| **Summary** |
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| This final rule takes 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. These improvements increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care.**Effective Date: July 9, 2024****Ensuring Access to Medicaid Services Final Rule (CMS-2442-F)****Provisions and Relevant Timing Information and Dates\***

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| **Regulation Section(s) in Title 42 of the CFR** | **Applicability Dates** |
| Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC) § 431.12 | Establishment of MAC and BAC: 1 year after the effective date of the final rule.BAC crossover on MAC: For the period from the effective date of the final rule through 1 year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.Annual report: states have 2 years from the effective date of the final rule to finalize the first annual report. After the report has been finalized, states will have 30 days to post the annual report. |
| Person-Centered Service Plans §§ 441.301(c)(1) and (3), 441.450(c), 441.540(c), and 441.725(c) | Beginning 3 years after the effective date of the final rule.\*\*\* |
| Grievance Systems §§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii) | Beginning 2 years after the effective date of the final rule. |
| Incident Management System §§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), and (b)(1)(i) | Beginning 3 years after the effective date of the final rule\*\*\*; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins 5 years after the effective date of the final rule.\*\*\* |
| HCBS Payment Adequacy §§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi) | Beginning 6 years after the effective date of the final rule.\*\*\* |
| Reporting Requirements §§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii) | Beginning 3 years after the effective date of the final rule\*\*\* for § 441.311(b) (compliance reporting) and § 441.311(d) (access reporting).Beginning 4 years after the effective date of the final rule\*\*\* for § 441.311(c) (reporting on the HCBS Quality Measure Set) and (e) (HCBS payment adequacy reporting). |
| HCBS Quality Measure Set §§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v) | HHS Secretary begins identifying quality measures no later than December 31, 2026, and no more frequently than every other year.HHS Secretary shall make technical updates and corrections to the HCBS Quality Measure Set annually as appropriate. |
| Website Transparency §§ 441.313, 441.486, 441.595, and 441.750 | Beginning 3 years after the effective date of the final rule.\*\*\* |
| Payment Rate Transparency Publication § 447.203(b)(1) | July 1, 2026, then updated within 30 days of a payment rate change. |
| Comparative Payment Rate Analysis Publication § 447.203(b)(2) to (4) | July 1, 2026, then every 2 years. |
| Payment Rate Disclosure § 447.203(b)(2) to (4) | July 1, 2026, then every 2 years. |
| Interested Parties Advisory Group § 447.203(b)(6) | The first meeting must be held within 2 years after effective date of the final rule (then at least every 2 years). |
| Rate Reduction and Restructuring SPA procedures § 447.203(c)(1) and (2) | Effective date of the final rule. |

\* Regulatory provisions in this table are applicable at the time this rule becomes effective.\*\* In this final rule, including the regulations being finalized herein, we use the term “applicability date” to indicate when a new regulatory requirement will be applicable and when states must begin compliance with the requirements as specified in that regulation.\*\*\* In the case of the state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the managed care organization’s (MCO’s), prepaid inpatient health plan’s (PIHP’s), or prepaid ambulatory health plan’s (PAHP’s) contract, the applicability date is the first rating period for contracts with the MCO, PIHP or PAHP beginning on or after the applicability date specified in the chart. |

| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Part 431—State Organizational and General Administration—****Medical Care Advisory Committee** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §431.12***(with conforming changes to ***§431.408*** (Public Notice Process) that changes the committee title from MCAC to MAC and BAC).***Applicability Dates:****Establishment of the MAC and BAC*—July 9, 2025. **Except:** *BAC Crossover on the MAC* §431.12(d)(1)—For the period from July 9, 2024 through July 9, 2025, 10 percent of the MAC members must come from the BAC; for the period from July 10, 2025 through July 9, 2026, 20 percent of MAC members must come from the BAC; and thereafter, 25 percent of MAC members must come from the BAC. *Annual Report* §431.12(i)—states will recruit members and set up their MACs and BACs during the first implementation year (July 9, 2024 to July 9, 2025). In the second implementation year (July 9, 2025 to July 9, 2026), states will hold the required MAC and BAC meetings. states have 2 years from July 9, 2024 to finalize the first annual MAC report. After the report has been finalized, states will have 30 days to post the annual report. | * §431.12(a)—Expand the current requirements for a Medical Care Advisory Committee (MCAC) to require states to establish a (renamed) Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Council (BAC)
* §431.12(b) and (g)—Expand the scope and topic list the MAC and BAC should discuss to include Medical and non-medical topics related to policy development and matters related to the effective administration of the Medicaid program.
