Medicaid and CHIP All State Call
May 7, 2024

Agenda

- Medicaid Drug Rebate Program (MDRP) Updates
- Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule
- Questions

Medicaid Drug Rebate Program (MDRP) Updates

Medicaid and CHIP All State Call

May 2024

Section 1927 Coverage Standards

- Under Section 1927 of the Social Security Act, with limited exceptions, if a manufacturer participates in the rebate program, states must cover that manufacturer's drugs when they meet the definition of covered outpatient drug (COD). Unless subject to one of the limited exceptions, the states must cover that COD for its medically accepted indications.
- Medically accepted indication:
  - FDA-approved indication
  - Indication supported by designated compendia
- Certain drugs or medical uses of a drug may be excluded from coverage or otherwise restricted pursuant to Section 1927(d)(2) of the Act. If a drug has a medically accepted indication that may be subject to restriction, states are not required to cover the drug for that indication.

Example: WEGOVY (the green highlighted indication must be covered):

Original FDA indications	FDA indications as of 03/2024
WEGOVY® is a glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to a reduced calorie diet and increased physical activity **for chronic weight management** in adult patients with an initial body mass index (BMI) of • 30 kg/m2 or greater (obesity) or • 27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, or dyslipidemia).	WEGOVY® is a glucagon-like peptide-1 (GLP-1) receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: • **To reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight** • **To reduce excess body weight and maintain weight reduction long term in:** • Adults and pediatric patients aged 12 years and older with obesity • Adults with overweight in the presence of at least one weight-related comorbid condition.

Drug Shortages

- There continue to be shortages of some drugs. In certain cases, FDA allows temporary importation of non-FDA approved drugs from other countries to mitigate the effects of the drug shortages and assist with access to these drugs.
  - These drugs generally do not meet the definition of COD and therefore are not rebate-eligible under MDRP.
  - States are eligible for FFP for these prescribed drugs.
  - Example: Current shortage for long-acting penicillin (Extencilline).
- If states are interested in covering these imported drugs and do not already have language included in their state plan, please consider submitting a SPA on Attachment 3.1-A/B, Section 12.a. Prescribed Drugs, to include the following recommended language:

  Drug Shortages: Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are covered when medically necessary during drug shortages identified by the Food and Drug Administration.

- Please reach out to your Pharmacy SPA analyst for any assistance.

Overview of CMS's New Final Rule

Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-F)

Medicaid and CHIP All State Call

May 2024

Final Rules Released on April 22, 2024

- CMS released two final rules:
  - ***Ensuring Access to Medicaid Services*** **(CMS-2442-F)**
  - ***Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality*** **(CMS-2439-F)**

- These final rules support the Biden-Harris Administration's efforts to advance groundbreaking, high-impact solutions to ensure greater access to Medicaid and CHIP services for all eligible individuals.

- These rules establish historic national standards for access to care regardless of whether that care is provided through managed care plans or directly by states through fee-for-service (FFS).

- These rules include staggered applicability dates to allow states and managed care plans adequate time to implement changes, some of which will require significant process and system updates.

Summary of Key Provisions in Final Rules (1 of 2)

- **Establishing national maximum standards for certain appointment wait times for Medicaid and CHIP managed care enrollees,** and stronger state monitoring and reporting requirements related to access and network adequacy for Medicaid and CHIP managed care plans, which now cover the majority of Medicaid and CHIP beneficiaries.

- **Requiring states to conduct independent secret shopper surveys** of Medicaid and CHIP managed care plans to assess compliance with appointment wait time standards and to identify inaccurate information in provider directories.

- **Creating new payment transparency requirements for states** by requiring disclosure of provider payment rates in FFS, and a comparison to Medicare rates for certain services in FFS and managed care, with the goal of greater insight into how Medicaid payment levels affect access to care.

- **Establishing additional transparency and interested party engagement requirements for setting Medicaid payment rates for home and community-based services** (HCBS), as well as a requirement that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead or profit).

Summary of Key Provisions in Final Rules (2 of 2)

- **Creating timeliness-of-access measures for HCBS,** strengthening necessary safeguards to ensure beneficiary health and welfare, and promoting quality of care and health equity in HCBS.

- **Strengthening how states use state Medicaid Advisory Committees,** through which various interested parties can advise Medicaid agencies about health and medical care services, to ensure all states are using these committees optimally to realize a more effective and efficient Medicaid program that is informed by the experiences of Medicaid beneficiaries, their caretakers, and other interested parties.

- **Requiring states to conduct enrollee experience surveys annually for each managed care plan** to gather input directly from enrollees.

- **Establishing a framework for states to implement a Medicaid and CHIP quality rating system, a "one-stop-shop" for enrollees to compare Medicaid and CHIP managed care plans** based on quality of care, access to providers, covered benefits and drugs, cost, and other plan performance indicators.

Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F)

Medicaid and CHIP All State Call

May 2024

Managed Care (1 of 2)

Background

- 85% of Medicaid beneficiaries [1] (83% for separate CHIP [2]) are enrolled in managed care, which accounts for $450B+ (54%) of total Medicaid and CHIP spending.[3] Oversight of managed care is a key priority focus for CMS.

- There is significant variation among Medicaid and CHIP managed care programs both within and across states. This variation can result in measurable differences in access and quality of care, as well as fiscal sustainability and program integrity.

- Unlike in Medicare and the Marketplace, Medicaid and CHIP beneficiaries in some states do not have a way to compare managed care plans based on quality or that meets a minimum Federal standard.

- To advance our ability to monitor the effectiveness of states' managed care programs and promote other Biden-Harris Administration priorities, we finalized a managed care rule that will enable CMS to strengthen its oversight of Medicaid and CHIP programs.

1: https://www.medicaid.gov/sites/default/files/2023-07/2021-medicaid-managed-care-enrollment-report.pdf
2: CMS Statistical Enrollment Data System (SEDS) Form 21E, Children Enrolled in Separate CHIP, and Form 64.21E, Children enrolled in Medicaid expansion CHIP.
3: Medicaid and CHIP 2023 Scorecard

Managed Care (2 of 2)

Overview of Final Rule

- The *Medicaid and CHIP Managed Care Access, Finance, and Quality* final rule (CMS-2439-F) displayed in the Federal Register on April 22, 2024, will be published on May 10, 2024, and be effective on July 9, 2024. Applicability dates for the provisions vary and are specified in the final rule.
- In the forthcoming slides, we will summarize:
  - Notable provisions* in the final rule (CMS-2439-F) as well as the prior regulatory requirement(s), major changes from the Notice of Proposed Rulemaking (NPRM) published on May 3, 2024, and the applicability date of each provision.
  - Differences between the provisions that apply to Medicaid and separate CHIP.
  - Proposed provisions that were not finalized.

