Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442-P)
Summary of Proposed Rule

On May 3, 2023, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (FR) a proposed rule entitled "Medicaid Program; Ensuring Access to Medicaid Services" (88 FR 27960-28089). The rule proposes policies that take a comprehensive approach to improving access to care, quality and health outcomes, and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS) programs. The stated goals of these policies are to increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs, which are all designed to improve access to care. **The public comment period will end on July 3, 2023.**

I. Background

CMS notes that as of December 2022, more than 85 million individuals were enrolled in Medicaid. In 2020, 70 percent of Medicaid beneficiaries were enrolled in comprehensive managed care plans while the remainder received care through FFS. CMS describes its approach to promoting consistent access to health care for all Medicaid beneficiaries across all types of health care delivery systems. Specifically, it views the continuum of health care access across three dimensions of a person-centered framework: (1) enrollment in coverage; (2) maintenance of coverage; and (3) access to services and supports. In September 2022, CMS published the Streamlining Eligibility & Enrollment proposed rule[1] to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, CHIP, and the Basic Health Program (BHP). This proposed rule and the proposed rule entitled "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (CMS-2439-P) are both designed to improve access to services by using tools such as FFS rate transparency, standardized reporting for HCBS, and improving the process for interested parties, especially Medicaid beneficiaries, to provide feedback to State Medicaid agencies and for Medicaid agencies to respond to the feedback. Federal financial participation (FFP) would be available for expenditures necessary to implement activities states would need to undertake to comply with the provisions of the proposed rules, if finalized.

[1] Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility, Determination, Enrollment, and Renewal Processes (87 FR 54760).

CMS acknowledges that states will face challenges after the end of the COVID-19 public health emergency (PHE), noting that the expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act. The loss of other PHE temporary authorities will complicate state efforts to resume regular operations across their programs (the unwinding period). The effective date of the rule, if finalized, would be 60 days after publication in the Federal Register, and there would be different compliance dates depending on the policy (described below). Comment is sought on the appropriateness of the effective date and the proposed compliance dates.

The major provisions in the proposed rule include the following:

Medical Care Advisory Groups. CMS believes the current regulations requiring states to establish Medical Care Advisory Groups (MCACs) lack the specificity in a number of areas to ensure that state Medicaid plans are informed by the experiences of beneficiaries and their caretakers and that states are meaningfully engaging Medicaid beneficiaries and other low-income people in matters related to the operation of the state Medicaid plans. Proposed policies include changes to the committee membership, expansion of the scope of topics addressed by MCACs, a new annual report requirement, and the addition of a related beneficiary-only group.

Home and Community-Based Services (HCBS). All states provide for coverage of HCBS though the type and scope of the services vary. The agency's expectation is that high-quality HCBS be made available to eligible Medicaid beneficiaries; however, measuring HCBS quality has been problematic. Quality and reporting requirements vary across authorities and are often inadequate in providing the information necessary to assess whether the services are provided in a high-quality manner that best protects the health and welfare of beneficiaries. Additionally, states may choose their HCBS quality measures, which results in thousands of metrics and measures currently being used across the states. This frustrates efforts to compare HCBS quality and outcomes across states or to compare HCBS program performance for different populations. Additionally, poor oversight of HCBS has resulted in high-profile instances of abuse and neglect, and the shortage of direct care workers compounds challenges in ensuring access to high-quality, cost-effective HCBS for people with disabilities and older adults.

CMS proposes new federal requirements for HCBS that it believes would improve access to care, quality of care, and health and quality of life outcomes. They are also designed to promote health equity for people receiving Medicaid-covered HCBS and ensure safeguards are in place for beneficiaries who receive HCBS through FFS and managed care delivery systems. Proposals include a new strategy for oversight, monitoring, quality assurance, and quality improvement for HCBS programs; improving person-centered service planning and incident management systems in HCBS; requiring states to establish grievance systems in FFS HCBS programs; and requiring additional reporting on provider payment rates and waiting lists in section 1915(c) waiver programs. The proposals are also intended to promote public transparency for the administration of Medicaid HCBS programs.

Fee-For-Service Payment. Section 1902(a)(30)(A) of the Social Security Act ("Act") generally requires that rates paid to providers under state Medicaid plans must be sufficient to ensure

access to care by Medicaid beneficiaries is at least as great as that enjoyed by the general population in the geographic area. Every three years, states submit access monitoring review plans (AMRPs) to CMS for a core set of services, which rely on state data to support the conclusion that those rates are sufficient to ensure that level of access. States have previously complained about the administrative burden associated with developing and submitting AMRPs and have asked for clarification on the data that must be included. Citing the unstandardized nature of AMRPs, CMS questions whether the data and analysis consistently address the payment rate access issue.

The agency is also concerned that AMRPs are generally limited to FFS delivery systems and focus on targeted payment rate changes for certain broad categories of Medicaid services.[2] A number of AMRP data elements are overly broad, subject to interpretation, or difficult to obtain. For example, analyzing whether beneficiaries' needs are fully met is subject and could require states to conduct surveys. Also, states struggle to meet the requirement to compare Medicaid program rates to private payer rates because they cannot access private payer rates. CMS finds AMRPs to be difficult to interpret or to use in assessing compliance with section 1902(a)(30)(A) of the Act.

CMS believes that payment rate transparency is a critical component in assessing whether states are complying with section 1902(a)(30)(A) of the Act. It proposes to require states to make all FFS Medicaid payment rates public and accessible on a state website and to report on their state Medicaid rates relative to comparable Medicare FFS rates for certain categories of services. CMS would also replace the current AMRP requirements with a tiered approach to data submission for determining whether states' rate change proposals comply with section 1902(a)(30)(A) of the Act, including comparing Medicaid payments to Medicare payments as an important basis for understanding whether Medicaid rates are likely to be sufficient. Finally, an interested parties advisory group comprised of beneficiaries, providers, and other interested parties would be established to advise on current or proposed payment rates.

II. Provisions of the Proposed Regulations

A. Medicaid Advisory Committee and Beneficiary Advisory Group (§431.12)

Section 431.12 currently establishes requirements for Medical Care Advisory Committees (MCACs) to advise a state Medicaid agency about health and medical care services under the state Medicaid plan. CMS believes the current regulation lacks specificity to fully promote beneficiary perspectives. It proposes changes to the regulatory requirements for these committees, including a name change to Medicaid Advisory Committee, and also proposes to require the establishment of a separate Beneficiary Advisory Group (BAG).

General Statement of Requirements. The basis and purpose of §431.12 would be expanded to require a state to establish a public Medicaid Advisory Committee (MAC) that must also have a dedicated BAG. Additionally, the state plan requirement would be revised to specify that the MAC and the BAG would advise on matters of concern related to policy development, and

[2] The broad service categories are primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services, and home health services.

matters related to the effective administration of the Medicaid program; this is an expansion of the current requirement for the MCAC to only advise on health and medical care services. The proposed changes are intended to ensure feedback is also provided on services beyond medical care, such as for social determinants of health and health-related social needs. Discretion on the topics to be discussed with the MAC would be left to the state.

CMS proposes to require the MAC and BAG to determine, in collaboration with the state, which topics to provide advice on related to the following: (i) additions and changes to services; (ii) coordination of care; (iii) quality of services; (iv) eligibility, enrollment, and renewal processes; (v) beneficiary and provider communications by the state Medicaid agency and Medicaid managed care plans; (vi) cultural competency, language access, health equity, and disparities and biases in the Medicaid program; or (vii) other issues that impact the provision or outcomes of health and medical care services in the Medicaid program as specified by the MAC, BAG, or state.

Appointment of Members. The current requirement for the state Medicaid agency director, or a higher state authority, to appoint members to the MAC on a rotating and continuous basis would be retained and also applied to appointment of members to the BAG. States would also have to establish a public process for recruitment and appointment of members and publish this information on the state's website in a manner that is easily accessible by the public.

Membership. CMS proposes that at least 25 percent of the membership of the MAC must be from the BAG. The remaining membership of the MAC would have to include representation from each of the following categories:

- State or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries;
- Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care, including providers or administrators of primary care, specialty care, and long-term care;
- Participating Medicaid managed care plans, or the State health plan association representing such plans, as applicable; and
- Other state agencies that serve Medicaid beneficiaries (e.g., a foster care agency, mental health agency, or health department) as ex-officio members.

CMS encourages states to consider the demographics of the Medicaid population in their states as part of their member selection process. In selecting clinical providers, the agency recommends a wide range of providers and administrators, including in the areas of primary care, behavioral health, reproductive health, pediatrics, dental and oral health, clinics, and long-term care services and supports. **Comment is sought** on the proposed requirement that 25 percent of the MAC be from the BAG.

Beneficiary Advisory Group. The current requirement at §431.12(c) to further the participation of beneficiary members would be replaced by requirements for states to both establish and support a BAG. The BAG would have to be comprised of current or former Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries (i.e., their family members and caregivers). As noted above, a BAG would advise on matters of concern related to policy

development, and matters related to the effective administration of the Medicaid program. They would have to meet separately from the MAC on a regular basis and before each MAC meeting. This is designed to ensure BAG members are prepared for each MAC meeting.

MAC and BAG Administration. A number of changes are proposed to the regulatory requirements for administration of the MAC and BAG; these are designed to promote transparency and establish standardized processes and practices. State agencies would have to develop and post publicly on their website bylaws for governance of the MAC and BAG, current membership lists of the MAC and BAG, and past meeting minutes for the MAC and BAG. They would also have to develop and post publicly on their websites a process for MAC and BAG member recruitment and appointment and for the selection of MAC and BAG leadership.

Regular meeting schedules would be required and made publicly available; both the MAC and the BAG would have to meet quarterly but could meet more frequently. CMS proposes to require that at least two MAC meetings be made open to the public, each requiring 30-day advance notice to the public. BAG meetings would not be required to be public though a BAG could decide to do so. States would have to offer in-person and virtual attendance options, including at a minimum a telephone dial-in option for MAC and BAG meetings. States would also have to ensure meeting times and locations for these meetings are chosen to maximize participation and are accessible to people with disabilities or to people with Limited English Proficiency. Minutes of public meetings would have to be publicly posted, which would list attendance by members.

State agency staff assistance, participation, and financial help. CMS proposes to expand existing State responsibilities for managing the MAC and BAG with regard to staff assistance, participation, and financial support. The changes are intended to ensure members are adequately prepared for meetings and can provide more meaningful feedback. State agencies would have to provide staff to support planning and execution of the MAC and the BAG, including recruitment of members, planning and execution of all MAC and BAG meetings, and producing minutes for meetings. Minutes would have to be publicly posted within 30 days.

CMS proposes to specify in regulations a number of activities staff must carry out to support members of the MAC and BAG who are Medicaid beneficiaries. These include facilitating MAC and BAG member engagement, providing necessary financial support to facilitate Medicaid beneficiary engagement in the MAC and the BAG, and requiring the attendance by at least one staff member from the state agency's executive staff at all MAC and BAG meetings.

Annual Report. CMS proposes to add a new annual reporting requirement for the MAC, which would describe its activities, topics discussed, and recommendations. Feedback from the BAG would be included as well. The report would be submitted to the state agency, which would review it and respond to any recommendations. The MAC would be permitted to complete a final review of the report, which would include the state's review and response, before it is publicly posted on its website. **CMS invites comments** on other ways it can increase what it refers to as the feedback loop among the state, MAC and BAG.

Federal Financial Participation. FFP for expenditures for activities of the MAC and BAG would continue to be available at its current 50 percent rate.

CMS proposes an effective date of 60 days after publication of the final rule, which it says would provide states one year to implement the revised requirements. **Comment is sought** on the appropriateness of the proposed one-year implementation timeframe.

Estimates for the proposed information collection requirements (ICRs) for the MAC and BAG proposals are as follows, 50 percent of which is the state share:

- To develop and publish the processes and annual report, an annual burden cost of $932,688 [12,240 hours (240 hr/response x 51 responses) x $76.20/hr].
- To review and approve bylaws and help with recruitment and appointment and selection of MAC and BAG leadership every 2 years, a biennial cost of $535,867 [4,080 hours (80 hr/response x 51 responses) x $131.34/hr].
- To review the updates and prepare the required annual report for publication, an annual cost of $113,036 [1,020 hours (20 hr/response x 51 responses) x $110.82/hr].

