue technical information on attribution rules.

Request for public comment CMS welcomes comments on considerations to address in the attribution rules or other topics to address in the technical information.

- New § 441.312(e) requires the Secretary to 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.
- New § 441.312(f) requires the Secretary to consider whether stratified sampling of mandatory measures can be accomplished based on valid statistical methods, without risking a violation of beneficiary privacy, and, for measures obtained from surveys, whether the original survey instrument collects the variables or factors necessary to stratify the measures.
- New § 441.312(f) describes the phased-in approach for reporting stratified HCBS Quality Measure Set data, such that states are required to provide stratified data for 25% of the measures in the HCBS Quality Measure Set for which the Secretary specifies.
- ***Request for public comment*** CMS invites comment on the proposed schedule for phasing in reporting of HCBS Quality Measure Set data, in addition to whether a phase-in reporting approach should be used for all of the measures in the HCBS Quality Measure Set.
- New § 441.312(g) lists the interested parties whom the Secretary must consult to specify and update the quality measures established in the HCBS Quality Measure Set.

- Modifies regulations for § 1915(j), (k), and (i) State plan services to apply the requirements at § 441.312 by cross-referencing at §§ 441.474(c), 441.585(d), and 441.745(b)(1)(v), respectively.

- ***Request for public comment*** CMS seeks input on the application of these provisions to § 1915(j), (k), and (i).

Website Transparency

(§§ 441.313, 441.486, 441.595, and 441.750)

- New § 441.313(a) requires states to operate a website that meets the availability and accessibility requirements at § 435.905(b) and 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).

- Request for public comment: CMS seeks input 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.

- New § 441.313(a)(1) requires the data and information states 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.

- ***Request for public comment*** CMS invites comment on whether States should be permitted to link to web pages of these managed care entities and whether there should be limits on the number of separate web pages that a state could link to, in place of directly reporting the information on its own web page.

- New § 441.313(a)(2) requires the web page to include clear and easy-to-understand labels on documents and links.

- ***Request for public comment*** CMS requests comment on whether these requirements are sufficient to ensure the accessibility of the information for people receiving HCBS and other HCBS interested parties and for specific requirements to ensure the accessibility of the information.

- New § 441.313(a)(3) requires that states verify the accurate function of the website and the timeliness of the information and links at least quarterly.

- ***Request for public comment*** CMS requests comment on whether this timeframe is sufficient or if a shorter or longer timeframe should be required.

- New § 441.313(a)(4) requires states to 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.

- New § 441.313(b) requires CMS to report on their website the information reported by states (noted under § 441.311).

- Modifies regulations for § 1915(j), (k), and (i) State plan services to apply the requirements at § 441.313 by cross-referencing at §§ 441.486, 441.595, and 441.750, respectively.

Applicability of Proposed Requirements to Managed Care Delivery Systems

- Applies requirements at §§ 441.301(c)(3), 441.302(a)(6), 441.302(k), 441.311, and 441.313 to both FFS and managed care delivery systems.

- New cross-reference to the requirements in proposed § 438.72 to explicitly require states that include HCBS in their MCO, PIHP, or PAHP contracts to comply with the requirements at §§ of states implementing managed care LTSS programs clear, consistent, and easy to locate. No changes will be made to the regulatory language at § 441.301(c)(1) or (2) or to § 438.208(c)(3)(ii) through this rule, but requirements in § 441.301(c)(1) or (2) continue to apply when states include HCBS in their MCO, PIHP, or PAHP contracts.

Effective Date

- Person-Centered Service Plans:

  - For FFS systems: effective three years after the effective date of the final rule.

  - For managed care delivery systems: the first managed care plan contract rating period that begins on or after three years after the effective date of the final rule.

  - ***Note on request for public comment*** CMS seeks public comment on whether this timeframe is sufficient, whether they should require a shorter timeframe (two years) or longer timeframe (four years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

- Grievance System: Effective two years after the effective date of the final rule.