* Please see the final rule in the Federal Register for details on every provision in this final rule.

Managed Care Access, Finance, and Quality Final Rule

Topics covered:

- Access in managed care
- Addressing Health-Related Social Needs with In Lieu of Services and Settings (ILOSs)
- State Directed Payments (SDPs)
- Medical Loss Ratio (MLR) and Program Integrity
- Quality Rating System (QRS)
- Separate Children's Health Insurance Program (CHIP)

Improving Access to Care in Managed Care (1 of 3)

1. Require appointment wait time standards to expand oversight of network adequacy.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
A quantitative network adequacy standard	• Require states to develop and enforce appointment wait time (AWT) standards (in addition to another quantitative standard) within regulatory established maximums, which are consistent with the Marketplace) for: – Primary care services (adult and child) within 15 business days – Mental health and substance use disorder services (adult and child) within 10 business days; – Ob/Gyn services, within 15 business days; and – A state-selected service within a state-established timeframe. • Managed care plans must achieve 90% compliance with these standards. • CMS may select additional types of services after consultation and public comment. [42 CFR §§ 438.68(e), 438.206(c)(1)(i), 457.1218, and 457.1230(a)]	Align the applicability date for AWT contractual requirements with the AWT standards	First rating period beginning on or after July 9, 2027

Improving Access to Care in Managed Care (2 of 3)

2. Increase state oversight of managed care plan performance and enrollee experience.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
None	Require annual independent secret shopper surveys to assess managed care plan performance with the appointment wait time standards and provider directory accuracy (e.g., real vs. ghost networks). [42 CFR §§ 438.68(f) and 457.1218]	None	First rating period beginning on or after July 10, 2028
None	Require states to conduct an annual enrollee experience survey that is posted on states' websites and reported to CMS as part of an existing reporting vehicle. [42 CFR § 438.66(c)(5)]	None	First rating period beginning on or after July 9, 2027
None	Require states to submit remedy plans to address areas in which managed care plans' access to care could be improved. Remedy plans will include specific steps, timeframes, and responsible parties to achieve improvement within 12 months. [42 CFR §§ 438.207(f) and 457.1230(b)]	None	First rating period beginning on or after July 10, 2028

Improving Access to Care in Managed Care (3 of 3)

3. Increase transparency on managed care plan payment to providers.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
None	Require states to submit an annual payment analysis comparing certain managed care provider payments to Medicare or Medicaid FFS. This analysis will include separate reporting for (1) primary care, obstetrics and gynecology, mental health, substance use disorder services; and (2) personal care, homemaker, home health aide, and habilitation services. [42 CFR §§ 438.207(b)(3) and 457.1230(b)]	Addition of habilitation services to the annual payment analysis	First rating period beginning on or after July 9, 2026

Addressing Health-Related Social Needs with ILOSs

Background

- In line with Biden-Harris Administration priorities, CMS has developed several opportunities for states to cover services that address the social determinants of health (SDOH), or more specifically, health-related social needs (HRSN), including nutrition and housing supports.
- An innovative opportunity to cover these services is as "in lieu of services and settings" (ILOSs), which allow managed care plans to substitute innovative, cost-effective, medically appropriate alternatives for state plan services or settings.
  - For example, states can cover medically-tailored meals "in lieu of" nursing facility care or hospitalizations.
- CMS approved this flexibility for California in December 2021 and published sub-regulatory guidance about ILOSs on January 4, 2023 (SMD 23-001). CMS codified this updated ILOS policy to strengthen access to care while also maintaining appropriate enrollee protections, enabling better monitoring and oversight, and improving fiscal guardrails.
  - CMS reviews and approves states' proposed ILOSs as part of our review and approval of the associated managed care plan contracts.

Addressing Health-Related Social Needs with ILOSs (1 of 3)

1. Expand opportunities for states to utilize ILOSs to address SDOH and HRSN and align opportunities across Medicaid authorities.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No explicit definition for ILOSs though interpreted to be an immediate substitute	Specify that ILOSs can be immediate or longer-term substitutes for covered state plan services or settings, or when the ILOSs can be expected to reduce or prevent the future need for such state plan services or settings. [42 CFR §§ 438.2 and 457.10]	None	July 9, 2024
None	Align ILOSs with approvable services or settings under the state plan or a section 1915(c) waiver. [42 CFR §§ 438.16(b) and § 457.1201(e)]	None	First rating period beginning on or after September 9, 2024

Addressing Health-Related Social Needs with ILOSs (2 of 3)

2. Ensure beneficiary, programmatic, and fiscal protections in the use of ILOSs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No explicit regulatory requirement, but consistent with expectation	Reinforce existing enrollee protections related to ILOSs, including that services must be optional for enrollees and the provision or offer of ILOSs does not absolve managed care plans from providing other medically necessary state plan services. [42 CFR §§ 438.3(e)(2) and 457.1201(e)]	None	July 9, 2024
The approved ILOSs are authorized and identified in the plan contract	Codify contract requirements including documenting ILOS definitions, linking each ILOS with the services and settings for which they may substitute, identifying clinically defined target populations, and specifying billing codes (such as CPT/HCPCS codes and modifiers) for identifying ILOSs in encounter data. [42 CFR §§ 438.16(d) and 457.1201(e)]	None	First rating period beginning on or after September 9, 2024
None	Limit total ILOS spending to no more than 5% of total managed care capitation payments, as certified by the state's actuary, for each applicable managed care program. [42 CFR §§ 438.16(c) and 457.1201(c)]	None	First rating period beginning on or after September 9, 2024

Addressing Health-Related Social Needs with ILOSs (3 of 3)