* §431.12(c), (d) and (e)—Minimum requirements for MAC and BAC membership composition, member selection, and BAC member representation on the MAC (25 percent crossover BAC to MAC).
* §431.12(f)—Require standardized processes for MAC and BAC administration and for states to make information (bylaws, membership, minutes) on the MAC and BAC publicly available.
* §431.12(h)—Requirement for state agency staff assistance.
* §431.12(h)(3)(i)—Require states to create and publicly post an annual report summarizing the MAC and BAC activities.
* §431.12(i)—*Annual Report.*

***Note:*** CMS anticipates posting a MAC best practices toolkit (no date indicated. | **Impact—Administrative burden:** * For states to create and support two separate committees, each required to meet quarterly. state agency support-§431.12 (h).
* Public notification of bylaws, agendas, minutes and 30 calendar day advance notice of meetings.
* May choose between all in-person, all virtual, or hybrid and include telephone call-in option regardless of meeting model chosen.
* Two MAC meetings per year must be open to the public for public comment.
* Federal financial participation remains at 50 percent of expenditures §431.12(j)
* Training and working with BAC members to ensure meaningful participation and understanding of their rights:
	+ While other MAC members’ names must be listed publicly, BAC members may choose whether the state will post the BC members’ names.
	+ “For both MAGI and non-MAGI methodologies, reimbursements (such as for meals eaten away from home, mileage, and lodging) do not count as income, but other compensation (such as a daily stipend) for participating in an advisory council s countable income under applicable financial methodologies. For non-MAGI methodologies, the state could submit a state plan amendment to CMS to disregard such stipends or other countable income under section 1902(r)(2) of the Act. Other means tested programs may have other rules for counting income, and we encourage states to assess those rules and advise Medicaid beneficiary members of the MAC and BAC accordingly.
 | General Administrative requirement, although MAC composition requirements state, “…committee members must include representation of at least one from each of the following categories:(A) state or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries.(B) 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. This includes providers or administrators of primary care, specialty care, and long-term care. (C) As applicable, participating Medicaid MCOs, PIHPs, PAHPs, PCCM entities or PCCMs as defined in §438.2, or a health plan association representing more than one such plans; and(D) Other state agencies that serve Medicaid beneficiaries (for example, foster care agency, mental health agency, health department, state agencies delegated to conduct eligibility determinations for Medicaid, state Unit on Aging), as ex-officio, non-voting members. |

| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Home and Community-Based Services** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §441.301***(with conforming changes to ***§438.208(c)*** to apply to HCBS managed care) ***by—***Revising §441.301(c)(1) and (c)(3).***Adding §438.72(b)***To direct states to comply with the revised requirements at §441.301(c)(1) through (3) for services authorized under HCBS authorities and provided under managed care delivery systems.***Applicability Date:*** Beginning 3 years from the effective date of the final rule; and in the case of the state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the MCO’s, PIHP’s, or PAHP’s contract, the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024. | * §441.301(c)(1)—Adding language to clarify that when the term “individual is used throughout section 441.301(c)(1) through (3) (not §441.301(c) in its entirety), it includes the individual’s authorized representative.