Table 30 of the proposed rule shows estimated annual costs to states for the updates to §413.12 to be $665,000 and estimated aggregate 5-year costs to be $3,275,000; more than 80 percent of those costs are attributable to logistical and administrative support to both the MAC and BAG.

B. Home and Community-Based Services (HCBS)

Coverage of Home and Community-Based Services (HCBS) is a state option under Medicaid and, varying by state, can include medical and non-medical services, such as case management, homemaker, personal care, adult day health, habilitation, and respite care services. It provides eligible individuals the opportunity to receive services in their home and community rather than in an institution.

Under an HCBS waiver under section 1915(c) of the Act, comparability, statewideness, and certain income and resource rules may be waived for states to cover HCBS for certain individuals with long-term care services and supports (LTSS) needs who would otherwise need a level of care provided in an institutional setting. A state HCBS waiver program must demonstrate that providing the services under the waiver won't cost more than providing services in an institution, ensure the protection of participants' health and welfare, provide adequate standards for provider participation to meet the needs of the HCBS program participants, and assess the needs of participants and ensure the services follow an individualized and person-centered plan of care.

States may also provide HCBS under section 1115 waivers or a combination of state plan amendment and waiver options. Under section 1915(i) of the Act, a state through a state plan amendment may offer a broad range of HCBS, using individualized person-centered plans of care, to specific populations who meet needs-based criteria, based on independent assessments and individualized person-centered plans of care. For purposes of providing HCBS under such amendment the state may waive comparability and certain income and resource rules and vary the benefit package, as well as the amount, duration, or scope of the benefits for each such population. Under the state option under section 1915(j) of the Act, a state may waive the statewideness Medicaid rule and limit the number of individuals served under the option to cover

self-directed personal care services for Medicaid enrollees who would otherwise but for the provision of such services require and receive personal care services under the plan or HCBS provided pursuant to a waiver under 1915(c). Under section 1915(k) of the Act states may provide through a state plan amendment, on a statewide basis and in the most integrated community-based setting, home and community-based attendant services and supports, through person-centered plans of care based on needs assessments, to certain eligible beneficiaries needing LTSS who would otherwise need a level of care provided in an institutional setting.[3]

CMS describes their HCBS proposals in this section as guided by and consistent with the requirements of section 2402 of the Patient Protection and Affordable Care Act (ACA), which provides that HCBS systems are to be responsive to the needs and choices of beneficiaries receiving HCBS, maximize independence and self-direction, and provide support and coordination to facilitate the participant's full engagement in community life, and should follow an approach that is consistent and coordinated with public programs providing HCBS.
To that end and consistent with section 2402(a)(3) of the ACA, which requires states to improve coordination among, and the regulation of, HCBS programs, CMS notes the similarities in requirements across 1915(c), 1915(i), 1915(j), and 1915(k) programs and proposes to apply the proposals under this section for the section 1915(c) waiver programs to section 1915(j), (k), and (i) state plan services as well. In the headings in the proposed rule, and this summary, for each 1915(c) proposal that would also apply to authorities under section 1915(i), (j), and (k), there are referenced corresponding regulatory sections for those authorities, each of which CMS proposes to amend with a cross reference to the 1915(c) proposed regulatory requirement to clearly apply the requirement.

CMS clarifies that the proposed requirements, if finalized, for section 1915(c) waiver programs and section 1915(j), (k), and (i) state plan services would apply to such services included in approved section 1115 demonstration projects, unless CMS waives the requirement under the approval process of the demonstration project. CMS does not propose to apply any of such proposed requirements to the Program of All-Inclusive Care of the Elderly (PACE).

CMS does not at this time propose to apply the requirements proposed under this section to section 1905(a) medical assistance state plan personal care, home health, or case management services, citing differences in data collection and reporting capabilities for these services versus HCBS services under 1915(c), (i), (j), and (k), and the substantial differences in the person-centered planning and service plan requirements.

Tables 39 and 40 in the proposed rule show the total projected costs over the 5-year period beginning with 2024 would be $267.18 million, including $74.54 million in state costs, $74.54 million in federal costs, $109.23 million in HCBS provider costs, and $7.35 million in MCE costs.

[3] States receive a 6 percentage point increase to their FMAP with respect to expenditures for providing services under this state plan option.

1. Person-Centered Service Plans (42 CFR §§441.301(c), 441.450(c), 441.540(c), 441.725(c))

Section 1915(c) of the Act requires that services provided through a section 1915(c) waiver program be provided under a written plan of care ("service plan"). In accordance with §441.301(c)(3), a service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. CMS describes that each step of a state's person-centered planning process is crucial to delivery of care and the health and welfare of the waiver participant, and integral to complying with section 2402 of the ACA.

CMS released guidance in 2014 (2014 Guidance) on section 1915(c) waivers, which included expectations for states to report state developed performance measures to demonstrate compliance with section 1915(c) and, if scoring below an 86 percent threshold on any measure, to perform remediation and implement a Quality Improvement Project. The 2014 Guidance specified states could demonstrate such compliance by attesting to having in place adequate systems for: (1) evaluating a waiver participant's level of care consistent with care provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities; (2) reviewing the adequacy of service plans for waiver participants; (3) assuring all waiver services are provided by qualified providers; (4) assuring waiver participant health and welfare; (5) ensuring financial accountability of the waiver program; and (6) ensuring the Medicaid state agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

CMS proposes a different approach for states to demonstrate compliance with section 1915(c) and §441.301(c)(3), which focuses on priority areas (person-centered planning, health and welfare, access, beneficiary protections, and quality improvement) identified by states, oversight entities, consumer advocacy organizations, and other interested parties. Accordingly, CMS proposes to establish new reporting requirements for section 1915(c) waiver programs and a new minimum performance level of 90 percent to demonstrate that states meet the requirements at §441.301(c)(3), which would fully replace the reporting requirements and the 86 percent performance level threshold for performance measures described in the 2014 Guidance.

Specifically, CMS proposes, at a new §441.301(c)(3)(ii), that states must demonstrate that:

- A reassessment of functional need was conducted at least annually for at least 90 percent of individuals continuously enrolled in the waiver for at least 365 days; and
- The service plan was reviewed and revised as appropriate based on the results of the required reassessment of functional need at least every 12 months for at least 90 percent of individuals continuously enrolled in the waiver for at least 365 days.

The higher threshold of 90 percent is intended to strengthen the person-centered planning requirements and address feedback that beneficiaries may be at risk for preventable harm due to unnecessary delays in person-centered planning processes. CMS is not proposing good cause exceptions to the threshold, as the 90 (as opposed to 100) percent threshold is already intended to account for circumstances that may affect a state's abilities to comply all of the time.

CMS also proposes revisions to the text of §441.301(c)(1) to clarify that every waiver participant does not require an authorized representative and to the text of §441.301(c)(3) to make clear the state is the required actor to make sure the service plan is reviewed and revised, as appropriate, and that changes to the service plan are not required if the reassessment does not indicate a need for changes.[4]

CMS proposes that a state must ensure compliance with the requirements in §441.301(c)(3), with respect to HCBS delivered under both FFS and managed care delivery systems, and therefore proposes adding the requirements at §441.301(c)(3) to 42 CFR 438.208(c).

Recognizing that it will take states time to implement these proposed requirements and changes, CMS proposes to make the performance levels under §441.301(c)(3)(ii) effective:

- With respect to HCBS delivered under FFS delivery systems, beginning 3 years after the effective date of the final rule; and
- With respect to HCBS delivered under managed care delivery systems (through a contract with an MCO, PIHP, or PAHP), beginning with the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the one-time burden estimate for states for these requirements at §441.301(c)(3) would be $31,102. In aggregate, CMS estimates, across managed care entities, a one-time burden of 966 hours at a cost of $120,463.

CMS invites comment on these proposals, including on whether the proposed timeframe for implementation is sufficient, whether an alternative timeframe should be implemented (and if so, the rationale for the recommended alternative), on the proposed application of the proposed requirements to section 1915(i), (j), and (k) authorities, and on whether the proposed requirements should be applied to 1905(a) personal care, home health, and case management services.

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

Section 2402(a)(3)(B)(ii) of the ACA requires development and monitoring of an HCBS complaint system. Section 1902(a)(19) of the Act requires states to provide safeguards to assure that eligibility for Medicaid-covered care and services will be determined and provided in a manner that is consistent with simplicity of administration and the best interest of Medicaid beneficiaries. Fair hearing rights[5] apply to all Medicaid applicants and beneficiaries, including those receiving HCBS regardless of delivery system, including for a termination, suspension, or reduction of Medicaid eligibility or in benefits or services. Medicaid managed care plans must[6]

[4] The proposed revisions would include revising the following sentence in §441.301(c)(3) by adding the underlined text: "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."

[5] See 42 CFR part 431, subpart E for the right to a fair hearing before the state Medicaid agency.

[6] See 42 CFR part 438, subpart F for Medicaid managed care plan appeal system and grievance system requirements.

have in place both an appeals process (which allows a Medicaid managed care enrollee a review by the Medicaid managed care plan of an adverse benefit determination issued by the plan, and if the plan's appeals process is exhausted, a request for a fair hearing before the state Medicaid agency) and a grievance process (which allows a Medicaid managed care enrollee to file a grievance with the plan about any matter other than an adverse benefit determination, which would be outside of the fair hearing scope). In contrast, a FFS HCBS beneficiary does not have a comparable process to such a grievance process to raise concerns outside of the fair hearing scope.

CMS proposes at a new §441.301(c)(7) to require states to establish grievance procedures under which Medicaid beneficiaries receiving HCBS through a FFS delivery system can file a grievance related to the state's or a provider's compliance with the person-centered planning and service plan requirements and the HCBS settings requirements. CMS notes the proposed grievance procedures with respect to FFS delivery systems are similar to the grievance requirements for Medicaid managed care plans, with any differences designed to make the requirements appropriate for FFS systems.

Specifically, CMS proposes the following under §441.301(c)(7):

- A grievance would be defined as an expression of dissatisfaction or complaint 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), regardless of whether any remedial action is requested to be taken to address the area of dissatisfaction or complaint.
- A grievance system would be defined as the processes the state implements to handle, and collect and track information about, grievances.
- States would be required to (i) have written policies and procedures for the grievance process; (ii) provide beneficiaries with reasonable assistance (in a manner that complies with the availability and accessibility requirements at §435.905(b)) to complete the forms and steps related to grievances; (iii) ensure punitive action is not threatened or taken against someone filing a grievance; (iv) accept grievances, requests for expedited resolution of grievances, and requests for extensions of timeframes from beneficiaries; (v) provide beneficiaries with notice and information on the system, including rights under the system, and ensure the information is available and accessible; (vi) review grievance resolutions with which beneficiaries are dissatisfied; and (vii) provide information on the grievance system to HCBS providers and subcontractors.
- Processes for handling grievances would be required to (i) allow beneficiaries to file a grievance orally or in writing; (ii) acknowledge receipt of each grievance; (iii) ensure that decisions are made by individuals with appropriate expertise and who have not been previously involved in review or decision-making related to the problem or issue; (iv) consider all of the information submitted by the beneficiary related to the grievance; (v) 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 arguments related to their grievance; and (vi) provide beneficiaries, free of charge, with language services in accordance with 435.905(b) to support their participation in and use of grievance processes and, in advance of resolution, with their own case files and any state-generated new or additional evidence.

- A beneficiary or authorized representative would be permitted to file a grievance (or another individual on the beneficiary's behalf if the beneficiary or representative gives written consent). A grievance would be able to be filed by such person at any time and a request for an expedited resolution would be permitted if there is a substantial risk that resolution within standard timeframes would adversely affect the beneficiary's health, safety, or welfare. The proposal regarding expedited resolution (as well as the timing for such expedited resolution below) differs from the grievance system for Medicaid managed care plans as the regulations for such grievance system (part 438, subpart F) do not include specific requirements for expedited resolution.
- States would be required to resolve and provide written notice (and, in the case of expedited resolutions, make reasonable efforts to provide oral notice) of resolution as quickly as the beneficiary's health, safety, and welfare requires and within state-established timeframes that are not more than:
    - For a standard resolution of grievance, 90 calendar days after receipt of the grievance (which may be extended up to 14 days by the state if requested by the beneficiary or if the state documents there's a need for additional information and the delay is in the best interest of the beneficiary); and
    - For expedited resolution of a grievance, 14 calendar days after receipt of the grievance (which may be extended up to 14 days under the same circumstances as stated above).
- States would be required to maintain records of grievances (and review them as part of monitoring procedures) including 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.