3. Ensure appropriate monitoring and oversight of ILOSs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
None	Require a retrospective evaluation for states with ILOS spending above 1.5% of total capitation payments. [42 CFR §§ 438.16(e)(1) and 457.1201(e)]	Clarify the expectations for ILOS evaluations related to the timeframes for completing evaluations and submitting these evaluation to CMS	First rating period beginning on or after September 9, 2024
Monitor performance of managed care programs, but ILOSs not explicitly identified	Require states to conduct on-going monitoring of ILOSs and develop a transition of care policy when an ILOS is terminated. [42 CFR §§ 438.16(e)(2) and 457.1201(e)]	Revise the timeframe for submitting an ILOS transition plan to CMS to 30 calendar days after applicable notice rather than 15 calendar days of a decision to allow states sufficient time to develop these plans	First rating period beginning on or after September 9, 2024

State Directed Payments

Background

- State directed payments (SDPs) are contractual obligations that enable states to direct Medicaid managed care plans' expenditures for services under the contract.
- SDPs have become a significant payment method for states, accounting for more than $52 billion annually across 39 states.[1]
- SDPs allow states to take a more proactive role in directing managed care plans towards key policy and delivery system investments. However, some SDPs are correlated with financing challenges.

1: Regulatory Impact Analysis in Medicaid and CHIP Access, Finance, and Quality final rule

State Directed Payments (1 of 5)

1. Reduce state burden by implementing appropriate flexibilities for SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
CMS approval of a preprint was required	Eliminate the need for CMS approval of a preprint for SDPs that are minimum fee schedules at 100 percent of Medicare. [42 CFR § 438.6(c)(2)(i) and § 438.6(c)(1)(iii)(B)]	None	July 9, 2024
SDPs for value-based purchasing must be based on utilization and delivery of services during the rating period only	Eliminate unnecessary regulatory limitations on value-based purchasing arrangements to enable states to more easily link SDP payments to quality metrics and other performance-based data while ensuring payments are tied to actual performance and not reporting only. [42 CFR § 438.6(c)(2)(vi)]	None	Applicability date varies with some provisions aligned with effective date
Fee schedule based SDPs are not allowed for non-network providers	Allow states to utilize SDPs for non-network providers to ensure access to care that is often provided by non-network providers, such as family planning services. [42 CFR § 438.6(c)(1)(iii)]	None	July 9, 2024

State Directed Payments (2 of 5)

2. Strengthen fiscal and program integrity for SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulation, but this provision reflects existing standards in statute, regulation, and prior rulemaking	Ensure that existing requirements for allowable sources of non-federal share are explicitly applied to SDPs, and noting CMS may disapprove and take enforcement action on SDPs that do not comply with non-federal share financing requirements. [42 CFR § 438.6(c)(2)(ii)(G)]	None	July 9, 2024
None	Require states to ensure that providers attest that they do not participate in a hold harmless arrangement, as defined by statute and regulation. [42 CFR § 438.6(c)(2)(ii)(H)(*1*)] Require states provide such attestations upon request, or a satisfactory explanation about why attestation(s) are unavailable. [42 CFR § 438.6(c)(2)(ii)(H)(*2*)]	Revised the applicability date Added language allowing states the opportunity to explain why a provider did not attest	First rating period beginning on or after January 1, 2028

State Directed Payments (3 of 5)

2. Strengthen fiscal and program integrity for SDPs (cont.).

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No regulatory ceiling but this is consistent with operational practice	Establish a payment rate ceiling at the average commercial rate (ACR) for hospital services, nursing facility services, and qualified practitioner services furnished at academic medical centers. [42 CFR § 438.6(c)(2)(iii)]	None	First rating period beginning on or after July 9, 2024
Allows post-payment reconciliation processes	Require states to condition fee schedule based SDPs on actual utilization during the rating period and prohibit post-payment reconciliation processes that initially condition payment on historical utilization outside the rating period. [42 CFR § 438.6(c)(2)(vii)]	Revise the applicability date to allow states additional time to make the necessary operational changes (initially proposed 2 years)	First rating period beginning on or after July 9, 2027

State Directed Payments (4 of 5)

2. Strengthen fiscal and program integrity for SDPs (cont.).

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
Allow separate payment terms with required documentation	Require SDPs to be included in actuarially sound capitation rates (i.e., prohibit use of separate payment terms). [42 CFR § 438.6(c)(6)]	This was an option considered that was finalized	First rating period beginning on or after July 9, 2027
Require submission of preprint prior to the end of the rating period	Establish submission timeframes for all SDP preprints to require submission before the start date of the SDP or the start date of the amendment. [42 CFR § 438.6(c)(2)(viii)]	Simplify the submission timing requirements	First rating period beginning on or after July 9, 2026
None	Establish submission timeframes for documentation of SDPs in rate certifications and managed care plan contracts to require submission no later than 120 days after the start date of the SDP. [42 CFR §§ 438.6(c)(5)(v) and 438.7(c)(6)]	Simplify the submission timing requirements	First rating period beginning on or after July 10, 2028

State Directed Payments (5 of 5)

3. Enhance evaluation and reporting of SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
States were required to include an evaluation plan as part of SDP submission	Strengthen evaluation requirements for SDPs, require states with SDP spending above 1.5% of total capitation payments to submit evaluation results to CMS, and post these evaluation results publicly. [42 CFR §§ 438.6(c)(2)(ii)(D) and (F), 438.6(c)(2)(iv) and (v), and 438.6(c)(7)]	Require all states to provide an evaluation report upon CMS request	First rating period beginning on or after July 9, 2027
No regulatory requirement to capture SDP actual spending separately, but expect data to be included in the Transformed Medicaid Statistical Information System (TMSIS) in enrollee encounter data paid amounts	Require provider level reporting on actual SDP expenditures in TMSIS. [42 CFR § 438.6(c)(4))]	Require reporting one year after each rating period to allow additional time for claims runout and data validation (initially proposed 180 days)	No later than the date specified in the T-MSIS reporting instructions released by CMS

Medical Loss Ratio (MLR) and Program Integrity Provisions

Background

- MLR is a common financial metric used to report and benchmark the financial performance of a managed care plan.
- In Medicaid and CHIP managed care, the MLR represents the proportion of revenue used by the plan to fund claim expenses and quality improvement activities.
- The specifications for managed care plans' reporting to states were finalized in 42 CFR §§ 438.8 and 457.1203 in the 2016 final rule. State must submit summaries of these reports to CMS under 42 CFR § 438.74 and 457.1203. The modifications to these regulations finalized in this final rule are based on reviews of plan and state summary reports as well as alignment with recent MLR regulatory changes for Marketplace plans.