* §441.301(c)(3)(i)—Requirement to review person-centered plans and revise based on reassessment of functional needs required at least every 12 months (and retain “or if requested by the individual”).
* §441.301(c)(3)(ii)—Changed performance requirement for revision of person-centered plans to 90 percent.
* §438.72(b)—Applies requirements to HCBS managed care programs.

***Note:*** CMS expects to implement new HCBS reporting forms (date not indicated). | **Impact:*** Although the performance standard is 90 percent, the expectation is that states fully comply with person-centered planning requirements for all individuals (not to be interpreted as revisions being required for only 90 percent of individuals).
* Finalizing the application of §441.301(c)(3), as finalized in this rule, to section 1915(j), (k), and (i) state plan services by finalizing relevant requirements at §441.450(c), §441.540(c), and §441.725(c), respectively.
 | * Changes do not apply to Programs for all-inclusive care for the elderly (PACE).
* Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services, and applicable services in section 1115 demonstration projects.
* Applies to HCBS programs delivered under FFS and managed care.
* Requirements do not apply to section 1905(a) services.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Grievance System** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §441.301 by—***Adding(c)(7)***Applicability Date:***Beginning 2 years from the effective date of the final rule. | * §441.301(c)(7)—Requires that states establish grievance procedures related to the state’s or provider’s performance of person-centered planning processes.
* §441.301(c)(7)(ii)—Added definitions for grievance and grievance system.
* §441.301(c)(7)(iii) through (vii)—Finalized required processes mirroring 438 Subpart F.
 | **Impact:*** states may need to add administrative processes and personnel needed to receive and respond to grievances by individuals receiving services through FFS. states may have the grievance system activities performed by contractors; however, retain ultimate responsibility.
* state must have policies, procedures, and processes substantially similar to those required of managed care plans.
* Finalizing the application of §441.301(c)(7), as finalized in this rule, to section 1915(j), (k), and (i) state plan services by finalizing relevant requirements at §441.464(d), §441.555, and §441.745(a)(1)(iii), respectively.
* For application to section 1915(i) services, we are finalizing a new §441.745(a)(1)(iii) with modification to clarify that the state must maintain a grievance process in accordance with §441.301(c)(7), except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act. We are redesignating the existing §441.745(a)(1)(iii) as §441.745(a)(1)(iv).
 | * Did not apply this section to HCBS managed care as it would be duplicative of grievance procedures required of managed care plans at 438 Subpart F. Instead, the regulations for FFS are meant to mirror the managed care regulations related to grievance procedures to the extent possible.
* Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Incident Management System** |
| **Change and Applicability Dates** | **Summary of Changes** | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §441.302 by—*** Adding §441.302(a)(6) and revising §441.302(h)***Applicability Date:***§441.302(a)(6) and (h)—Beginning 3 years from the effective date of the final rule. **Except** §441.302(a)(6)(i)(B)(electronic incident management system) **—** Beginning 5 years after the effective date of the final rule. | * §441.302(a)(6)(i)(A)—Requires states to provide assurances that the states operates and maintains an incident management system that identifies, reports, tracks, and trends critical incidents, establishes a standard definition for critical incident.
* §441.302(a)(6)(i)(B)—Requires states to have an electronic critical incident system to enable electronic collection, tracking, and trending of data.
* §441.302(a)(6)(i)(C)—Requires providers to report to the state any critical incidents that occur during the delivery of services.
* §441.302(a)(6)(i)(D)—Requires states to use claims data, Medicaid Fraud Unit Data, and data from other state agencies (child and adult protective services, etc.) to identify unreported critical incidents.
* §441.302(a)(6)(i)(E)—Requires sharing among entities within the state responsible for investigation of critical incidents.
* §441.302(a)(6)(i)(F)—Requires states to separately investigate critical incidents if other investigative agency fails to report the resolution of an investigation.
* §441.302(a)(6)(i)(G) and §441.302(a)(6)(ii)—Requires annual reporting on states’ incident management system (numbers, types, corrective actions) incidents.