Request for public comment CMS welcomes comments on considerations to address in the attribution rules or other topics to address in the technical information.

- Incident Management System:

  - For FFS systems: three years to implement these requirements following effective date of the final rule.

- For managed care delivery systems: the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule.

- ***Note on request for public comment CMS*** seeks public comment on whether this timeframe is sufficient, whether they should require a shorter timeframe (two years) or longer timeframe (4 years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

- HCBS Payment Adequacy

  - For FFS systems: four years to implement these requirements following effective date of the final rule.

  - For managed care delivery systems: the first managed care plan contract rating period that begins on or after four years after the effective date of the final rule.

Note on request for public comment CMS seeks public comment on whether this timeframe is sufficient, whether they should require a shorter timeframe (such as three years) or longer timeframe (such as five years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

- Reporting on Home and Community-Based Services (HCBS) Quality Measure Set

  - For FFS systems: three years following effective date of the final rule to implement the compliance reporting requirements at § 441.311(b), the HCBS Quality Measure Set reporting requirements at § 441.311(c), and the access reporting requirements at § 441.311(d).

  - For managed care delivery systems: the first managed care plan contract rating period that begins on or after three years after the effective date of the final rule to implement the compliance reporting requirements at § 441.311(b), the HCBS Quality Measure Set reporting requirements at § 441.311(c), and the access reporting requirements at § 441.311(d).

  - For FFS systems: four years following effective date of the final rule to implement the payment adequacy reporting requirements at § 441.311(e).

  - For managed care delivery systems: the first managed care plan contract rating period that begins on or after three years after the effective date of the final rule to implement the payment adequacy reporting requirements at § 441.311(e).

- States may implement some of these requirements in advance of any effective date. Should the rule be finalized, CMS will work with states to phase previous guidance (in 2014) as the new requirements are implemented.

- HCBS Quality Measure Set
  - The phased-in approach to reporting stratified measures as described in § 441.312(f) requires measures be stratified by three years after the effective date of these regulations, 50% of such measures by five years after the effective date of these regulations, and 100% of measures by seven years after the effective date of these regulations.

- Website Transparency
  - For FFS systems: three years following effective date of the final rule to implement the website transparency requirements.
  - For managed care delivery systems: the first managed care plan contract rating period that begins on or after three years after the effective date of the final rule to implement the website transparency requirements.

Documentation of Access to Care and Service Payment Rates

(§ 447.203)

Regulatory Background

In 2015, CMS finalized regulations to establish access monitoring review plans (AMRPs), a new process whereby states were required to analyze data related to the availability of certain Medicaid services. States were required to conduct this analysis every three years, in consultation with the Medical Care Advisory Committee, and submit the plan to CMS. States submitted the first round of AMRPs on October 1, 2016. Recognizing the administrative burden of the current AMRP requirements, CMS proposes to repeal and replace the regulations and to update the procedures states must follow when taking certain rate reduction actions.

Summary of New or Amended Provisions

Fully Fee-For-Service States

Note on request for public comment CMS seeks public comment on whether additional access standards, such as those described in the proposed managed care rule, might be appropriate for states operating a fully FFS delivery system.

FFS Payment Rate Transparency

(§ 447.203(b))

- CMS proposes to rescind and replace § 447.203(b).

- New § 447.203(b)(1) requires states to publish all FFS payment rates on a public website. States must make the fee schedule easy to locate and ensure members of the public can easily identify the amount Medicaid would pay for a service. In the event rates vary by provider type, geography, or other category, the state must separately identify rates by category. States must publish their fee schedule no later than January 1, 2026, must identify the date rates were last updated, and must update the published fee schedule no later than one month following CMS' approval of revised rates or rate methodologies, or one month following the adoption of a new rate if CMS approval is not needed.

- New § 447.203(b)(2) requires states to develop and publish an analysis comparing payment rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health services. States must also publish a payment rate disclosure for personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency. The analysis must identify variations by category, such as geography, population, or provider type.