Medical Loss Ratio (MLR) and Program Integrity Provisions (1 of 2)

1. Clarify and strengthen MLR requirements.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
Consistent with operational practice given regulatory requirements	Explicitly require Medicaid managed care plans to include actual expenditures and revenue for SDPs as part of their MLR reports to states. [42 CFR §§ 438.8(e)(2)(iii)(C) and 438.8(f)(2)(vii)]	None	July 9, 2024
None for provider incentives; Others are consistent with operational practice given regulatory requirements	Improve consistency in MLR reporting, allowing CMS to better compare MLRs across plans and states through technical revisions for provider incentive arrangements, quality improvement expenditures, and expense allocation reporting to align with Marketplace plan MLR calculations. [42 CFR §§ 438.8(e)(2)(iii)(A), 438.8(e)(3)(i), 438.8(k)(1)(vii), 457.1203(c) and 457.1203(f)]	None	July 9, 2024
Consistent with operational practice given regulatory requirements	Technical revisions for state MLR summary report data requirements, and the publication of credibility adjustment factors. [42 CFR §§ 438.74(a), 438.8(h)(4), 457.1203(e) and 457.1203(c)]	None	July 9, 2024

Medical Loss Ratio (MLR) and Program Integrity Provisions (2 of 2)

2. Expand program integrity provisions for provider incentives and overpayments.

Prior Requirement(s)	Final Rule	Major Changes from NPRM*	Applicability Date
None	Require managed care plans' provider incentive arrangements to reflect sound contracting practices. [42 CFR §§ 438.3(i)(3)-(4), 438.608(e) and 457.1285]	See detail below*	First rating period beginning on or after July 9, 2025
No Federal definition for prompt reporting	Require managed care plans to report overpayments within 30 calendar days. [42 CFR §§ 438.608(a)(2) and 457.1285]	Initially proposed 10 business days and revised to allow sufficient investigation time for plans; also see detail below*	First rating period beginning on or after July 9, 2025
Report recoveries of overpayments	Require plans to report annually to the state on all overpayments identified or recovered rather than just on their recoveries of overpayments. [42 CFR §§ 438.608(d)(3) and 457.1285]	See detail below*	First rating period beginning on or after July 9, 2025

** The applicability date for these three provisions was revised to allow states additional time to make the necessary operational changes. Provider incentive requirements were initially proposed to be applicable for the first rating period on or after 60 days following the effective date while the other two provisions were initially proposed for the effective date.*

Increasing Transparency of Plan Quality and Access Information

Background

- States are required to develop and maintain a managed care quality strategy, which includes performance measures and performance improvement projects implemented through managed care contracts as part of a plan's quality assessment and performance improvement program.

- In addition, each state must ensure that a qualified external quality review organization (EQRO) performs an external quality review (EQR) for each contracted managed care plan.

- Previous rulemaking established CMS's authority to require states to develop and operate a Medicaid and CHIP managed care quality rating system (MAC QRS) using a CMS-developed framework or an alternative that is substantially comparable. This rule establishes such framework, aimed to empower beneficiary choice and ensure monitoring of plan performance.

Increasing Transparency of Plan Quality and Access Information (1 of 4)

1. Modify existing quality strategy and external quality reporting requirements, aiming to make reporting more transparent and meaningful for driving quality improvement, and to reduce burden on certain external quality reporting requirements.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
Require states to make their quality strategy available for public comment when adopted and when revisions are made and post on its website the results of its 3-year review	Require states to make their quality strategy available for public comment and post the evaluation of the quality strategy every 3 years. [42 CFR §§ 438.340(c)(1) and (2)(ii) and 457.1240(e)]]	None	No later than July 9, 2025
A qualified EQRO performs an annual EQR for each MCO, PIHP, PAHP or PCCM entity	Remove mandatory external quality requirements for PCCM entities. [42 CFR §§ 438.350(a) and 457.1250(a)]	Maintain optional activities for PCCM entities so states can continue to access FFP at the 50 percent match rate if they choose [42 CFR §§ 438.358(b)(2) and 457.1250(a)]	July 9, 2024

Increasing Transparency of Plan Quality and Access Information (2 of 4)

1. Modify existing quality strategy and external quality reporting requirements, aiming to make reporting more transparent and meaningful for driving quality improvement, and to reduce burden on certain external quality reporting requirements (cont.).

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
None	Add a new optional EQR activity to support states' evaluations for quality strategies, SDPs and ILOSs. [42 CFR §§ 438.358(c)(7) and 457.1250(a)]	None	July 9, 2024

Increasing Transparency of Plan Quality and Access Information (3 of 4)

2. Implement the MAC QRS framework, which includes a set of mandatory measures, a methodology for calculating quality ratings for a mandatory measures, and a website display.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
Must adopt the QRS developed by CMS or adopt an alternative QRS within 3 years of the date of a final notice published in the Federal Register	Must adopt the QRS framework developed by CMS, which must implement either the MAC QRS methodology developed by CMS, or an alternative MAC QRS rating methodology approved by CMS. [42 CFR §§ 438.505(a)(1) and 457.1240(d)]	Add ability for states to request a one-year, one-time extension to implement CMS methodology requirements;- reduce the steps states must take to implement an alternative MAC QRS methodology	December 31, 2028

Increasing Transparency of Plan Quality and Access Information (4 of 4)

3. Implement a website display that allows beneficiaries to access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to beneficiary decision making, such as plan coverage of services and their cost and the plan's drug formulary and provider network; and identify a plan that best meets their needs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
The State must prominently display the quality rating given by the State to each MCO, PIHP, or PAHP on the state's Medicaid website	Establish a MAC QRS website in 2 phases so beneficiaries can access information about Medicaid and CHIP eligibility and managed care, and compare plans based on quality and other factors key to beneficiary decision making, including quality ratings for a set of mandatory measures. [42 CFR §§ 438.520 and 457.1240(d)]	Add ability for states to request a one-year, one-time extension to implement certain website requirements in both Phase I and Phase II; Clarify that states must display mandatory measures *applicable* to the state; Reduce the steps states must take to implement additional website features as part of their MAC QRS	*Phase I*: December 31, 2028 *Phase II*: To be determined by CMS, but no earlier than December 31, 2030 (2 years after QRS implementation)

Separate CHIP Alignment with Medicaid

CMS has mostly aligned separate CHIP with Medicaid managed care regulatory requirements with a few exceptions.