***Note:*** CMS plans to provide technical assistance.  | **Impact:*** Potential administrative burden to develop electronic systems.
* Finalizing §441.464(e), §441.570(e), and §441.745(a)(1)(v), and (b)(1)(i) (applying §441.302(a)(6) to section 1915(j), (k) and (i) services, respectively).
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS programs delivered under FFS and managed care.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Rates and Payment (HCBS)** |
| **Change and Applicability Dates** | **Summary of Changes** | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §441.302 by—*** Adding §441.302(k)(with conforming requirements at §441.311(e) (reporting)***Applicability Date:***(k)—Beginning 6 years after July 9, 2024; and in the case of the state that implements a managed care delivery system under the authority of section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes homemaker, home health aide, or personal care services, as set forth at §440.180(b)(2) through (4) in the MCO’s, PIHP’s, or PAHP’s contract, the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 6 years after July 9, 2024. | * §441.302(k) introductory language and (k)(1)—Requires states to ensure a sufficient HCBS direct care workforce and adds definitions for compensation, direct care worker, and excluded costs.
* §441.302(k)(2) through (6)—Sets a minimum spending performance level for providers (requires that at least 80 percent of all Medicaid payments related to homemaker services, home health aide services, and personal care services) be spent on direct care workers, and requires annual reporting to demonstrate compliance with the 80 percent performance level.
 | **Impact:** * Finalizing §441.464(f), §441.570(f), and §441.745(a)(1)(vi) (applying §441.302(k) to section 1915(j), (k) and (i) services, respectively)
* Difficulty related to developing and training the direct care workforce.
* Allowances for a self-directed care delivery model, and possible hardship exemption from minimum performance level for small providers (administrative burden for calculation to demonstrate and CMS approval).
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS services delivered through FFS and managed care.
* Does not apply to section 1905(a) services.
* *Exemption for the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641.* The Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641 are exempt from the requirements at paragraph (k).
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| ***Amend §441.303 by—***Revising §441.303(f)((6)***Applicability Date:***Beginning 3 years after the effective date of the final rule. | * §441.303(f)((6)—Requires supporting documentation. states must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the state requests and the Secretary approves a greater number of waiver participants in a waiver amendment. If the state has a limit on the size of the waiver program and maintains a list of individuals who are waiting to enroll in the waiver program, the state must meet the reporting requirements at §441.311(d)(1).
 | **Impact:*** Additional documentation and reporting.
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS services delivered through FFS and managed care.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Reporting Requirements** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §441 by—***Adding Subpart G***Applicability Dates*:**Reporting requirements at paragraphs (b) and (d)(compliance and access reporting)—Beginning 3 years after July 9, 2024; and in the case of a state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the MCO’s, PIHP’s, or PAHP’s contract, the first rating period for contracts with the MCO, PIHP, or PAHP—Beginning on or after the date that is 3 years after July 9, 2024.Reporting requirements at paragraphs (c) and (e) (HCBS measure set and payment adequacy)—Beginning 4 years after July 9, 2024; and in the case of a state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the MCO’s, PIHP’s, or PAHP’s contract, the first rating period for contracts with the MCO, PIHP or PAHP—Beginning on or after the date that is 4 years after July 9, 2024. | * §441.311(a)—This section describes the reporting requirements for states for section 1915(c) waiver programs, under the authority at section 1902(a)(6) and (a)(19) of the Act.
* §441.311(b) ***Compliance Reporting***
* (b)(1) ***Incident Management System*.** Requires the state to report every 24 months on the incident management system, unless CMS has determined that the incident management system meets the requirements of §441.302(a)(6), then reporting may be reduced to every 60 months.
* (b)(2) ***Critical Incidents*.** Annual reports on critical incidents must include:
	+ Number and percent of critical incidents for which an investigation was initiated within state-specified timeframes;
	+ Number and percent of critical incidents that are investigated and for which the state determines the resolution within state-specified timeframes;
	+ 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.