CMS proposes these requirements at §441.301(c)(7) be effective 2 years after the effective date of the final rule. CMS believes this effective date balances the recognition that states may need time to implement the new grievance system requirements, with the potential substantial risk of harm to beneficiaries without the grievance system in place.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time cost to states to implement this proposal would be $1,240,963, and the estimated state share of the estimated ongoing burden for states would be $540,687 per year.

CMS invites comment on these proposals, including on whether the expedited resolution proposals should be included in the FFS proposed grievance process, if the proposed timeframe to meet the requirements is sufficient, whether an alternative timeframe should be implemented (and if so the rationale for the alternative), and the application of the grievance system provisions to section 1915(i), (j), and (k) authorities.

3. Incident Management System (§§441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v))

CMS explains (and provides examples of several reports demonstrating) that despite states implementing the 2014 Guidance described in the preamble, there have been a number of instances of abuse and neglect that highlight the concerns with the quality of care under, and

inadequate oversight of, HCBS in Medicaid. In a January 2018 report, the GAO recommended that requiring states to report information on incidents would strengthen the effectiveness of state and federal oversight. CMS issued in July 2019 a survey to states with section 1915(c) waivers to collect information on their approach to administering incident management systems. The survey found that definitions of critical incidents varied across states (and within states for different HCBS programs and populations), some states did not use standardized forms, some states did not have electronic incident management systems, and many states lacked communication within and across state agencies.

Based on the reports and survey findings, CMS proposes a new requirement at §441.302(a)(6) to require that states provide an assurance that they operate and maintain an incident management system to identify and address critical incidents of abuse, neglect, exploitation, and other harm with respect to the provision of HCBS. Specifically, CMS proposes:

- A critical incident would be defined 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."
- States would be required to have electronic critical incident systems that, at a minimum, enable the electronic collection, tracking, and trending of data on critical incidents; require providers report to states critical incidents that occur in providing HCBS services specified in the person-centered service plan and critical incidents that are a result of the failure to deliver authorized services; and use specified data[7] to identify critical incidents that are unreported by providers.
- States would be required to data share with other state entities on the status and resolution of investigations and to investigate a critical incident if the investigative agency fails to do so within specified timeframes.
- States would be required to report on standardized federally prescribed quality measures rather than the state developed measures required in the 2014 Guidance, which vary state by state, specifically to meet the reporting requirements at §441.311(b)(1) (described in section II.B.7) related to incident management systems.

Under the proposed §441.302(a)(6)(ii) states would be required to demonstrate that they satisfied each of the new requirements for no less than 90 percent of critical incidents, including demonstrating an investigation was initiated for no less than 90 percent of critical incidents, an investigation was completed and the resolution of the investigation was determined for no less than 90 percent of critical incidents, and corrective action was completed for no less than 90 percent of critical incidents that require corrective action. CMS believes the previous 86 percent threshold in the 2014 Guidance provided states too much latitude to account for unexpected delays in responding to critical incidents and the delays could result in harm to beneficiaries. CMS is not proposing to allow good cause exceptions to the performance level because the 90

[7] CMS proposes to require states to 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.

percent threshold is intended to capture delays that may result from good cause scenarios affecting the state's ability to achieve performance levels. CMS also points out there are existing disaster authorities that a state could use in the case of a public health emergency or disaster.

CMS proposes to require states to comply with these proposed requirements with respect to HCBS delivered through FFS and managed care delivery systems.

Recognizing that it will take states time to implement these proposed requirements, CMS proposes to apply the requirements:

- With respect to HCBS delivered under FFS delivery systems, beginning 3 years after the effective date of the final rule; and
- With respect to HCBS delivered under managed care delivery systems (through a contract with an MCO, PIHP, or PAHP), beginning with the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule.

The proposed requirements would replace the existing reporting expectations and performance level for state performance measures described in the 2014 Guidance, and CMS would work with states to phase out the 2014 Guidance requirements if the proposals are finalized.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the one-time estimated burden for implementing these requirements would be $62,437,063, and the estimated state share of the on-going estimated burden would be $12,366,309 per year. In aggregate, CMS estimates an ongoing burden for service providers of $3,141,193 per year. In aggregate, CMS estimates a one-time burden for managed care entities of $2,576,084, and an on-going burden at a cost of $503,622 annually.

CMS invites comment on these proposals, including specifically on:

- Whether the proposed timeframe to meet the requirements is sufficient or whether an alternative timeframe should be implemented (and if an alternative is recommended the rationale);
- The application of the requirements to section 1915(i), (j), and (k) authorities, and on whether similar requirements should be established for section 1905(a) state plan personal care, home health, and case management services;
- The proposed definition for a critical incident and whether there are specific types of events or instances of serious harm to HCBS waiver participants that would not be captured in this definition that should be, and whether the inclusion of any specific type of event or instance proposed in the definition could lead to overidentification of incidents;
- Associated burden with requiring electronic critical incident systems as proposed and if there is specific functionality that should be required or encouraged for such systems; and
- Whether states should, as proposed, be required to use claims data, Medicaid Fraud Control Unit data, and data from other state agencies such as Adult Protective Services or Child Protective Services to identify critical incidents that are not reported by providers, and whether there are other data sources that should be specified.

4. Reporting (§441.302(h))

CMS believes that standardizing reporting across HCBS authorities will make reporting for providers more efficient, improve states' and CMS' ability to oversee and assess HCBS quality and performance, and better enable states to improve HCBS programs. CMS is proposing consolidating and standardizing reporting expectations in one new section at proposed §441.311, described in section II.B.7. of the proposed rule. CMS, therefore, proposes to remove the duplicative provisions in §441.302(h).

5. HCBS Payment Adequacy (§§441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

Section 1902(a)(30)(A) of the Act requires state Medicaid programs to ensure that payments to providers are sufficient to enlist enough providers so that care and services are available to beneficiaries at least to the extent as the general population in the same geographic area. Access to most HCBS requires access to direct care workers who provide nursing services, assistance with activities of daily living[8] and instrumental activities of daily living[9], behavioral supports, employment supports, and other services to promote community integration for older adults and people with disabilities. Workforce shortages of direct care workers (resulting from low wages and limited benefits) limit access to and impact the quality of HCBS. CMS describes that a sufficient direct care workforce is necessary to comply with statutory requirements[10].

In order to stabilize the direct care workforce, CMS proposes at §441.302(k) to provide a federal standard that requires state Medicaid agencies to demonstrate that a sufficient percentage of state FFS and managed care payments for HCBS go directly to compensate direct care workers and that payment rates for certain HCBS authorized under section 1915(c) are enough to ensure a sufficient direct care workforce.

Specifically, CMS proposes at §441.302(k)(3)(i) to require at least 80 percent of all Medicaid payments for homemaker services, home health aide services, and personal care services be spent on compensation to direct care workers. CMS also proposes that states demonstrate such minimum performance level is met through new federal reporting requirements at §441.311(e) discussed in section II.B.7 of the proposed rule summarized below.

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[11], benefits (such as health and dental benefits, sick leave, and tuition reimbursement), and the employer share of payroll taxes for direct care workers delivering services under section 1915(c) waivers.

[8] Activities of daily living include activities such as mobility, personal hygiene, and eating.
[9] Instrumental activities of daily living include activities such as cooking, grocery shopping, and managing finances.
[10] Sections 2402(a)(1) and 2402(a)(3)(B)(iii) of the ACA requires states to allocate resources for services in a manner that is responsive to the changing needs and choices of HCBS beneficiaries receiving HCBS and to oversee and monitor HCBS system functions to assure there is a sufficient number of such workers to provide self-directed personal assistance services.
[11] See 29 U.S.C. 201 et seq., 29 CFR parts 531 and 778.

CMS proposes to define direct care workers:

- As including workers who provide nursing services, assist with activities of daily living or instrumental activities of daily living, and provide behavioral supports, employment supports, or other services to promote community integration, including such workers who are employed by (or contracted with) a Medicaid provider, state agency, or third party or who deliver services under a self-directed service model;
- As specifically including registered nurses, licensed practical nurses, nurse practitioners, clinical nurse specialists, licensed or certified nursing assistants, direct support professionals, personal care attendants, and home health aides who provide nursing services to Medicaid beneficiaries receiving HCBS, and other individuals who are paid to directly provide services to such beneficiaries; and
- As excluding nurses in supervisory or administrative roles who are not directly providing nursing services to people receiving HCBS**.**

CMS proposes to apply these requirements with respect to HCBS delivered both under FFS and managed care delivery systems.

CMS expects that it will take a substantial amount of time for managed care plans and providers to establish the necessary systems, data collection tools and process to collect the required information to report to states, as well as time for states to implement these requirements. Therefore, CMS proposes to apply these requirements:

- With respect to HCBS delivered under FFS delivery systems, beginning 4 years after the effective date of the final rule; and
- With respect to HCBS delivered under managed care delivery systems (through a contract with an MCO, PIHP, or PAHP), beginning with the first managed care plan contract rating period that begins on or after 4 years after the effective date of the final rule.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time burden to implement these proposals would be $458,347, and the estimated state share of the estimated ongoing burden would be $23,616 per year. CMS estimates a one-time cost to providers of $81,897,911, and an annual cost to providers of $21,553,542. In aggregate, CMS estimate a one-time burden on managed care entities at a cost of $1,486,877, and an ongoing cost of $155,713 per year.

CMS invites comments on these proposals, including specifically on:

- The alternate options of 75 percent, 85 percent, and 90 percent for the proposed minimum percentage of payments, and if an alternate minimum percentage is recommended, the rationale;
- Whether the proposed minimum percent of payments requirements should apply to other services listed at §440.180(b), particularly residential habilitation services, day habilitation services, and home-based habilitation services; and, if so, on whether a 65

percent, 70 percent, 75 percent, or 80 percent minimum payment percent threshold should be applied for such other services;[12]

- Whether the proposed definition of compensation should include any other forms of compensation;
- Any other specific types of direct care workers that should be included in the definition of direct care worker, and whether any of the types of workers listed should be excluded;
- The application of payment adequacy provisions across section 1915(i), (j), and (k) authorities, and on whether CMS should exempt, from these requirements, services delivered using any self-directed service delivery model under any Medicaid authority;
- Whether the requirements should be applied to section 1905(a) state plan personal care and home health services; and
- The overall burden associated with implementing these proposals, whether the implementation timeframe is sufficient or whether there should be a shorter (such as 3 years) or longer (such as 5 years) timeframe (and if so, the rationale for the alternate timeframe).

6. Supporting Documentation Required (§441.303(f)(6))

CMS notes that states vary in whether and how they maintain waiting lists for section 1915(c) waiver services. The number of people who need Medicaid-covered HCBS may be an overestimate because the waiting lists may include individuals who are not eligible for services. There are also some states operating waiting lists even though they have not reached their CMS-approved enrollment cap.

CMS proposes to amend §441.303(f)(6) to require that if a state has a limit on the size of the 1915(c) 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), described in the next section. This proposal is aimed to improve public transparency and processes related to states' HCBS waiting lists to better CMS' ability to adequately oversee and monitor states' use of waiting lists in their section 1915(c) waiver programs.

7. Reporting Requirements (§§441.311, 441.474(c), 441.580(i), 441.745(a)(1)(vii))

The 2014 Guidance requested states to report on state-developed performance measures and established an expectation that states conduct systemic remediation and implement a Quality Improvement Project when they score below 86 percent on any of their performance measures. Pursuant to CMS' authority under section 1902(a)(6) of the Act[13], CMS proposes requirements at §441.311, in combination with the other proposed requirements discussed in the proposed rule, to supersede and fully replace the 2014 Guidance reporting metrics and the minimum 86 percent

[12] CMS requests that commenters respond separately on the minimum percentage of payments for services delivered in a non-residential community-based facility, day center, senior center, or other dedicated physical space, which would be expected to have higher other indirect costs and facility costs built into the Medicaid payment rate than other HCBS, and to provide the rationale for any alternate minimum percentage recommended.