  - ***Note on request for public comment*** CMS seeks public comment on whether the analysis should include other types of payment adjustments or factors that are included in rate development, such as adjustments based on the Consumer Price Index, Medicare Economic Index, or State-determined inflationary factors or budget neutrality factors. CMS also seeks public comment on whether the services it has identified are the best ones to include, including whether it was appropriate for CMS to exclude inpatient behavioral health.

- New § 447.203(b)(3) establishes requirements for the comparative analysis and payment rate disclosure.

  - New § 447.203(b)(3)(i) requires states to compare Medicaid FFS payment rates for the evaluation and management (E/M) codes applicable to primary care services, obstetrical and gynecological services, and outpatient behavioral health services to the Medicare payment rates for the same services effective during the same time period. States must conduct this analysis at the CPT/HCPCS level. The analysis must:

        - Be organized by category of service.
        - Identify the base Medicaid payment rates for each code, including any variation by category.
        - Identify the Medicare base payment rates for each code that corresponds to each Medicaid code, including any variation by category.
        - Express each Medicaid payment rate for each code as a percentage of each Medicare code.
        - Specify the number of Medicaid-paid claims and number of beneficiaries who received the service during a calendar year during which each payment rate is effective.
        - ***Note on request for public comment*** CMS seeks public comment on the contents of the analysis and any challenges states anticipate in completing it. CMS also seeks public comment on whether Medicare is the optimal benchmark for comparison. CMS also seeks public comment regarding its decision not to propose requiring states that do not pay varying Medicaid rates by geographical location weight the statewide average of the Medicare non-facility payment rates by the distribution of Medicare beneficiaries in the State. CMS seeks comment on its approach to identifying the number of paid claims and beneficiaries for each service, including its decisions to not specify unique beneficiaries in the analysis and to not identify the total number of beneficiaries eligible for each service.
    - New § 447.203(b)(3)(ii) requires states to publish a payment rate disclosure for personal care, home health aide, and homemaker services identifying the average hourly rate and identifying any variation between the rate for services provided by individual providers and providers employed by an agency. The disclosure must:
        - Be organized by category of service.
        - Identify the average hourly rate by category of service, including any variation by provider type, geography, or other category.
        - Specify the number of Medicaid-paid claims and number of beneficiaries who received the service during a calendar year during which each average hourly rate is effective.
        - ***Note on request for public comment*** CMS requests public comment on its approach to separate breakdowns for home health aide, personal care, and homemaker services. CMS seeks comment on its approach to identifying the number of paid claims and beneficiaries for each service.
- New § 447.203(b)(4) requires states to publish their initial comparative analysis and payment rate disclosure no later than January 1, 2026, to be based on the rates in effect on January 1, 2025. States must then publish an updated analysis and disclosure every two years thereafter and must post the analysis and disclosure to their public website.

- ***Note on request for public comment*** CMS requests public comment on its proposed location for posting the analysis and disclosure.

- New § 447.203(b)(5) specifies that CMS may reduce FFP to states failing to comply with payment rate transparency, comparative analysis, and rate disclosure requirements.

- New § 447.203(b)(6) requires states to establish an advisory committee related to provider rates where payments are made to direct care workers. The committee must include direct care workers, beneficiaries, beneficiaries' authorized representatives, and other parties as determined by the state. The committee must meet at least every two years to consider whether direct care worker rates are adequate to ensure access to care and make recommendations to the Medicaid agency about direct care worker rates. The state Medicaid agency must publish the committee's recommendations.

  - ***Note on request for public comment:*** CMS requests public comment on the makeup of the committee and whether its scope should include additional services.

State Analysis Procedures for Rate Reduction or Restructuring

(§ 447.203(c))

- New § 447.203(c) establishes analyses that states would be required to perform, document, and submit concurrently with the submission of rate reduction and rate restructuring SPAs, with additional analyses required in certain circumstances due to potentially increased access to care concerns. It also establishes two-tiered approach for determining the level of access analysis States would be required to implement when proposing provider payment rate reductions or payment restructurings.