* (b)(3) ***Person-Centered Planning***. Requires the state to report annually and demonstrate that the state meets the requirements for person-centered panning (§441.301(c)(1) through (3)). The report must include:
	+ Percent of beneficiaries continuously enrolled for at least 365 days for whom a reassessment of functional need was completed within the past 12 months. The state may report this metric using statistically valid random sampling of beneficiaries.
	+ Percent of beneficiaries continuously enrolled for at least 365 days who had a service plan updated as a result of a re-assessment of functional need within the past 12 months. The state may report this metric using statistically valid random sampling of beneficiaries.
* (b)(4) Requires the state to report annually on the waiver’s impact on the type, amount, and cost of services provided under the state plan
* §441.311(c) ***Reporting on the Home and Community-Based Services Quality Measure Set*** *(see §441.312).*
* (c)(1)
	+ Requires reporting every other year on all measures identified at §441.312(d)(1)(ii).
	+ May report on additional measures at the state’s discretion*.*
	+ Must establish state performance targets (subject to CMS approval.
	+ Must describe quality improvement strategies that the state will use to achieve performance targets.
	+ May establish state performance targets for additional measures and describe quality improvement strategies that the state will use to achieve performance targets.
* (c)(2) CMS may identify some measures it will report on behalf of the state.
* (c)(3) the state may report on measures prior to being required.
* §441.311(d) ***Access Reporting***. Requires annual reporting on:
	+ Waiver waiting lists (limits on the size of the waiver program, how the list is maintained, screening processes, average time on the waiting list).
	+ Access to homemaker, home health aide, personal care, and habilitation services (average time between approval and receipt of services, percent of authorized hours provided (may be reported using statistically valid random sampling).
* §441.311(e) ***Payment Adequacy***.
	+ Requires reporting to CMS on the percentage of total costs for furnishing homemaker services, home health aide services, personal care, and habilitation services, that is spent on compensation for direct care workers (and report separately for self-directed services).
	+ *Payment adequacy reporting readiness*. One year prior to the applicability date for paragraph (e)(2)(i) of this section, the state must report on its readiness to comply with the reporting requirement in (e)(2)(i) of this section.
 | **Impact:*** Increased administrative reporting related to HCBS.
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS services delivered through FFS and managed care.
* states are required to exclude data from the Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641 from the required reporting at §441.311(e).
* states may not require submission of data by, or include any data from, the Indian Health Service or Tribal health.
* programs subject to the requirements at
* 25 U.S.C. 1641 for the state’s reporting
* required under §441.311(e)(2).
 |
| ***Adding §441.312 to Subpart G******Applicability Dates:***CMS begins identifying quality measures no later than December 31, 2026. | §441.312—This section:* (a) Describes the Home and Community- Based Services Quality Measure Set, which states are required to use in section 1915(c) waiver programs to promote public transparency related to the administration of Medicaid-covered HCBS.
* (b) Provides definitions for Attribution rules and *Home and Community-Based Services Quality Measure Set.*
* (c) Describes CMS responsibilities.
* (d) Describes the process for developing measures.
* (e) Describes phasing in of reporting.
* (f) Describes selection of measures for stratification and for determining by which factors.
* (g) CMS must consult with interested parties.
 | **Impact:*** Finalizing the application of §441.312 to section 1915(j) services by finalizing a reference to §441.312 at §441.474(c).
* Finalizing the application of §441.312 to sections 1915(k) and 1915(i) services at §441.585(d) and §441.745(b)(1)(v).
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS services delivered through FFS and managed care.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Website Transparency** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Adding §441.313 to Subpart G******Applicability Date:***Beginning 3 years after July 9, 2024; and in the case of the state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), and 1115(a) of the Act and includes HCBS in the MCO’s, PIHP’s, or PAHP’s contract, the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024. | §441.313 * (a) and (b) requires states to operate a website that provides the results of the reporting required at §441.302(k)(6) (to the extent to and as reporting requirements are finalized):
* Incident management program.