Topic	Differences than Medicaid
Access	For the enrollee experience survey provision, states are required for separate CHIPs to post summary comparative Consumer Assessment of Healthcare Providers and Systems (CAHPS) results on the state's website and review CAHPS results in the state's annual analysis of network adequacy rather than through MCPAR with an applicability date of two years after the effective date of the Final Rule. [42 CFR §§ 457.1200(d), 457.1207, and 457.1230(b)].
ILOSs	Actuarial certification requirements and reporting for state directed payments do not apply.
SDPs	Not applicable to CHIP.
MLR and Program Integrity	Provisions related to SDPs and reporting for Medicare-Medicaid dually eligible enrollees are not applicable.
Quality	Provisions for Medicare-Medicaid dually eligible enrollees do not apply.

Summary of Notable Proposals Not Finalized

State Directed Payments

- An expenditure limit for all SDPs.

Medical Loss Ratio and Program Integrity

- Separate SDP line items for plans' MLR reports and states' MLR summary reports.
- A restriction on plans' MLR resubmissions.

Quality

- Revision to the date annual EQR technical reports must be finalized and posted.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Questions

Questions about the final rule can be sent to: Managedcarerule@cms.hhs.gov

Ensuring Access to Medicaid Services

Previously presented at the April 30, 2024 Medicaid & CHIP All State Call

Access Strategy: Background

- Medicaid and CHIP provide essential health care coverage for 85 million people.
- Beneficiaries access their health care services using managed care and FFS delivery systems. Previous regulations addressing access were not comprehensive or consistent across payment systems and programs.
- Addressing these issues requires a thorough programmatic review and coordinated strategy with the following goals to improve and strengthen Medicaid and CHIP:
  - Remove barriers for eligible people when enrolling in and maintaining coverage
  - Ensure equitable access to Medicaid-covered health care services and supports
- CMS plans to achieve these goals through three rules:

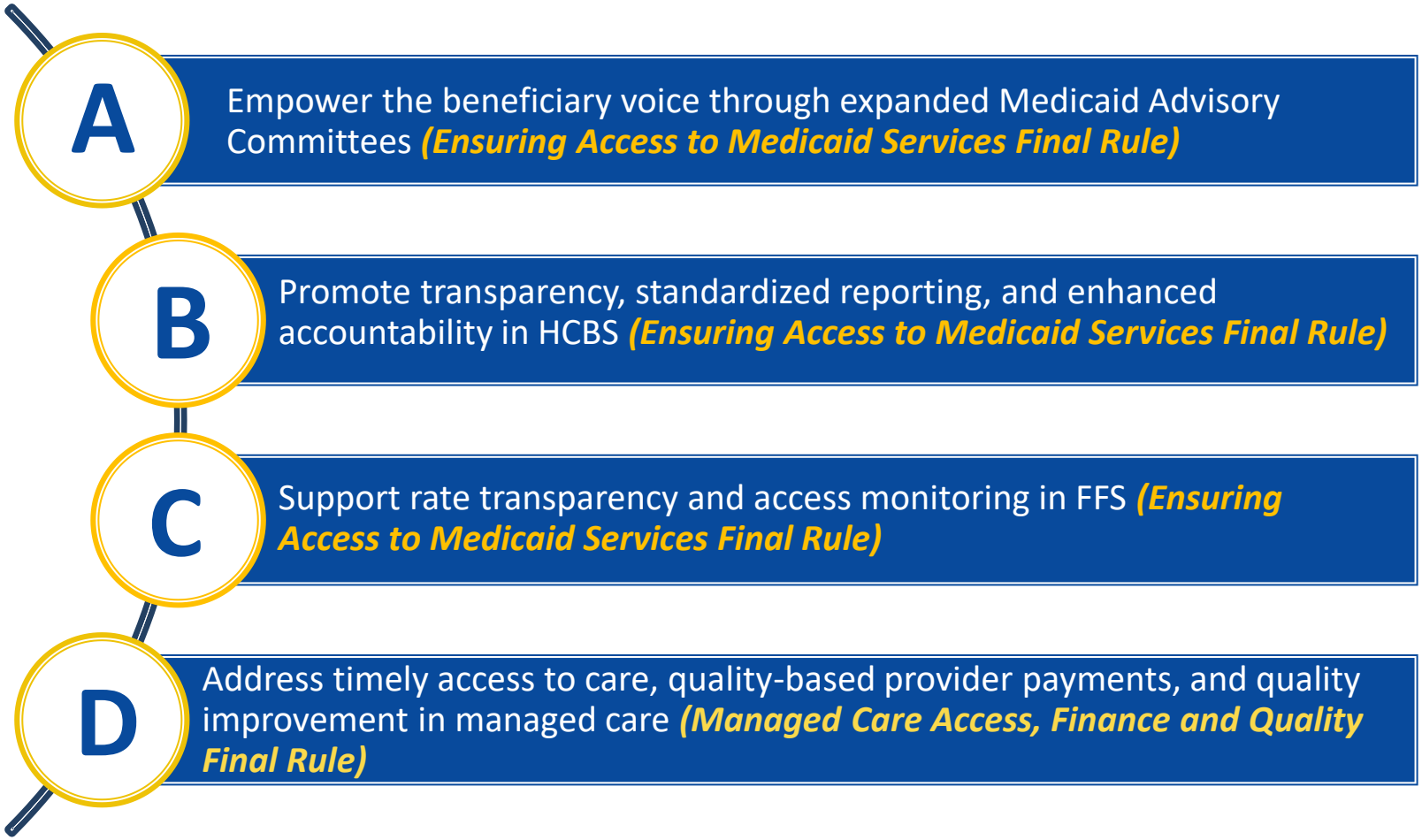
Eligibility & Enrollment Final Rule
(released 3/27/24)

Ensuring Access to Medicaid Services Final Rule
(released 4/22/24)

Managed Care Final Rule

(released 4/22/24)

Regulatory Strategy: Enhancing Access to Medicaid Services



Ensuring Access to Medicaid Services Final Rule

Topics covered:

- Medicaid Advisory Committee & Beneficiary Advisory Council
- Home and community-based services (HCBS)
- Fee-for-service

Medicaid Advisory Committees (formerly Medical Care Advisory Committees)

Background

- The former regulations require states to establish Medical Care Advisory Committee (MCAC), but these Committees are limited to medical topics and do not address how the beneficiary perspective and the lived Medicaid experience should be considered
  - Beneficiary perspectives need to be central to operating a high-quality and equitable health coverage program.
- There is wide variation across states in how they use Medical Care Advisory Committees
  - Opportunity to finalize more robust requirements to ensure all Medicaid agencies are using these Committees optimally to realize a more equitable, effective, and efficient Medicaid program that is informed by the experiences of beneficiaries, their caretakers, providers, and other interested parties.