[13] Section 1902(a)(6) of the Act requires state Medicaid agencies to make such reports, in such form and containing such information, as the Secretary may from time to time require, and to comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.

performance level expectations for states' performance measures. CMS believes the proposed reporting requirements will better enable it to assess states' compliance with section 1915(c) statutory and regulatory requirements.

CMS proposes to apply all of the proposed reporting requirements to both FFS and managed care delivery systems.

a. Compliance Reporting

Incident Management System Assessment: At §441.311(b) CMS proposes new compliance reporting requirements to enable it to better assess state compliance with the incident management system requirements proposed under II.B.3 of the preamble. Specifically, CMS proposes to require that states report every 24 months on the results of an incident management system assessment to demonstrate that the state operates and maintains an incident management system, in accordance with requirements discussed in II.B.3. CMS also proposes to allow states with incident management systems that are determined to meet the proposed requirements to reduce the frequency of reporting to up to once every 60 months.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated ongoing burden to states would be $3,988 per year.

CMS invites comment on the proposed frequency of reports, including whether CMS should require reporting more (every year) or less (every 3 years) frequently, and whether CMS should require more frequent (every 3 or 4 years) reporting than the 60 months proposed for a state with an incident management system that is determined to meet the proposed requirements**.**

Critical Incidents: CMS proposes to require at §441.311(b)(2) that states report annually on the number and percent of critical incidents for which an investigation was initiated within state-specified timeframes, the number and percent of critical incidents that are investigated and for which the state determines the resolution within state-specified timeframes, and the 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. CMS would use the reported data to determine if states meet the proposed requirements relating to critical incidents, as described in II.B.3. **CMS invites comment** on the proposed timeframe, including whether reporting should be less frequent (every 2 years), and if an alternate timeframe is recommended, the rationale.

Person-Centered Planning: CMS proposes at §441.311(b)(3) to require states to report annually to demonstrate compliance with the proposed requirements at §441.301(c)(3)(ii) (as described in section II.B.1 of the preamble). CMS proposes to allow states to report on a statistically valid random sample of beneficiaries, rather than for all individuals continuously enrolled in the waiver program for at least 365 days. **CMS invites comment** on whether there are other compliance metrics related to person-centered planning on which states should be required to report, either in place of or in addition to the proposed metrics, and on the proposed timeframe for states to report and whether reporting should be less frequent (every 2 years) (and, if so, the rationale for the alternate frequency).

Type, Amount, and Cost of Services: CMS proposes to keep applying the reporting requirement currently at §441.302(h)(1) that states must report on the type, amount, and cost of services, but to remove the requirement from its placement at §441.302(h)(1) and to instead include the requirement in the new consolidated reporting section at §441.311.

CMS estimates that the state share of the net reduction in annual burden resulting from reporting requirements on critical incidents, person-centered service planning, and type, amount, and cost of services is $319,594.

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

CMS proposes to require states to report every other year on the HCBS Quality Measure Set described in section II.B.8. of the preamble, including measures identified as mandatory measures for states to report and measures for which the Secretary will report on behalf of states, and to allow states to report every other year on measures in the HCBS Quality Measure Set that are not identified as mandatory, as described in section II.B.8.

With respect to each of the mandatory measures, CMS proposes to require states to establish performance targets, subject to CMS review and approval and to describe the quality improvement strategies the states will use to achieve those performance targets. With respect to non-mandatory measures, CMS proposes to allow states to establish performance targets and to describe quality improvement strategies for achieving those targets.

CMS proposes to report, on behalf of the states, on a subset of measures in the HCBS Quality Measure Set that would be identified as measures on which CMS would so report; and to allow states 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.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time burden to implement this policy would be $2,570,959, and the estimated state share of the estimated ongoing burden would be at a cost of approximately $2,034,112 per year. CMS estimates the aggregate annual burden related to completing the beneficiary experience survey used to derive measures in the HCBS Quality Measure Set would be $372,780.

CMS invites comment on the adequacy of the reporting timeframe proposed, whether there should be more (every year) or less (every 3 years) frequent reporting (and the rationale for an alternative frequency), and any additional changes that should be considered.

c. Access Reporting

To enhance transparency regarding waiting lists (as discussed in section II.B.6), CMS proposes at §441.311(d)(1) to require states that have a limit on the size of their 1915(c) waiver program and maintain a list of individuals who are waiting to enroll in the waiver program to annually report how they maintain such list. The report would include at least information on whether the

state screens (and re-screens) individuals on the waiting list for eligibility and the frequency of any re-screening, the number of people on the waiting list, and the average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time burden to implement the waiting list reporting requirements at §441.311(d)(1) would be $84,618, and the estimated state share of the estimated ongoing burden would be $33,820 per year.

CMS also proposes to require annual state reports on:

- The average amount of time from when homemaker services, home health aide services, and personal care services are initially approved to when services began, for individuals newly approved to begin receiving services within the past 12 months; and
- The percent of authorized hours for such services provided within the past 12 months.

States would be allowed to report on a statistically valid random sample of individuals for each of the above.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time burden to implement the access reporting requirements would be $295,577, and the estimated state share of the estimated ongoing burden would be $111,444 per year. In aggregate, CMS estimates a one-time burden to managed care entities at a cost of $918,479, and an ongoing cost to such entities of $558,303 per year.

CMS invites comment on these proposals, including specifically on:

- The proposed timeframes, whether the reporting should be less frequent (every 2 or 3 years), and if so, the rationale for that alternate timeframe;
- Other specific metrics or reporting requirements related to waiting lists that would be instead of or in addition to what is proposed;
- Whether there are other specific metrics related to individuals' use of authorized homemaker services, home health aide services, or personal care services (or related to the amount of time it takes to begin receiving such services) that should be reported, either in place of or in addition to what is proposed; and
- Whether the requirement should apply to additional services authorized under section 1915(c) of the Act.

d. Payment Adequacy

At §441.311(e) CMS proposes states report annually on the percent of payments for homemaker, home health aide, and personal care services that are spent on compensation for direct care workers. CMS proposes states would report separately for each service subject to the reporting requirement and, within each service, separately on payments for services that are self-directed, and in the aggregate for each service across all programs as opposed to separately report for each waiver or HCBS program.

CMS requests comment on these proposals, including specifically on:

- Whether states should be able 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 of reporting should be reduced to every other year;
- Whether states should be required to report on the percent of payments for certain HCBS spent on compensation for direct care workers at the delivery system, HCBS waiver program, or population level; or on the median hourly wage and compensation by category;
- Whether states should be required to report on the percent of payments for other services that are spent on compensation for direct care workers, specifically for residential habilitation services, day habilitation services, and home-based habilitation services;
- Whether states should be able to exclude, from their reporting to CMS, payments to providers of agency directed services that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, and if so, whether there should be a specific limit on the exclusion, such as to limit the exclusion to providers in the lowest 5th, 10th, 15th, or 20th percentile of providers in terms Medicaid revenues for the service, number of beneficiaries served, or number of direct care workers serving the beneficiaries; and
- Whether payments for self-directed services should be permitted to be excluded.

e. Effective Date

CMS proposes the following timeframe for states to be in compliance with these requirements:

- With respect to HCBS delivered under FFS delivery systems:
    - For 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) requirements, beginning 3 years after the effective date of the final rule; and
    - For the payment adequacy reporting requirements at §441.311(e), beginning 4 years after the final rule effective date; and
- With respect to HCBS delivered under managed care delivery systems (through a contract with an MCO, PIHP, or PAHP):
    - For 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) requirements, beginning with the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule; and
    - For the payment adequacy reporting requirements at §441.311(e), beginning with the first managed care plan contract rating period that begins on or after 4 years after that effective date.

CMS invites comment on the proposed timeframes, including on whether shorter or longer (by a year) timeframes should be applied (and if so, the rationale for the alternative timeframe), the application of these provisions across section 1915(i), (j), and (k) authorities; and whether similar reporting requirements should be applied for section 1905(a) medical assistance state plan personal care, home health, and case management services.

8. Home and Community-Based Services (HCBS) Quality Measure Set (§§441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v))

CMS issued State Medicaid Director Letter # 22-00388 on July 21, 2022, to release the first official version of the HCBS Quality Measure Set, which is a set of nationally standardized quality measures for Medicaid-covered HCBS. CMS proposes to add a new section at §441.312, Home and Community-Based Services Quality Measure Set, to require use of the standardized measure set to assess the quality of Medicaid HCBS 1915(c) waiver programs and promote public transparency related to the administration of Medicaid-covered HCBS.

CMS proposes a process in which it would regularly update and maintain the required measures set. CMS proposes to define the 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". That process would require the Secretary consult with states and other interested parties[14] in developing and updating the measures.

Specifically, under the process, at least every other year, the Secretary would, after soliciting comment from states and other interested parties, establish priorities, identify newly developed and other measures that should be added to the set, identify measures for removal, and ensure all measures in the set are evidence-based, are meaningful for states, and are feasible for state-level and program-level reporting as appropriate.[15]

The process would identify mandatory measures, measures in the set that the Secretary will report on behalf of states, measures a state can elect to have the Secretary report on behalf of the state, measures the state may have additional time to report and how much time, and the subset of measures that must be stratified by race, ethnicity, Tribal status, sex, age, rural/urban status, disability, language, or such other factors as may be specified by the Secretary.

The process would also provide for a standardized reporting format and schedule and inform states how to collect, calculate, and report data on the measures, identify populations for which states must report data, provide attribution rules[16] for determining how states report on measures

[14] At §441.312(g) CMS proposes the list of interested parties with whom the Secretary must consult to specify and update the quality measures in the HCBS Quality Measure Set, including 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.

[15] Aspects of the proposed process are aligned with proposed processes for the Secretary to update and maintain the Child, Adult, and Health Home Core Sets as described in the Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting proposed rule (87 FR 51303).

[16] Attribution rules would be defined at §441.312(b)(1) as the process states use to assign beneficiaries to a specific health program or delivery system for calculating the measure set.

for each such population group, and identify and describe how to establish state performance targets for each of the measures.

CMS proposes a phase-in over a specified period of mandatory state reporting for some measures and of reporting for certain populations, such as older adults or people with intellectual or developmental disabilities.

CMS also proposes stratification by states in reporting HCBS Quality Measure Set data. Stratified sampling allows a sampling of data to be divided into subpopulations and would enable CMS to identify the health and quality of life outcomes of underserved populations and potential differences in outcomes based on subpopulation. However, CMS also describes challenges to data stratification, including that the validity of the stratified data is threatened when the demographic data are incomplete and CMS does not often have complete demographic data since Medicaid beneficiaries are not required to provide race and ethnicity data. CMS also describes potential beneficiary privacy violations in the case of states with smaller populations and less diversity, which may result in the need for suppression of some data.

CMS proposes that stratification would be implemented through a phased-in approach in which the Secretary would specify which measures and by which factors states must stratify reported measures. States would be required to provide stratified data for 25 percent of the measures in the HCBS Quality Measure Set for which the Secretary has specified that reporting should be stratified by 3 years after the effective date of the final regulations, 50 percent of such measures by 5 years after the effective date of these regulations, and 100 percent of measures by 7 years after the effective date of these regulations.

CMS acknowledges states may need to make enhancements to their data and information systems or incur other costs in implementing the HCBS Quality Measure Set, and reminds states that the enhanced FFP is available at a 90 percent[17] match rate for the design, development, or installation of improvements of mechanized claims processing and information retrieval systems and that the enhanced FFP at a 75 percent[18] match rate is also available for operations of such systems.

CMS invites comment on these proposals, including specifically on the proposed timeframes for updating and developing the measure set (as well as the process for such updates and development), whether the activities should be conducted more frequently (every year) or less frequently (every 3 years) (and if another timeframe is recommended, the rationale for such frequency), the proposed schedule for phasing in reporting of the HCBS Quality Measure Set data; and whether reporting on all of the measures in the HCBS Quality Measure Set should be phased-in.