* Critical incidents.
* Person-centered planning.
* Service provision compliance.
* HCBS Quality Data Set measure results.
* Access data.
* Payment adequacy data.
* (a)(1) through (4) describes requirements for the website (contents on one website, may link to managed care plans’ websites, clear language, easy to read, labels, prominent language explaining the availability of language assistance and auxiliary aides, verify functionality quarterly.
 | **Impact:*** Website functionality and content development and monitoring.
* Apply the requirements of §441.313 to section 1915(j), (k), and (i) state plan services at §441.486, §441.595, and §441.750, respectively.
* Adding a cross reference at §438.72 to be explicit that states that include HCBS in their MCO’s, PIHP’s, or PAHP’s contracts would have to comply with the requirements at §441.301(c)(1) through (3), §441.302(a)(6) and (k), §441.311, and §441.313. We believed this would make the obligations of states that implement LTSS programs through a managed care delivery system clear, consistent, and easy to locate.
 | * Applies to section 1915(c) waiver programs, 1915(i), (j), and (k) state plan services.
* Applies to HCBS services delivered through FFS and managed care.
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| **Changes/Potential Impact—As Finalized** |
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| **Changes Related to Documentation Required to Assure FFS Access to Care and Adequate Service Payment Rates** |
| **Change and Applicability Dates** | **Summary of Changes**  | **Potential Impact to states and Managed Care Entities** | **Applicability to Managed Care** |
| ***Amend §447—by***Revising §447.203(b) and adding (c)***Applicability Date:***§447.203(b)(1)—Beginning July 1, 2026§447.203(c)—The effective date of the final rule. | * §447.203(b) Rescinds the requirement for the AMRP and replaces the process with new documentation requirements.
* (b)(1) *Payment rate transparency*. Requires states to publish all Medicaid FFS fee schedule payment rates on a website that is accessible to the general public and must:
	+ Be easily reached through a hyperlink.
	+ Be organized so that the public can understand the rates.
	+ For bundled rates, include constituent rates.
	+ If rates vary by population (pediatric, adult) or geographic area, include the rates for each.
	+ Include rates publish date and update dates.
* (b)(2) *Comparative payment rate analysis and payment rate disclosure.* Requires states to develop and publish comparative payment rate analysis of Medicaid FFS rates for each of the following categories (if rates vary, the state must separately identify all rates):
	+ Primary care services.
	+ Obstetrical and gynecological services.
	+ Outpatient mental health and substance use disorder services.
	+ Personal care, home health aide, homemaker, and habilitation services.
* (b)(3) *Analysis and disclosure requirements*. Requires the state to compare the Medicaid FFS rates to the most recently published Medicare payment rates effective for the same time period for the evaluation and management codes applicable to the category of service and reporting must:
	+ Be at the HCPCS or CPT code level as applicable.
	+ Be organized (as required in (b)(2).
	+ Clearly identify the Medicaid FFS rate by CPT/HCPS for each code identified by CMS.
	+ Identify separate rates if rates vary by population or geographic area.
	+ Specify the Medicaid non-facility payment rate as a percentage of the Medicare non-facility payment rate.
	+ Specify the number of Medicaid paid claims.
	+ Specify the number of Medicaid beneficiaries who received each of the services during the calendar year the rate was in effect.
	+ Identify the average hourly rate by service category.
* (b)(4) *Timeframe*. The state must publish the initial comparative payment rate analysis and payment rate disclosure of its Medicaid fee-for-service fee schedule payment rates in effect as of July 1, 2025 as required under paragraphs (b)(2) and (b)(3) of this section, by no later than July 1, 2026. Thereafter, the state agency must update the comparative payment rate analysis and payment rate disclosure no less than every 2 years.