Medicaid Advisory Committees & Beneficiary Advisory Councils:

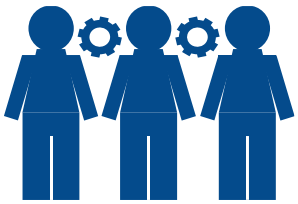
Promoting Feedback, Transparency & Accountability

- **Basis and purpose** (§ 431.12 (a))
- State plan requirement (§ 431.12 (b))
- Selection of members (§ 431.12 (c))
- **MAC membership & composition** (§ 431.12 (d))
- **Beneficiary Advisory Council** (§ 431.12 (e))
- MAC & BAC administration (§ 431.12 (f))
- MAC & BAC participation and scope (§ 431.12 (g))
- State agency staff assistance, participation, & financial help (§ 431.12 (h))
- **Annual report** (§ 431.12 (i))
- Federal financial participation (§ 431.12 (j))
- Applicability dates (§ 431.12 (k))

- **Bolded** provisions are covered in the slides
- Except as noted in:
  - *MAC Membership & Composition* §431.12 (d)(1); and
  - *Annual Report* §431.12 (i)(3)

  the requirements in §431.12 (a) through (j) are applicable on July 9, 2025.
- MAC & BAC Toolkit for states available later in 2024

Basis and Purpose (§ 431.12 (a))



Renames and expands the use of the Medical Care Advisory Committees. Creates a Beneficiary Advisory Council that will also share feedback and advise the State Medicaid agency.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
Section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.	Establishes the Medicaid Advisory Committee (MAC) and the Beneficiary Advisory Council (BAC) to advise the State Medicaid agency on matters of concern related to policy development, and matters related to the effective administration of the Medicaid program.	Name of Beneficiary Advisory Group changed to Beneficiary Advisory Council.	July, 9, 2025

MAC Membership and Composition (§ 431.12 (d))

The membership of the MAC must be composed of certain representative categories of interested parties in the State.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
The committee must include— (1) Board-certified physicians and other representatives of the health professions; (2) Members of consumers' groups**,** including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and (3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency	(d)(1) A percentage of MAC members must come from the BAC [10 percent, 20 percent, and then 25 percent thereafter]. *--MAC membership requirements continued on next slide--*	Replacing the language at § 431.12 (d)(1) to clarify the timeframe for States to reach 25 percent of MAC members coming from the BAC.	**10 percent** For the period from July 9, 2025 through July 9, 2026. **20 percent** For the period July 10, 2026 through July 10, 2027. **25 percent** Thereafter starting July 11, 2027. *correct dates shown.

MAC membership and composition (§ 431.12 (d))
continued

The membership of the MAC must be composed of certain representative categories of interested parties in the State.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
The committee must include— (1) Board-certified physicians and other representatives of the health professions; (2) Members of consumers' groups, including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and (3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency	(d)(2)Remaining 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. (C) As applicable, participating Medicaid MCOs, PIHPs, PAHPs, PCCM entities or PCCMs or a health plan association representing more than one such plans. (D) Other State agencies that serve Medicaid beneficiaries as ex-officio, non-voting members.	None	July 9, 2025

Beneficiary Advisory Council (§ 431.12 (e))

Creates a dedicated Beneficiary Advisory Council to amplify the voices of people with lived Medicaid experiences.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
None	States must form and support a Beneficiary Advisory Council (BAC) to advise the state regarding their experience with the Medicaid program. The BAC, which can be an existing beneficiary group, is comprised of: • individuals who are currently or have been Medicaid beneficiaries • individuals with direct experience supporting Medicaid beneficiaries (family members and paid or unpaid caregivers of those enrolled in Medicaid). BAC must meet separately from the MAC, on a regular basis, and in advance of each MAC meeting.	Name of Beneficiary Advisory Group changed to Beneficiary Advisory Council. Clarified that that caregivers on the BAC can be “paid or unpaid.”	July 9, 2025

Annual Report (§ 431.12 (i))

Creates a requirement that the MAC, with state support, must write an annual report about its activities, including its recommendations.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
None	The MAC, with support from the state, must submit an annual report describing its activities, topics discussed, and recommendations. The state must review the report and include responses to the recommended actions. The state agency must then – • (1) Provide MAC members with final review of the report; • (2) Ensure that the annual report of the MAC includes a section describing the activities, topics discussed, and recommendations of the BAC, as well as the state's responses to the recommendations; and • (3) Post the report to the state's website.	Additional time provided to states to finalize and post its first annual report.	July 9, 2026 to finalize the first annual report. After the report has been finalized, states will have 30 days to post the annual report. Annually thereafter.

Home and Community-Based Services (HCBS)

Background

- Workforce shortages are reducing access to services and are expected to worsen in the future.
- Inadequate investment in oversight and monitoring increases risks for poor quality of care and harm for people receiving HCBS.
- Gaps in measurement and reporting prevent CMS and states from assessing and improving HCBS quality and outcomes and addressing racial and other disparities.