9. Website Transparency (§§441.313, 441.486, 441.595, and 441.750)

CMS proposes a new website transparency section, at §441.313 to promote public transparency related to the administration of Medicaid-covered HCBS, as a method to hold states accountable

[17] See section 1903(a)(3)(A)(i) of the Act.
[18] See section 1903(a)(3)(B) of the Act.

for the quality and performance of their HCBS systems. CMS proposes to require compliance with respect to HCBS delivered both under FFS and managed care delivery systems.

Specifically, CMS proposes to require 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 the proposed §441.311; to verify at least quarterly the accurate function of the website and timeliness of information and links; to include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost; and to include information on the availability of oral interpretation written translation, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number. The data and information that states are required to report under §441.311 would be provided on a single web page (directly or by linking to the web pages of the MCO, PAHP, PIHP, or primary care case management entity). The information reported by states under §441.311 to CMS would be included on the CMS website.

CMS proposes these requirements apply:

- With respect to HCBS delivered under FFS delivery systems, beginning 3 years after the effective date of the final rule; and
- With respect to HCBS delivered under managed care delivery systems (through a contract with an MCO, PIHP, or PAHP), beginning with the first managed care plan contract rating period that begins on or after 3 years after the effective date of the final rule.

Taking into account the federal contribution to Medicaid administration, the estimated state share of the estimated one-time state burden to implement these requirements would be $258,817, and the estimated state share of the estimated ongoing state burden would be $333,114 per year.

CMS seeks comment on these proposals, including 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, whether states should be permitted to link to web pages of these managed care entities, the frequency at which state should verify the information, the implementation dates, and the application of these provisions across section 1915(i), (j), and (k) authorities.

C. Documentation of Access to Care and Service Payment Rates (§447.203)

CMS proposes an overhaul of §447.203, replacing Access Monitoring Review Plans (AMRPs) with a more limited payment rate transparency requirement under proposed §447.203(b). In proposed §447.203(c)(1), the agency proposes a streamlined analysis process for when a state proposes provider rate reductions or restructurings. However, if those payment changes exceed certain thresholds, a more detailed access impact analysis would be required, under proposed §447.203(c)(2). With this updated process, states would be required to document and CMS would ensure compliance with section 1902(a)(30)(A) of the Act (hereafter simply referred to as "1902(a)(30)(A)"), which requires Medicaid state plans to:

> *"assure that [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 reviews how it codified in 2015 the current requirements that states complete and make public AMRPs. CMS notes these regulations give states discretion in establishing their AMRP processes, including the specification of data sources and analytical methodologies, but result in a large analytical burden on states without a standardization that would allow CMS and others to compare data between states to understand whether access is consistent with 1902(a)(30)(A). Since AMRPs focus on FFS Medicaid, states with high managed care penetration were concerned about the AMRP process because their remaining FFS populations often reside in long-term care facilities or require only specialized care that is carved out from managed care, but long-term care and specialized care services were not required to be analyzed under the AMRP process. Some medical associations and non-profit organizations commented that the approach gave states too much discretion in developing access measures, which could lead to ineffective monitoring and enforcement as well as challenges comparing access across states.

The 2015 Supreme Court decision in Armstrong v. Exceptional Child Center is particularly relevant to CMS' responsibility regarding 1902(a)(30)(A). In a 5-4 ruling, the Supreme Court said that Medicaid providers and beneficiaries do not have a private right of action to challenge Medicaid payment rates in federal courts. This means that legal challenges by providers and beneficiaries are unavailable in federal court to supplement CMS' oversight of 1902(a)(30)(A). The Armstrong decision also underscored HHS' and CMS' unique responsibility for resolving issues concerning the interpretation and implementation of 1902(a)(30)(A). By concluding that the responsible federal administrative agency (CMS) is better suited than federal courts to make determinations regarding the sufficiency of Medicaid payment rates, the Supreme Court's Armstrong decision placed added importance on CMS' administrative review of SPAs proposing to reduce or restructure FFS payment rates.

Although the 2015 rule was an effort by CMS to establish a more robust oversight and enforcement strategy regarding 1902(a)(30)(A), it now proposes to rescind and replace the AMRP requirements currently in §447.203(b)(1) through (8) with a streamlined and standardized process in proposed §447.203(b) and (c). These changes reflect lessons learned under the AMRP process and emphasize transparency and data analysis, with specific proposed requirements varying depending on various factors:

- The state's current payment levels relative to Medicare,
- The magnitude of the proposed rate reduction or restructuring, and
- Any access to care concerns raised to a state Medicaid agency by interested parties.

With these proposed provisions, CMS aims to balance federal and state administrative burden with the shared obligation to ensure compliance with 1902(a)(30)(A).

1. Fully Fee-For-Service States

At the same time this rule was released, CMS also released a proposed rule pertaining to managed care in Medicaid and CHIP.[19] That rule proposes timeliness standards at §438.68, which would not apply to states with a fully FFS delivery system. CMS is considering mirroring those timeliness standards to fully FFS states regarding its 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 services; primary care, adult and pediatric services; obstetrics and gynecology services; and any additional type of service determined by the state.

CMS seeks comment on whether additional access standards for states with a fully FFS delivery system may be appropriate and, if so, on a potentially appropriate method for CMS to collect data demonstrating that states meet the established standards at least 90 percent of the time.

2. FFS Payment Rate Transparency (§447.203(b))

a. Publication of FFS Payment Rates (§447.203(b)(1))

CMS proposes to rescind §447.203(b), with its requirements for AMRPs, in its entirety. In its place, the new proposed process would require states to publish their FFS Medicaid payment rates in a clearly accessible, public location on the state's website. For certain services, a state would be further required to conduct a comparative payment rate analysis between the state's Medicaid payment rates and Medicare rates, or provide a payment rate disclosure for certain HCBS that would permit CMS to develop and publish HCBS payment benchmark data.

The state Medicaid agency would be required to publish all Medicaid FFS payment rates on a website developed and maintained by the single state agency that is accessible to the general public. The website would need to be easily reached from a hyperlink on the state Medicaid agency's website. The FFS Medicaid payment rates would need to be organized so that a member of the public can readily determine the amount that Medicaid would pay and, in the case of a bundled or similar payment methodology, identify each service included in the rate and how much of the bundled payment is allocated to each constituent service under the state's methodology.[20]

The state must separately identify the Medicaid FFS payment rates if they vary by population (pediatric and adult), provider type, and geographical location, as applicable. For example, if a state's FFS payment rate for a Current Procedural Terminology (CPT) code is higher for children than for adults, the state must separately publish both numbers. If a state's FFS payment rate for a CPT code is higher for doctors than for nurse practitioners, the state must separately publish

[19] "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (88 FR 28092); https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

[20] CMS also notes that longstanding legal requirements to provide effective communication with individuals with disabilities and the obligation to take reasonable steps to provide meaningful access to individuals with limited English proficiency would also apply.

both numbers. While CMS acknowledges the additional burden associated with this granularity, CMS believes it is important for ensuring compliance with 1902(a)(30)(A).

As proposed, the initial publication of FFS rates must include those in effect on January 1, 2026,[21] and be published by January 1, 2026. This timeframe provides states with at least 2 years from the effective date.[22] The proposed timeframe would set a consistent baseline for all states to first publish their payment rate transparency information and then set a clear schedule for states to update their payment rates based on any payment rate changes. CMS encourages states to then use this publication in the proposed comparative payment rate analysis and disclosures described in the next section.

Regarding updates to the payment rates, the proposal would require the state agency to do the following:

- Include on its website the date the payment rates were last updated;
- Keep Medicaid FFS payment rates current by making updates 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; and
- If a payment rate change occurs in accordance with a previously approved rate methodology, update its payment rate transparency publication no later than 1 month after the effective date of the most recent update to the payment rate.[23]

CMS says these new transparency requirements would help ensure that interested parties have access to updated payment rate schedules and could conduct analyses informing how state Medicaid payment rates compare, for example, to Medicare and other states. **The agency seeks public comment** on the following:

- The proposed requirement 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 and updates.

b. Categories of Services of Comparative Rate Analysis and Disclosure (§447.203(b)(2))

The proposal would require states to develop and publish:

- (1) A comparative payment rate analysis of Medicaid FFS payment rates to Medicare's published payment rates for the following services—
    - Primary care services,
    - Obstetrical and gynecological services, and

[21] Thus, this excludes any rate changes for which a Medicaid state plan amendment (SPA) or similar amendment request is pending CMS review or approval.
[22] If the date when this regulation is finalized does not provide a full 2 years, then CMS would use an alternative date of July 1, 2026, for both the initial publication and the effective date of the rates—and would push the dates back in 6 month increments as necessary.
[23] This is intended to capture Medicaid FFS rate changes that occur because of previously approved SPAs containing payment rate methodologies—for example, if the Medicaid payment is based on a percentage of a Medicare payment that is updated.

    - Outpatient behavioral health services.
- (2) A payment rate disclosure of certain FFS HCBS payment rates—
    - Personal care services (§440.180(b)(4)),
    - Home health aide services (§440.180(b)(3)), and
    - Homemaker services (§440.180(b)(2)).

For both the comparative payment rate analysis and HCBS payment rate disclosure, if the rates vary by population (pediatric and adult), provider type, or geographical location, the state must separately identify the payment rates for each—similar to the payment rate transparency breakdowns described earlier. CMS says this would help ensure that the state's comparative payment rate analysis contains the highest level of granularity by accounting for these factors, as currently required in the AMRP process.[24] For example, Medicare pays non-physician practitioners (NPPs) such as nurse practitioners and physician assistants 85 percent of the full Medicare physician fee schedule (PFS) amount. The PFS also varies rates by location to reflect the variation in practice costs from one location to another. Thus, the comparative payment rate analysis accounting for these payment rate variations is crucial.

Regarding the comparative payment rate analysis, although there may be additional burden associated with this level of granularity, CMS believes that any approach requiring a comparative rate analysis would involve some level of burden that is greater for those states employing such payment rate differentials. Any mathematically reasonable approach would need to take these into account.

That level of granularity is also important for ensuring compliance with 1902(a)(30)(A). For example, multiple types of providers—physicians, nurse practitioners and physician assistants—are delivering similar services to Medicaid beneficiaries of all ages, across multiple Medicaid benefit categories, throughout every state. A targeted payment rate reduction to nurse practitioners, who are often paid less than 100 percent of the state's physician fee schedule rate, could have a negative impact on access to care for services provided by nurse practitioners without directly impacting physicians or their willingness to participate in Medicaid. By proposing that the comparative payment rate analysis include a breakdown by provider type, the analysis would capture this payment rate variation among providers of the same services and provide information to aid in determining if access to care is sufficient.

For the comparative rate analysis, CMS believes that the specific services proposed—primary care services, obstetrical and gynecological services, and outpatient behavioral health services—are critical preventive, routine and acute medical services that often serve as gateways to access to other needed medical services, including specialist services, laboratory and x-ray services, and prescription drugs. According to the recent key findings from public comments on the February 2022 RFI, payment rates are a key driver of provider participation in Medicaid. By proposing that states compare their Medicaid payment rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health services to Medicare payment rates, states would be required to analyze if and how their payments are consistent with 1902(a)(30)(A). In the rule, CMS elaborates further on each of these service types and why it chose them for the comparative rate analysis.

[24] CMS cites §447.203(b)(1)(iv) and (v), and (b)(3).

CMS seeks public comment on the proposal to require the comparative payment rate analysis of specific services—primary care services, obstetrical and gynecological services, and outpatient behavioral health services—and to include separate identification of payment rates by the characteristics described above. Public comment is also sought on any additional types of payment adjustments states make that should be identified in the comparative payment rate analysis and how the inclusion of any such additional adjustments or factors should be accounted for in the selection of the Medicare PFS rate to compare to Medicaid payment rates, as described below.

For the Medicaid HCBS payment rate disclosure, if those rates paid by the state vary between what is paid to individual providers versus those employed by an agency, those average hourly payment rates are also to be reported separately. No comparison to Medicare payment rates would be required, in recognition that Medicare generally does not cover these services—and when it does, Medicare's covered HCBS services are very limited and provided on a short-term basis. The services required for rate disclosure—homemaker, home health aide, and personal care services—are the ones for which CMS also proposed annual state reporting on access and payment adequacy metrics, as described earlier in section II.B. CMS restates its reasons for choosing those particular services—in short, because CMS expects them to be most commonly conducted in individuals' homes and general community settings and, therefore, constitute the vast majority of FFS payments for direct care workers delivering services under FFS.