  - New § 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. If all three of the below conditions are met, states would not be required to submit a more detailed analysis -outlined further below- establishing that the proposal meets the access requirement in section 1902(a)(30)(A) of the Act.

    - New § 447.203(c)(1)(i) requires states 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% of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services.

    - New § 447.203(c)(1)(ii), requires states 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% reduction in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a single state fiscal year.

        - New § 447.203(c)(1)(iii) requires states 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).

    - New § 447.203(c)(2) requires states to conduct a more extensive access analysis 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 send specified information to CMS as part of the SPA submission as a condition of approval, in addition to the information required under paragraph (c)(1).

        - New § 447.203(c)(2)(i) requires 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.

- New § 447.203(c)(2)(ii) requires states 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 the proposed reduction or restructuring, 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 a comparison to the most recently available payment rates of other health care payers in the state or the geographic area.

- New § 447.203(c)(2)(iii) requires states to provide information about the number of actively participating providers of services in each benefit category affected by the proposed reduction or restructuring.

- New § 447.203(c)(2)(iv) requires 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.

- New § 447.203(c)(2)(v) requires states to provide information about the number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring.

- New § 447.203(c)(2)(vi) requires states to submit 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).

- New § 447.203(c)(3) offers 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.

- Redesignates current § 447.203(b)(7) to proposed § 447.203(c)(4). CMS is not making any changes to the public process described in current paragraph (b)(7).

- Redesignates § 447.203(b)(8) to proposed § 447.203(c)(5) to better organize § 447.203 to reflect the policies in this proposed rule. CMS is not making any changes to the methods for addressing access questions and remediation of inadequate access to care, as described in current paragraph (b)(8).

- Redesignates current § 447.204(d) to proposed § 447.203(c)(6). CMS is not making any changes to defining the remedy for the identification of an unresolved access deficiency, as described in current § 447.204(d).

- ***Note on request for public comment*** CMS requests comment on proposed procedures and requirements for state analysis for payment rate reduction or payment restructuring SPAs, including the qualification criteria for streamlined analysis, the proposed additional analysis elements for those proposed payment rate reductions or payment restructurings that do not meet the criteria, the proposed methods for ensuring compliance, the proposed mechanisms for ongoing beneficiary and provider input, the proposed methods to address access questions and remediation of inadequate access to care, and the proposed compliance actions for access deficiencies.

Medicaid Provider Participation and Public Process to Inform Access to Care

(§ 447.204)

Note on request for public comment

CMS seeks public comment on proposed conforming changes to § 447.204 to reflect proposed changes in § 447.203 if codified.

Proposed changes in this section are limited to § 447.204(a)(1) and (b) and are essential for consistency with the newly proposed changes in § 447.203(b). The additional paragraphs of § 447.204 would remain unchanged.

- Amends language in § 447.204(a)(1), which currently references § 447.203, to instead reference § 447.203(c).

- Amends language in § 447.204(b)(1), which 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; CMS proposes to remove this requirement to align with CMS' proposal to rescind the AMRP requirements in current § 447.203(b).

- Removes § 447.204(b)(2) and (3) because these current requirements are addressed in proposed § 447.203(c)(1) and (2). The objective processes proposed under § 447.203(c)(1) and (2) would be sufficient for CMS to obtain the information necessary to assess the state's proposal.

- Amends § 447.204(b) to read as follows, "[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."

- Removes and relocates § 447.204(d) since the nature of this provision is better suited to codification in § 447.203(c)(6).

Effective Date

States must publish their FFS fee schedules under § 447.203(b)(1) no later than January 1, 2026.

States must publish the comparative payment rate analysis and payment rate disclosure under § 447.203(b)(2)- § 447.203(b)(4) no later than January 1, 2026.