HCBS Provisions: Focused on Improving Access and Quality, Promoting Health Equity, and Strengthening the HCBS Workforce

- **Person-Centered Service Planning and Reporting Requirements** (§§ 441.301(c), 441.450(c), 441.540(c), 441.725(c), 441.311(b)(3), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Incident Management Systems and Critical Incident Reporting Requirements** (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **FFS Grievance Systems** (§§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii))
- **HCBS Payment Adequacy Reporting Requirements** (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Payment Adequacy Minimum Performance Level** (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))
- **Waiting List and Access Reporting Requirements** (§§ 441.311(d), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Quality Measure Set and Reporting Requirements** (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Website Transparency** (§§ 441.313, 441.486, 441.595, and 441.750)

Person-Centered Service Planning and Reporting Requirements (§§ 441.301(c), 441.450(c), 441.540(c), 441.725(c), 441.311(b)(3), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Strengthens oversight of person-centered service planning in HCBS

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirements	Establishes standardized annual reporting requirements and sets a 90% minimum performance level for states related to: • Percent of individuals continuously enrolled for at least 365 days who received a reassessment of functional need at least every 12 months; and • Percent of individuals continuously enrolled for at least 365 days who had the person-centered service plan reviewed, and revised as appropriate, based on the results of the required reassessment of functional need at least every 12 months	Minor changes only	Beginning July 9, 2027

Incident Management Systems and Critical Incident Reporting Requirements (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii)) (1 of 3)

Requires states to meet nationwide incident management system standards for monitoring HCBS programs

Prior requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to define critical incidents 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	Minor changes only	Beginning July 9, 2027

Incident Management Systems and Critical Incident Reporting Requirements (cont.) (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii)) (2 of 3)

Requires states to meet nationwide incident management system standards for monitoring HCBS programs

Prior requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to operate and maintain an electronic incident management system to identify report, triage, investigate, resolve, track, and trend critical incidents	Changed applicability date from 3 years to 5 years	Beginning July 9, 2029
No prior regulatory requirement	Requires providers to report to the state, within state-established timeframes and procedures, any critical incident that occurs during the delivery of services or as a result of the failure to deliver services	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires states to use other data sources (e.g., claims, Medicaid Fraud Control Unit, Child and Adult Protective Services, law enforcement) to the extent permissible under state law to identify critical incidents that are unreported by providers and occur during the delivery of services or as a result of the failure to deliver services	Minor changes only	Beginning July 9, 2027

Incident Management Systems and Critical Incident Reporting Requirements (cont.) (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii)) (3 of 3)

Requires states to meet nationwide incident management system standards for monitoring HCBS programs

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to ensure there is information sharing about the status and resolution of investigations between the state and the entities responsible for investigating critical incidents if the state refers critical incidents to other entities for investigation	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires states to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Establishes standardized annual reporting requirements and sets a 90% minimum performance level for states related to whether the following occur within state-specified timeframes: • Critical incident investigations are initiated; • Critical incidents are investigated and resolved; and • Corrective actions related to critical incidents are completed	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires states to report on an incident management system assessment every 24 months (may be reduced to every 60 months for states that meet incident management system requirements)	Minor changes only	Beginning July 9, 2027

FFS Grievance Systems (§§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii))

Requires states to establish a grievance (complaint) system in FFS HCBS

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to establish a grievance (complaint) system in FFS HCBS, and sets requirements for the state's grievance system, to allow beneficiaries to file a grievance related to the state's or a provider's performance of person-centered planning and service plan requirements and HCBS settings requirements	• Revised to specify a beneficiary may file a grievance related to the state's or a provider's performance of (rather than compliance with) the person-centered planning and service plan requirements and the HCBS settings requirements • Revised to specify beneficiaries and their authorized representatives should be able to involve other individuals or entities of their choosing to assist them throughout the grievance process, in addition to filing a grievance • Revised to ensure that authorized representatives or other individuals (including family members or other beneficiaries) are protected from punitive action when helping beneficiaries file grievances • Removed the proposed expedited FFS grievance resolution process and filing timeframe requirements	Beginning July 9, 2026

HCBS Payment Adequacy Reporting Requirements (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers	Added as a new requirement	Beginning July 9, 2027

HCBS Payment Adequacy Reporting Requirements (cont.) (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	• Requires states to report annually on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers, subject to certain exceptions • Requires states to report separately on self-directed services and on facility-based services	• Added habilitation as a service subject to the reporting requirement • Exempted the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 • Clarified that clinical supervisors are included in the definition of direct care workers • Excluded costs associated with travel, training, and personal protective equipment (PPE) for direct care workers from the calculation • Required states to exclude data on self-directed services in which the beneficiary sets the direct care worker's payment rate • Required states to report separately on facility-based services	Beginning July 9, 2028

HCBS Payment Adequacy Minimum Performance Level (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))

Requires that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires that states generally ensure that a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions	• Changed applicability date from 4 years to 6 years • Exempted the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 • Clarified that clinical supervisors are included in the definition of direct care workers • Excluded costs associated with travel, training, and PPE for direct care workers from the calculation • Excluded self-directed services in which the beneficiary sets the direct care worker's payment rate	Beginning July 9, 2030

HCBS Payment Adequacy Minimum Performance Level (cont.) (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))

Allows flexibilities and exemptions to the requirement that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Gives states the option, subject to certain reporting requirements, to establish a hardship exemption based on a transparent state process and objective criteria for providers facing extraordinary circumstances. States must submit a plan, subject to CMS review and approval, for reducing the number of providers that qualify for a hardship exemption within a reasonable period of time	Added as a new flexibility for states	Beginning July 9, 2030
No prior regulatory requirement	Gives states the option, subject to certain reporting requirements, to establish a separate minimum performance level for small providers meeting state-defined criteria based on a transparent state process and objective criteria. States must submit a plan, subject to CMS review and approval, for small providers to meet the 80% minimum performance requirement within a reasonable period of time	Added as a new flexibility for states	Beginning July 9, 2030
No prior regulatory requirement	CMS may waive the plan reporting requirements if the state demonstrates it has applied the small provider minimum performance level or the hardship exemption to less than 10 percent of the state's providers	Added as a new flexibility for states	Beginning July 9, 2030

Waiting List and Access Reporting Requirements (§§ 441.311(d), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires states to report on waiting lists in waiver programs and on service delivery timeliness for certain services

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to report annually on waiting lists for section 1915(c) waiver programs (and section 1115 demonstrations), including: • A description of how the state maintains the waiting list; • Number of people on the waiting list; and • Average amount of time new waiver enrollees waited to enroll	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires states to report annually on: • Average amount of time from when services were approved to when they started for individuals newly approved for homemaker, home health aide, personal care, and habilitation services within the past 12 months; and • Percent of authorized hours for homemaker, home health aide, personal care, and habilitation services provided within the past 12 months Note: States may report metrics using statistically valid random sampling of beneficiaries	Added habilitation as a service subject to the reporting requirements	Beginning July 9, 2027