Specifically, CMS proposes to require that states' Medicaid HCBS payment rate disclosure include average hourly payment rates, claims volume, and the number of Medicaid enrolled beneficiaries who received those services. This would be used to ensure compliance with 1902(a)(30)(A). CMS also cites its authority under section 2402 of the ACA to promulgate regulations ensuring that all states develop service systems so that there is an adequate number of qualified direct care workers to provide self-directed services.

CMS seeks 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 proposed payment rate disclosure requirements in proposed §447.203(b)(2)(iv).

c. Comparisons Between Existing AMRP Requirements and Proposed Requirements

CMS reviews how the triennial AMRP requirements, which would be eliminated under this proposal, compare to the proposed comparative payment rate analysis and payment rate disclosure requirements.

Primary care services. Under AMRPs, states are required to provide a separate analysis for each provider type and site of service for primary care services (including those provided by a physician, FQHC, clinic, or dental care provider). The proposed comparative rate analysis would include primary care services but without the preceding parenthetical list, because the analysis is at the CPT or Healthcare Common Procedure Coding System (HCPCS) code level, as described

later, and thus requires less sub-categorization of the data analysis. In addition, the proposed analysis would exclude FQHCs and clinics.

Inpatient behavioral health services. The current AMRP process includes behavioral health services (including mental health and substance use disorder), while the proposed comparative payment rate analysis would include only outpatient behavioral health services. CMS seeks to narrow the scope of the analysis by excluding inpatient behavioral health services.[25] This focuses the analysis on ambulatory care provided by practitioners in an office-based setting, without duplicating existing requirements—for example, for upper payment limits (UPL) and the supplemental payment reporting requirements under section 1903(bb) of the Act.[26]

In general, the proposed categories of services in this rule are delivered as ambulatory care where the patient does not need to be hospitalized to receive the service, focusing on evaluation and management (E/M) CPT and HCPCS codes. Thus, the analysis would encompass a broad range of core services that would cover a variety of commonly provided services within the proposed service categories. The proposal excludes facility-based services. This is because such services are often paid using prospective payment rate methodologies, such as Diagnosis Related Groups (DRGs), or interim payment methodologies that are reconciled to actual cost that would complicate comparisons. Regarding inpatient hospital services, including inpatient behavioral health services, CMS reviews existing UPL and supplemental payment reporting requirements, which can include comparisons to Medicare and would thus be duplicative if such comparisons were required in this proposed rule. Nevertheless, such services are required as part of this rule's previously discussed transparency proposal. **CMS seeks public comment** on not including inpatient behavioral health services as one of the categories of services subject to the comparative payment rate analysis requirements.

Obstetrical and gynecological services. Pre- and post-natal obstetric services including labor and delivery, as required in AMRPs, would be required in the comparative payment rate analysis, but broadened to include both obstetrical and gynecological services.

Home health services. Home health services are included in the AMRP process, as in the proposed rule. The proposal has refinements to help ensure a more standardized effort to monitor access across Medicaid delivery systems. These reflect public comments received in response to the February 2022 RFI, in which many commenters indicated that direct care workers receive low payment rates and, for agency-employed direct care workers, home health agencies often cite low Medicaid payment as a barrier to raising workers' wages. Commenters suggested that states should be collecting and reporting to CMS the average of direct care worker wages while emphasizing the importance of data transparency and timeliness. CMS is responding by proposing to require states to publish a payment rate disclosure that collects and reports the average hourly rate paid to individual providers and providers employed by an agency for services provided by certain direct care workers (personal care, home health aide, and homemaker services).

[25] Inpatient behavioral health services include those furnished in psychiatric residential treatment facilities, institutions for mental diseases (IMDs), and psychiatric hospitals.
[26] This requirement was established in section 202 in Division CC, Title II, of the Consolidated Appropriations Act, 2021 (CAA) (P.L. 116-260).

Pediatric population. Within AMRPs, states are required to consider the characteristics of the beneficiary population, including "payment variations for pediatric and adult populations." The proposed rule continues to include separate consideration for pediatric populations, as described earlier.

AMRP requirements eliminated without replacement. CMS proposes to eliminate a few items from the current AMRP process without replacement in the comparative payment rate analysis requirement, including the following:

- 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; and
- Additional types of services selected by the state.

d. Required Content of FFS Comparative Payment Rate Analysis and HCBS Payment Rate Disclosure (§447.203(b)(3))

Under the proposal, states must develop and publish, consistent with the publication requirements for payment rate transparency data summarized in section II.C.2.a., a comparative FFS payment rate analysis ("analysis") and a FFS HCBS payment rate disclosure ("disclosure") for the aforementioned service categories.

Comparative payment rate analysis (§447.203(b)(3)(i). To provide an understanding of how Medicaid payment rates compare to those in FFS Medicare, the 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, on a code-by-code basis. Subregulatory guidance would also list the codes to be used in the analysis. Although not specified in the proposed regulatory text, CMS says the criteria for selecting codes would be as follows:

- 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.
- 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[27] for the same time period of the comparative payment rate analysis.

Based on the categories of services specified in proposed §447.203(b)(2)(i) through (iii), CMS expects the selected E/M CPT/HCPCS codes to fall under mandatory Medicaid benefit categories and that all states would cover and pay for the selected E/M CPT/HCPCS codes. CMS

[27] A code satisfying this criterion does not mean that Medicare covers the code. Even if Medicare has no coverage of such codes, Medicare may still establish RVUs and payment amounts.

intends to publish the initial and subsequent updates of codes so that states have approximately one full calendar year before the analysis' due date.

CMS acknowledges limitations in relying on particular E/M CPT/HCPCS codes for purposes of 1902(a)(30)(A). Although they do not encompass all services subject to 1902(a)(30)(A), E/M CPT/HCPCS codes are some of the most commonly billed codes; including them in the comparative payment rate analysis would allow CMS to uniformly compare Medicaid payment rates for these codes to Medicare PFS rates. They were also selected to balance administrative burden on states and CMS.

CMS seeks public comment on the following proposals:

- The requirement to conduct the analysis at the CPT/HCPCS code level,
- Criteria in selecting E/M CPT/HCPCS codes for inclusion in the required analysis, and
- The requirement for states to compare Medicaid payment rates for the selected E/M CPT/HCPCS codes to the most recently published Medicare non-facility PFS payment rate effective for the same time period.

In addition to being broken down by the particular categories of services, populations (pediatric versus adult), provider types and geographic locations (as applicable), the proposal would also have the following requirements on states' comparative payment rate analysis:

- Clearly identify the Medicaid base payment rates for each E/M CPT/HCPCS code;
- Clearly identify the Medicare PFS non-facility payment rates 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;
- Specify each applicable Medicaid payment rate as a percentage of the Medicare payment rate; and
- Specify the number of Medicaid-paid claims within a calendar year for each of the services.

CMS seeks public comment on the foregoing proposed requirements and content, including the requirement for states to break out their payment rates at the CPT/HCPCS code level separately for primary care services, obstetrical and gynecological services, and outpatient behavioral health services.

Regarding the required base payment rates, CMS notes that states' Medicaid base payment rates are typically determined through one of three methods: the resource-based relative value scale (RBRVS), a percentage of Medicare's payment rates, or a state-developed fee schedule using local factors. The agency acknowledges that only including Medicaid base payments in the analysis does not necessarily represent all of a provider's revenues for furnishing these services to Medicaid beneficiaries; other revenues not included in the proposed comparative analysis that may be relevant to a provider's willingness to participate in Medicaid include beneficiary cost sharing payments, disproportionate share hospital (DSH) payments for qualifying hospitals, and other supplemental payments. Commenters to the AMRP rule expressed differing views on whether to include such payments for comparisons between Medicare and Medicaid rates. This proposed rule 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. In other words, CMS is *not* proposing to include supplemental payments in the comparative payment rate analysis, which it says would be duplicative of existing requirements.

Regarding the required comparisons to Medicare payment rates, CMS states that it is not proposing to establish a threshold percentage of Medicare non-facility payment rates that states would be required to meet, but would use the Medicare rates as a benchmark to which states would compare their Medicaid payment rates. These comparisons would inform states' and CMS' assessments of whether the Medicaid payment rates are compliant with 1902(a)(30)(A). The accessibility and consistency of the Medicare PFS rates, compared to negotiated private health insurance payment rates that typically are considered proprietary information and therefore not generally available, makes Medicare's rates an available and reliable comparison point. Additionally, Medicare is widely accepted nationwide; in 2019, 95 percent of physicians accepted new patients overall, and 89 percent of office-based physicians were accepting new Medicare patients, according to recent findings from the National Electronic Health Records Survey. CMS provides specialty-specific findings.

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 in the comparative payment rate analysis requirements in proposed §447.203(b)(3)(i) to help assess—consistent with 1902(a)(30)(A).

CMS explains why it excludes providers' facility-based payments, which are often based on encounter rates that reflect reimbursement for total facility specific costs divided by the number of encounters, regardless of which specific services were provided. Such encounter payments can occur in hospitals, FQHCs, rural health clinics (RHCs), and other clinics. Proposing that states demonstrate economy and efficiency of their encounter rates would be an entirely different exercise to the fee schedule rate comparison proposed in this rule, according to CMS, because encounter rates are often based on costs unique to the provider, and states often require providers to submit cost reports for review to support payment of the encounter rate. Comparing cost between the Medicaid and Medicare programs would require a different methodology, policies and oversight than what is proposed here due to the differences within and between each program. As such, CMS believes the Medicaid fee schedule best represents the payment intended to pay physicians and non-physician practitioners for delivery of individual services in an office—that is, non-facility—setting, and the Medicare *non-facility* payment rate as listed on the Medicare PFS represents the best equivalent to that amount and consideration.[28]

Regarding the requirement that states report each applicable Medicaid payment rate as a percentage of the Medicare payment rate, CMS proposes that this pertain to each Medicaid base payment rate as a percentage of the corresponding Medicare non-facility payment rate effective for the same period of time. This information would give CMS a great deal of actionable information about access in the state to ensure consistency with 1902(a)(30)(A). For example, CMS could identify when and how the Medicaid base payment rate as a percentage of the

[28] Medicare non-facility payment rates can be obtained from CMS' Physician Fee Schedule Look-Up Tool (under the "Non-Facility Price" header) or, for codes not available there, Excel file downloads of the Medicare PFS Relative Value Files.

Medicare non-facility payment rate for E/M CPT/HCPCS codes for primary care services may decrease over time if Medicare adjusts its rates, while the state does not change its rates. CMS seeks comment on this particular requirement and on any challenges states might encounter when comparing their Medicaid payment rates to Medicare, particularly for any of the proposed categories of service, as well as suggestions for an alternative comparative analysis that might be more helpful, or less burdensome and equally helpful for purposes of 1902(a)(30)(A).

Although CMS cites multiple studies that found a direct, positive association between Medicaid payment rates and provider participation, it is also aware of access issues due to causes besides payment rates. For example, even if Medicaid rates are consistent with Medicare, Medicaid beneficiaries may have difficulty scheduling behavioral health care appointments because the overall number of behavioral health providers within a state is insufficient to meet the demand. Thus, a state's rates may be consistent with 1902(a)(30)(A) even when access concerns exist; states and CMS may need to examine other strategies to improve access to care beyond payment rate increases.

Regarding the final elements in proposed §447.203(b)(3)(i)—requiring states' analysis to specify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received each of the specified services—a claim would be counted for a particular calendar year when that beneficiary had a claim submitted on their behalf by a provider who billed one of the codes from the list of CMS-identified E/M CPT/HCPCS code(s) and the state *paid* the claim. This would provide insights into the Medicaid-paid claims volume of each CMS-identified E/M CPT/HCPCS code. With this proposal, CMS seeks to ensure the comparative payment rate analysis reflects actual services received by beneficiaries and paid for by the state—that is, realized access. For example, a decrease in the number of Medicaid-paid claims for primary care services (when the number of Medicaid-enrolled beneficiaries who received primary care services in the area is constant or increasing) could be an indication of an access to care issue. **CMS is seeking public comment** on the proposed requirement for states to include in their analysis the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received each CMS-identified E/M services.