* (b)(5) *Compliance*. If the state fails to comply with payment rate transparency, analysis, and disclosure requirements [(b)(1) through (4)], future grant awards may be reduced by the amount of FFP CMS estimates attributable to the state’s administrative expenditures… until the state complies.
* (b)(6) *Interested parties advisory group*. Requires the state to establish an advisory group that includes:
	+ Direct care workers.
	+ Beneficiaries.
	+ Beneficiaries’ authorized representatives.
	+ Other interested parties impacted by the service rates in question.

Requirements for the advisory group:* + The group will advise the state agency on current and proposed rates and payment adequacy, and meet at least every 2 years.
	+ The state must publish the recommendations within one month of when the group provides the recommendations to the state.
* §447.203(c) (c)(1) *Initial state analysis for rate reduction or restructuring.* For any state that proposes to reduce or restructure provider payments, when the changes could result in diminished access the state must provide written documentation of assurance the following criteria are met
	+ Aggregate Medicaid payment rates for each service category will remain at or above 80 percent of the published Medicare rates for the same period.
	+ The cumulative reduction is not likely to result in more than 4 percent reduction in the aggregate rate for each service category.
	+ The public process described in §447.204 yielded no significant access to care concerns from beneficiaries.
* (c)(2) *Additional state rate analysis.* For any state plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access where the requirements in paragraphs (c)(1)(i) through (iii) of this section are not met, the state must also provide the following to CMS as part of the state plan amendment submission as a condition of approval.
	+ Summary of the proposed change (reason, policy change, etc.), cumulative effect on Medicaid FFS expenditures for each benefit category.
	+ Medicaid payment rate before and after the restructuring (each benefit category with comparison of each to the Medicare rate.
	+ Information about the number of providers actively participating in each benefit category (for 3 years preceding the restructure), by geographic area and anticipated effect of providers.
	+ Information about the number of Medicaid beneficiaries receiving services through the FFS delivery system in each affected benefit category (for 3 years preceding the restructure), and qualitative and quantitative information about the beneficiaries and the anticipated affect.
	+ Information about the number of services furnished through the Medicaid FFS delivery system in each benefit category in each geographic area, qualitative and quantitative and anticipated effect on the number of services to be provided.
	+ A summary of the state’s response to any access to care concerns or complaints received from beneficiaries, providers, or other interested parties.
* (c)(3) *Compliance with requirements for state analysis for rate reduction or restructuring.* Any state that fails to provide required documentation may face state plan amendment (SPA) disapproval. If effects after the restructure suggests noncompliance with access requirements, CMS may take a compliance action.
* (c)(4) *Mechanisms for ongoing beneficiary and provider input.* states must have ongoing mechanisms for beneficiary and provider input, be promptly responsive to the input, and maintain records of the input.
* (c)(5) *Addressing access questions and remediation of inadequate access to care.* Requires states to submit a corrective action plan within 90 days after discovery of access deficiency. Planned improvements must be measurable, measured, and sustainable.
* (c)(6) *Compliance actions for access deficiencies.* CMS may take a compliance action.
 | **Impact:*** CMS anticipates decreased administrative burden with the new streamlined process.
 | Not Applicable (NA) |
| ***Amend §447—by***Revising §447.204(a)(1) and (b); and removing §447.204(d)***Applicability Date:***The effective date of the final rule. | §447.204 *Medicaid provider participation and public process to inform access to care.* * (a) The agency's payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population. In reviewing payment sufficiency, states are required to consider, prior to the submission of any state plan amendment that proposes to reduce or restructure Medicaid service payment rates:
* (a)(1) The data collected, and the state analysis performed, under §447.203(c).
* (b) The state must submit to CMS with any such proposed state plan amendment affecting payment rates documentation of the information and analysis required under §447.203(c) of this chapter.
 | **Impact:*** Increased documentation requirements.
 | NA |