HCBS Quality Measure Set and Reporting Requirements (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires states to report on a standardized set of HCBS quality measures and sets requirements for CMS to develop and update the measure set

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirements	Sets the process for CMS to develop and update, no more frequently than every other year, the HCBS Quality Measure Set through a process that allows for public input and comment, including through the Federal Register	• Revised the frequency for updating the measure set from at least every other year to no more frequently than every other year with the exception of annual technical updates and corrections • Required that CMS establish the measure set no later than December 31, 2026	No later than December 31, 2026

HCBS Quality Measure Set and Reporting Requirements (cont.) (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires states to report on a standardized set of HCBS quality measures and sets requirements for CMS to develop and update the measure set

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	• Requires states to report every other year on mandatory measures in the HCBS Quality Measure Set and establish performance targets and quality improvement strategies • Also allows for reporting on additional voluntary measures and for CMS to report on certain measures on a state's behalf	Changed applicability date from 3 years to 4 years	Beginning July 9, 2028
No prior regulatory requirement	Phases in requirements for stratification of data for certain measures by race, ethnicity, sex, age, rural/urban status, disability, language, or other factors	• Delayed phase-in schedule by one year • Removed Tribal status as a stratification factor	25%: July 9, 2028 50%: July 9, 2030 100%: July 9, 2032

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

Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires the state to operate a website (either directly or by linking to managed care plan websites) that provides the results of the HCBS reporting requirements and meets availability and accessibility requirements	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires CMS to report on its website the results of the HCBS reporting requirements that states report to CMS	None	Beginning July 9, 2027

Fee-For-Service

Background

- The Medicaid statute requires states to set rates that are sufficient to provide access to care consistent with care available to the general population in the same geographic areas.
- **CMS spends $805B (as of 2022) on Medicaid but has limited means to effectively benchmark state Medicaid rates relative to any absolute standards. This makes it difficult to define or enforce what is a "sufficient" rate and is the main motivating factor for this rulemaking provision.**
- CMS issued regulations in 2015 that required states to develop and update an access monitoring review plan (AMRP) that would rely on data and analysis to demonstrate access to care is consistent with the statutory requirement.
- States raised concerns over the burden associated with the 2015 requirements and the usefulness of the data analysis, while providers and other stakeholders also voiced dissatisfaction with the requirements.
- The new regulations focus on rate transparency and comparison to Medicare in certain instances – an effort to shed light on what has been historically low payment rates that can often impact provider participation and access to services.

FFS Provisions: Focusing on Transparency and Analysis

- Payment Rate Transparency Publication (§ 447.203(b)(1))
- Comparative Payment Rate Analysis (§ 447.203(b)(2) and (3))
- Payment Rate Disclosure (§ 447.203(b)(2) and (3))
- Interested Parties Advisory Group (§ 447.203(b)(6))
- Rate Reduction and Restructuring SPA Analysis Procedures (§ 447.203(c))

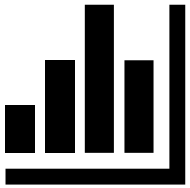
Payment Rate Transparency Publication (§ 447.203(b)(1))

Creates an extensive requirement for payment rate transparency of FFS rates and creates greater consistency in rate publication across states.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
Access Monitoring Review Plans (AMRPs) required States to provide an analysis of the actual or estimated levels of provider payment available from other payers, including other public and private payers for primary care, physician specialist services, behavioral health services, pre- and post-natal obstetric services including labor and delivery, and home health services.	Requires States to publish all Medicaid FFS fee schedule payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through a FFS delivery system on a website that is accessible to the general public and organized in a way the public can readily determine applicable rates for services.	None	July 1, 2026, and then updated as rates are updated

Comparative Payment Rate Analysis (§ 447.203(b)(2) and (3))

Creates a system to benchmark payment rates for certain services against Medicare rates for those services.



Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
AMRPs required States to provide an analysis of the actual or estimated levels of provider payment available from other payers, including other public and private payers for primary care, physician specialist services, behavioral health services, pre- and post-natal obstetric services including labor and delivery, and home health services.	Requires States to compare their rates for primary care, obstetrical and gynecological, and outpatient mental health and substance use disorder services to Medicare rates and publish the analysis every two years. CMS will provide States with the CPT codes and guidance for identifying the Medicare rates to be used for comparison.	None	July 1, 2026, and then every 2 years

Payment Rate Disclosure (§ 447.203(b)(2) and (3))

Creates a method for comparison of HCBS rates in the absence of an effective benchmark and standardizes the rate unit for more effective comparison of rates.

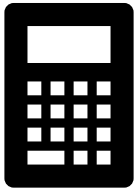
Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
AMRPs required an analysis of actual or estimated levels of provider payment available from other payers of payment rates for home health services compared to Medicaid every three years.	Requires states to publish the average hourly rate paid to direct care workers delivering personal care, home health aide, homemaker, and habilitation services and publish the disclosure every two years. The disclosure must also identify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services.	Addition of habilitation services	July 1, 2026, and then every 2 years

Interested Parties Advisory Group (§ 447.203(b)(6))

Establishes a focused group of workers and beneficiaries to examine rates for HCBS amidst a worker shortage

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
None	Requires states to establish an advisory group for direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties to meet at least every 2 years and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services	Addition of habilitation services	Within two years from the effective date, and at least every 2 years

Rate Reduction and Restructuring SPA Analysis Procedures (§ 447.203(c))



Reduces burden of previous requirements by creating a two-tier analysis and providing a template where states can demonstrate access is safeguarded when reducing or restructuring rates.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Dates
States were required to submit with any State Plan Amendment (SPA) that proposes to reduce or restructure provider payment rates where the changes could result in diminished access, an access review, in accordance with the AMRP, for each service affected by the SPA completed within the prior 12 months.	Requires states to demonstrate access sufficiency when submitting a state plan amendment with a rate reduction or restructuring. All states must complete a primary analysis examining if rates are at least 80% of Medicare, reduction <4%, and public process responses. If a state fails to meet these 3 standards, they must complete a secondary analysis examining provider and beneficiary data.	None	Effective date of the final rule

Questions

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- **HCBS provisions:** HCBSAccessRule@cms.hhs.gov
- **FFS provisions:** Jeremy Silanskis, Jeremy.Silanskis@cms.hhs.gov