An alternative CMS considered but did not propose was that states identify the number of *unique* Medicaid-paid claims and the number of *unique* Medicaid-enrolled beneficiaries who received a service. The agency presents an example of a beneficiary who has 6 visits to their primary care provider in a calendar year and the provider bills 6 claims with 99202 for that same beneficiary. CMS said this would lead to the beneficiary and claims for 99202 being counted as only one claim and one beneficiary. It chose not to propose this approach because the intent is for the comparative payment rate analysis to capture the total amount of actual services received by beneficiaries and paid for by the state. **CMS is seeking public comment** regarding its decision not to propose that states identify the number of unique Medicaid-paid claims and the number of unique Medicaid enrolled beneficiaries who received the service.

While the AMRP process required using payment rates from private payers, as well, it was challenging for states to obtain and, if obtained, to use this information for a number of reasons that CMS discusses. Based on its implementation experience and concerns from states about the

AMRP requirement to obtain private payer data, CMS proposes to require states to compare their Medicaid payment rates only to Medicare's.

HCBS Payment Rate Disclosure (§447.203(b)(3)(ii)). As previously mentioned, for homemaker, home health aide, and personal care services, CMS proposes that states publish a payment rate disclosure expressing 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). Given the previously mentioned limitations on other payers' coverage and availability of any such payment rates for these HCBS, as well as Medicaid's status as the most important payer for HCBS, CMS believes that scrutiny of Medicaid HCBS payment rates themselves, rather than a comparison to other payer rates that frequently do not exist, is most important. Such information will help ascertain whether such Medicaid payment rates satisfy 1902(a)(30)(A) and enable comparisons across states.

Specifically, the rate disclosure would be required to meet the following:

- Be organized separately for each category of service—homemaker, home health aide, and personal care services;
- Identify the average hourly payment rates, including separate identification (if the rates vary) of the average hourly payment rates for payments made to individual providers and to providers employed by an agency;
- Separately identify the rates by population (pediatric and adult), provider type, and geographical location, as applicable; and
- Quantify 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.

CMS seeks public comment on the proposed requirements on the HCBS disclosure. As with the comparative rate analysis, CMS seeks comment on its decision not to require states to provide information on the unique numbers of Medicaid-paid claims and beneficiaries receiving the specific services.

e. Biennial Publication Requirement (§447.203(b)(4))

As proposed, both the initial comparative payment rate analysis and the payment rate disclosure must be published no later than January 1, 2026, for rates in effect as of January 1, *2025*. They must be published at least every two years, by no later than January 1 of the second year following the most recent update.

As an example, the 2025 Medicare PFS final rule would be published in November 2024 and the Medicare non-facility payment rates as listed on the Medicare PFS would be effective January 1, 2025. Thus, states would compare their Medicaid payment rates effective as of January 1, 2025, to the Medicare PFS payment rates effective January 1, 2025, when submitting the initial comparative payment rate analysis that is due on January 1, 2026.

CMS considered proposing the same due date and effective time period for the comparative analysis—thus, it would have been due January 1, 2026, and would contain payment rates effective January 1, 2026. However, a two-month time period between Medicare publishing its

PFS payment rates in November and the PFS payment rates taking effect on January 1 was deemed an insufficient amount of time for CMS to publish the list of E/M CPT/HCPCS codes subject to the analysis and for states to develop and publish their analyses by January 1. While the proposed HCBS payment rate disclosure does not require a comparison to Medicare, CMS seeks to keep the dates consistent.

As proposed, states would have the CMS-published list of E/M CPT/HCPCS codes and Medicare non-facility payment rates as listed on the Medicare PFS available for approximately one full calendar year before the due date of their comparative payment rate analyses. CMS believes this provides sufficient time for states to gather necessary data and publish the first required comparative payment rate analysis and payment rate disclosure. The agency reviews its lessons learned from AMRPs[29] and other reasons for deriving its proposed timeline.

CMS says this proposed rule strives to reduce the amount of administrative burden from AMRPs on states while also fulfilling its oversight responsibilities regarding 1902(a)(30)(A). It believes updating the comparative payment rate analysis and the payment rate disclosure every 2 years achieves an appropriate balance between administrative burden and oversight responsibilities. The availability of this data could be used to inform state policy changes, to compare payment rates across states, or for research on Medicaid payment rates and policies.

The proposed requirement for payment rate transparency data would also apply for the analysis and disclosure. For example, the analysis and disclosure would have to be published on the website developed and maintained by the Medicaid state agency, to be accessible to the general public.

CMS is seeking public comment on the proposed timeframe and publication requirements for the initial publication and biennial update requirements for the comparative payment rate analysis and payment rate disclosure.

f. Deferral of Federal Medicaid Match for Noncompliance (§447.203(b)(5))

If a state fails to comply with the requirements for (1) payment rate transparency, (2) comparative payment rate analysis, or (3) payment rate disclosure, including requirements for the time and manner of publication, future grant awards for federal Medicaid matching funds may be reduced. The reduction in Medicaid federal financial participation (FFP) would be the CMS estimate attributable to the state's administrative expenditures for the categories of services for which the state has failed to comply. That reduction would continue until the state complies with all applicable requirements. Unless prohibited by law, FFP for those deferred expenditures would be released after the state has fully complied with all applicable requirements.[30]

This enforcement mechanism is similar to that for DSH reporting requirements in §447.299(e), which specifies that state failure to comply with reporting requirements will lead to future grant

[29] AMRPs were required triennially but have more required information and originally had a shorter timeline for development.

[30] The regulatory language says that, for a state out of compliance, CMS *may* reduce its future grant awards, but once the state is in compliance, CMS *will* release the deferred FFP, unless otherwise prohibited by law.

award reductions in the amount of FFP CMS estimates is attributable to expenditures made for payments to the DSH hospitals for which the state has not reported properly. CMS proposes this long-standing and effective enforcement mechanism because it believes it is proportionate and clear, and to remain consistent with other compliance actions it takes for state noncompliance with statutory and regulatory requirements. **CMS is seeking public comment** on this proposed method for ensuring compliance with the payment rate transparency, comparative payment rate analysis, and payment rate disclosure requirements.

g. Medicaid Payment Rate Interested Parties' Advisory Group (§447.203(b)(6))

While a robust workforce providing HCBS allows more beneficiaries to obtain necessary services in home and community-based settings, CMS cites MACPAC that the HCBS direct care workforce is currently experiencing notable worker shortages. In light of this shortage, combined with CMS' statutory mandate under section 2402(a) of the ACA, the agency proposes 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 for personal care, home health aide, and homemaker services. These are the minimum services for the advisory group to consider; states may choose to include other HCBS. The proposed broad definition of direct care workers, describer earlier (section II.B.5.), would apply here as well, by cross-reference to proposed §441.302(k)(1)(ii).

The interested parties' advisory group would consult on those rates, regardless of whether they are under the Medicaid state plan,[31] a section 1915(c) waiver, or section 1115 demonstration programs. It would be required to include direct care workers, beneficiaries and their authorized representatives,[32] and other interested parties. If it meets the requirements of this proposal, a state's MAC (section II.A.) could be used for this purpose.

As proposed, the interested parties' advisory group would advise and consult with the Medicaid agency on the following:

- Current and proposed payment rates,
- HCBS payment adequacy data (required at §441.311(e)), and
- Access to care metrics (§441.311(d)(2)) for personal care, home health aide, and homemaker services.

The group's purpose would be 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.

CMS proposes to require that the interested parties advisory group would meet at least every 2 years and make recommendations to the Medicaid agency on the sufficiency of direct care worker payment rates. The state agency would be required to ensure the group has access to

[31] For example, under sections 1905(a), 1915(i), 1915(j) and 1915(k) State plan authorities.
[32] "Authorized representatives" refers to individuals authorized to act on the behalf of the beneficiary. "Other interested parties" may include beneficiary family members and advocacy organizations.

current and proposed payment rates, HCBS provider payment adequacy minimum performance and reporting standards (§441.311(e)), and applicable access to care metrics for HCBS (§441.311(d)(2)) to produce these recommendations.[33]

The interested parties' advisory group would make recommendations to the Medicaid agency on the sufficiency of the established and proposed rates. In other words, based on the group's knowledge and experience, are current payment rates adequate to enlist a sufficiently large workforce to ensure beneficiary access, and whether a proposed rate change would be consistent with a sufficiently large workforce or would disincentivize participation in a way that might compromise beneficiary access?

Although CMS does not specify the process for selecting the group, it proposes that the process used by the state to select members and convene its meetings must be made publicly available. The Medicaid agency would be required to publish the group's recommendations within 1 month of when the group provides the recommendation to the agency and meet the same proposed requirements previously described for payment rate transparency data (§447.203(b)(1); section II.C.2.a.)—for example, to be clearly accessible through the state agency's website.

States can consider but would not be required to adopt the group's recommendations; the work of the advisory group would be regarded as an element of the state's overall rate-setting process. The group's feedback would not be required for rate changes; if a state seeks to adjust rates and it is not feasible to obtain a recommendation from the advisory group, the state would still be permitted to submit its rate change SPA to CMS. However, to the extent the group comments on proposed rate changes, its feedback would be considered part of the interested parties input described in proposed §§447.203(c)(4) and 447.204(b)(3), which states would be required to consider, analyze, and submit to CMS in connection with any SPA submission that proposes to reduce or restructure Medicaid service payment rates.

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

3. State Analysis Procedures for Rate Reduction or Restructuring (§447.203(c))

Because CMS' oversight role regarding 1902(a)(30)(A) is particularly important when states propose to reduce provider payment rates or restructure provider payments, the agency proposes a process for state access analysis whenever a state submits a SPA proposing to reduce provider payment rates or restructure provider payments. In such a case, under current regulations per the 2015 final rule, states are required to submit a detailed analysis of access to care (§§447.203(b)(1) and (b)(6) and 447.204(b)(1)). Many states found this to be overly

[33] Although this is not in the regulatory text, CMS says in the preamble that these materials would be required to be available with sufficient time for the group to consider them, formulate recommendations, and transmit those recommendations to the state—or if the state has asked the group to consider a proposed rate change, it would need to provide the group with sufficient time to review and produce a recommendation within the state's intended rate adjustment schedule. CMS contends this would be necessary because the group's recommendation would be part of the interested parties input described in proposed §§447.203(c)(4) and 447.204(b)(3), which states would be required to consider and analyze.

burdensome, and CMS agreed, proposing changes in 2018 and 2019 that were not finalized, including a proposed rescission of the AMRP process. CMS now says the 2018 and 2019 proposed rules did not adequately consider the agency's need for information and analysis from states seeking to reduce provider payment rates or restructure provider payments.

This proposed rule would establish standard information for states to submit with any proposed rate reductions or payment restructurings if the changes could result in diminished access. A streamlined set of data would be required in the following circumstances, which CMS says create a reasonable presumption that proposed reductions or restructuring would not reduce beneficiary access to care in a manner inconsistent with 1902(a)(30)(A):

- The state rates are above a certain percentage of Medicare payment rates,
- The reductions or restructurings are nominal, and
- There are no evident access concerns raised through public processes.

An additional set of data elements would be required when these criteria are not met.

For both sets, CMS proposes to standardize the data and information states would be required to submit with rate reduction or restructuring SPAs—information similar to that provided through the AMRP process but reducing state burden.

a. Initial (Streamlined) State Analysis for Rate Reduction or Restructuring (§447.203(c)(1))

When states submit a rate reduction or restructuring SPA that satisfies the three criteria above, they must accompany that SPA with written assurances and relevant supporting documentation that those criteria are met as well as a description of the state's procedures for monitoring continued compliance with 1902(a)(30)(A). The format for submission would be prescribed by CMS as a condition of approval.

The proposed regulatory text further defines the 3 criteria, respectively:

- Medicaid payment rates in the aggregate (including base and supplemental payments[34]) following the proposed reduction or restructuring for each benefit category affected would be no less than 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services.
- The proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the current state fiscal year, would likely result in no more than a 4 percent reduction in aggregate fee-for-service Medicaid expenditures for each affected benefit category.
- The public processes proposed in §447.203(c)(4), described below, and current §447.204 yielded no significant access concerns from beneficiaries, providers, or other interested parties regarding the affected service(s)—or if such processes did yield concerns, the state can reasonably respond to or mitigate the concerns, as documented in the analysis provided by the state pursuant to current §447.204(b)(3).

[34] The statutory definition of supplemental payments in section 1903(bb)(2) of the Act, which CMS relies on here, excludes DSH payments.

CMS believes these thresholds would likely satisfy 1902(a)(30)(A). However, even if these criteria are met, the agency may still need to request additional information to ensure all federal SPA requirements are met; meeting the three criteria does not guarantee the SPA would be approved if other requirements are not met.

CMS walks through the detail of the calculations for each of the 3 criteria, the rationales for and some of the research behind their selection, and alternatives considered. **The agency seeks comment** on the criteria, their calculation, and whether additional information should be required.

Following are some important nuances regarding these 3 criteria. Regarding the 80 percent of Medicare threshold, when an affected Medicaid benefit does not have a reasonably comparable Medicare-covered analogue, the state will need to use the expanded review because it is unable to demonstrate that this criterion was satisfied. Even when an exact analogue does not exist, it may be possible to use a comparable set of services that bear a reasonable relationship to each other. For example, even though Medicare does not have a clinic benefit directly analogous to Medicaid, a state could reasonably include Medicare payment rates for practitioner services that bear a reasonable similarity to clinic services, potentially including those provided in ambulatory surgical centers (ASCs).

Regarding the 4 percent Medicaid FFS reduction threshold, this test would be against the *cumulative* percentage of rate reductions or restructurings for a particular benefit category within each state fiscal year—rather than a SPA-specific application—to avoid circumstances where a state could submit multiple SPAs in order to pass this test and avoid providing additional analyses. Since effectively putting this threshold in place in a 2017 SMDL (#17-004), only 21 out of 849 SPAs approved in 2019 sought to reduce payments by more than 4 percent:

- 16 fell into an area described in the SMDL as being unlikely to result in diminished access and thus did not require an AMRP with the SPA;
    - 6 were rate freezes to continue a prior year's rates or eliminating an inflation adjustment;
    - 6 were payment reductions to comply with federal requirements (e.g., Medicaid upper payment limits (UPLs));
    - 4 were from broader programmatic changes (e.g., elimination of a benefit); and
- 5 had required AMRPs, potentially analogous to the number that may be required to submit additional analysis under the proposal, based on this criterion.

Regarding addressing significant access concerns from public processes, CMS says that the state's response to any such access concern and any mitigation approach, as appropriate, would be expected to be fully described in the state's submission to CMS. The agency notes that, under its proposal, state response is required to access complaints for circumstances—that is, in the context of rate reduction or restructuring SPAs—that are much narrowed than under the AMRP requirements.

Proposed §447.203(c)(1) does not list specific exemptions for situations that were listed in SMDL #17-004 where CMS did not expect payment rate reductions to diminish access.[35] **CMS requests comment** on whether this list should be included and, if any of those circumstances applies, if the state should qualify for the streamlined analysis process regardless of the 3 proposed criteria.

b. Additional State Rate Analysis for Rate Reduction or Restructuring (§447.203(c)(2))

If any criterion in the first tier is not met, the state would be required to conduct a more extensive access analysis. This would be in addition to the results of the analysis in the first tier. This more rigorous access analysis would be required because CMS believes that where the state is unable to demonstrate the preceding 3 criteria are met, more scrutiny is needed to ensure that the proposed payment rates and structure would be sufficient to enlist enough providers so that covered services would be available to beneficiaries at least to the same extent as to the general population in the geographic area (§1902(a)(30)(A)).

In this case, states would have to document current and recent historical levels of access to care, including a demonstration of counts and trends of actively participating providers, counts and trends of FFS Medicaid beneficiaries who receive the services, as well as service utilization trends—all for the 3-year period immediately preceding the submission date of the SPA. As with the current AMRP process, the information provided by the state would serve as a baseline of understanding current access to care within the state's program, from which the state's payment rate reduction or payment restructuring proposal would be scrutinized.

For similar situations, CMS acknowledges that the AMRP process resulted in often very long and complex documents that could include data not necessarily useful for understanding beneficiary access or for making administrative decisions about SPAs. CMS says this was driven partly by the flexibility provided to states that led to their uncertainty about what data to provide in order to obtain CMS approval. In addition, states were required to consult with the state's medical advisory committees and publish the draft AMRP for at least 30 days for public review and comment.

CMS proposes to maintain a number of the currently required data elements from the AMRP but to be more precise about the type of information required. CMS calls this a rigorous analysis but one that is only required when not meeting the criteria for streamlined analysis. CMS suggests this is less administrative burden than the ongoing triennial AMRP, particularly where CMS did not provide states with the specific direction on its preferred types of data elements.

To better balance ongoing state and federal administrative burden with its need to obtain access-related information to inform its approval decisions for payment rate reduction or restructuring SPAs, CMS proposes to end the ongoing AMRP requirement but maintain a requirement that

[35] That is, reductions necessary to implement CMS federal Medicaid payment requirements; reductions that will be implemented as a decrease to all codes within a service category or targeted to certain codes, but for services where the payment rates continue to be at or above Medicare and/or average commercial rates; and reductions that result from changes implemented through the Medicare program, where a state's service payment methodology adheres to the Medicare methodology.

states include similar data elements when submitting such SPAs that do not qualify for the proposed streamlined analysis process. The description of those 6 elements follows.

Summary and reason for change. For the additional state rate analysis, states would be required to provide to CMS 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. This includes the cumulative effect of all reductions or restructurings taken throughout the current state fiscal year in aggregate FFS Medicaid expenditures for each affected benefit category within a state fiscal year.

CMS requests comment as to whether a summary and explanation of the reason for change should also be required under the streamlined review.

Aggregate payment rates before and after change. For the additional state rate analysis, states would be required to provide to CMS the Medicaid payment rates in the aggregate (including base and supplemental payments) before and after the proposed change for each affected benefit category. In addition, the state would have to provide a comparison of each (that is, 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. As reasonably feasible, states would also be required to do the same comparison 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.

This is similar to a current AMRP requirement (§447.203(b)(1)(v)) but with some updates based on state feedback. First, because states struggled to obtain private payer data, this proposal focuses on more readily available Medicare payment data. Second, because states were confused about how to compare Medicare and Medicaid rates when there were no comparable services, CMS notes that the previously described E/M CPT/HCPCS code comparison methodology can serve as a framework. Where comparable services exist, states would be required to compare all applicable Medicaid payment rates within the benefit category to the Medicare rates for the same or comparable services.

Provider participation. For the additional state rate analysis, states would be required to provide to CMS information about the number of actively participating providers of services in each affected benefit category. For this purpose, an actively participating provider is a provider that is participating in Medicaid and actively seeing and providing services to Medicaid beneficiaries or accepting Medicaid beneficiaries as new patients. The state would provide the number of actively participating providers of services in each affected benefit category for each of the 3 years immediately preceding the SPA submission date, by state-specified geographic area (for example, by county or parish), provider type, and site of service. The State would be required to document observed trends in the number of actively participating providers in each geographic area over this period. The state may also provide estimates of the anticipated effect on the number of actively participating providers of services in each affected benefit category, by geographic area.

Here and elsewhere, 3 years is proposed as the timeframe for data elements. CMS says this is so statistical anomalies can be smoothed and data variations can be understood, but **CMS seeks public comment** on this.

Affected beneficiaries. For the additional state rate analysis, states would also be required to provide to CMS information about the number of Medicaid beneficiaries receiving services through FFS in each affected benefit category. The state would provide the number of beneficiaries receiving services in each affected benefit category for each of the 3 years preceding the SPA submission date, by state-specified geographic area (for example, by county or parish). The state must also document observed trends in the number of Medicaid beneficiaries receiving services in each affected benefit category in each geographic area over this period.

In addition, the state would have to provide quantitative and qualitative information about the beneficiary populations receiving services in the affected benefit categories over this period, including the number and proportion of beneficiaries who are adults and children and who are living with disabilities, and a description of the state's consideration of how the proposed changes may affect access and service delivery for beneficiaries in various populations. The State would have to provide estimates of the anticipated effect on the number of Medicaid beneficiaries receiving services through FFS in each affected benefit category, by geographic area.

Service utilization. For the additional state rate analysis, states would also be required to provide to CMS information about the number of Medicaid services furnished through FFS in each affected benefit category for each of the 3 years immediately preceding the SPA submission date, by state-specified geographic area, provider type, and site of service. The state must also document observed trends in the number of Medicaid services furnished in each affected benefit category in each geographic area over this period, along with quantitative and qualitative information about the Medicaid services furnished in the affected benefit categories over this period. This would include the number and proportion of Medicaid services furnished to adults and children and who are living with disabilities, and a description of the state's consideration of the how the proposed payment changes may affect access to care and service delivery. The state would be required to provide estimates of the anticipated effect on the number of Medicaid services furnished through FFS in each affected benefit category, by geographic area.

Access concerns. For the additional state rate analysis, states would also be required to provide to CMS 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.

c. Compliance with Requirements and Mechanisms for State Analysis for Rate Reduction or Restructuring (§447.203(c)(3)-(5))

As proposed, if a state submits a SPA that proposes to reduce provider payments or restructure provider payments that fails to provide the required information and analysis, it may be subject to SPA disapproval under §430.15(c). If a state submits relevant information but there are

unresolved access concerns related to the proposed SPA, including any raised by CMS in its review or through the public process in proposed §447.203(c)(4) or existing §447.204(a)(2), it may also be subject to SPA disapproval. Disapproval means 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.

After approval of a proposed rate reduction or restructuring, if state monitoring 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 that suggests possible noncompliance with 1902(a)(30)(A), CMS may take a compliance action using the procedures described in §430.35.

CMS proposes to move the current §447.203(b)(7) to §447.203(c)(4), with no changes proposed to that public process. In short, this requires states to have ongoing mechanisms for beneficiary and provider input on access issues, respond promptly to such input, and maintain a record of such input and the state's response, available to CMS upon request. The agency also proposes to move current §447.203(b)(8) to §447.203(c)(5), with no changes to the methods for addressing access questions and remediation of inadequate access to care, and to move current §447.204(d) to proposed §447.203(c)(6), with no changes regarding compliance actions and remedies for an access deficiency.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), CMS is required to provide 60-day notice in the Federal Register and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. The proposed rule includes 37 tables showing the CMS estimates of its potential information collection requirements (ICRs) related to this rule, if finalized. The burden estimates monetize the expected beneficiary costs and labor costs, applying estimated federal matching percentages when FFP is available to states. The estimates reflect net costs—for example, savings from deleting AMRP requirements, even though those savings are partially offset by CMS' proposed access monitoring replacement in proposed §447.203(b).

The combined annual burden estimate for all of the provisions of this proposed rule is shown in Table 37 (88 FR 28064) on the last row. The total annual burden for beneficiaries is estimated at $0.5 million, largely from beneficiary responses needed for the updated HCBS Quality Measure Set. Total labor costs are estimated at $279 million, with the state share estimated at $82 million. The vast majority of these state share costs are for the HCBS provisions. The costliest item, in terms of burden, is for the creation of HCBS incident management systems described in section II.B.3., with $62 million in one-time costs and $12 million in ongoing costs.

IV. Regulatory Impact Analysis

CMS is unable to quantify the benefits of this rule. The costs are summarized here according to the 5-year projections (2024-2028) of the major sections, although the rule provides annual breakdowns by specific policy.

Table 38 of the rule shows the 5-year costs of the MAC and BAG policy changes at $3.275 million. The 5-year costs of the HCBS policies total $267.18 million, of which $137.01 million is for the HCBS Incident Management System and $106.03 million for HCBS payment adequacy (Table 39). The group bearing the largest amount of the HCBS costs is the providers ($109.73), followed by the federal and state governments ($74.54 million each) and managed care entities ($7.35 million) (Table 40). The FFS Medicaid access provisions proposed in §447.203 are projected to save, on net, $0.267 million over 5 years (Table 41). While the new access requirements are projected to cost $2.733 million, that is more than offset by the $3 million saved from ending current AMRP requirements.