CHILDREN'S HOSPITAL ASSOCIATION

May 2024

Ensuring Access to Medicaid Services Final Rule Summary

Internal

On Apr. 22, the Centers for Medicare and Medicaid Services (CMS) released the Medicaid Program; Ensuring Access to Medicaid Services final rule. This rule includes provisions that aim to increase transparency of provider payments and access to quality services within the fee-for-service delivery systems, including a focus on home- and community-based services.

The final rule:

- Includes pediatrics in the fee-for-service comparative payment rate analysis requirements for states.
- Requires states to include Medicaid beneficiaries, their families, and/or caregivers in Medicaid Advisory Committee and Beneficiary Advisory Councils.
- Requires states to provide CMS with an analysis of the impact on access when submitting a state plan amendment that includes provider rate reductions.

The detailed summary below outlines the key provisions of this final rule most relevant to children's health and children's hospitals. Several of the finalized provisions align with CHA's comments on the proposed rule.

Please reach out to Gabby Ahearn with any questions.

KEY PROVISIONS WITHIN THE RULE

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<tr><th>Issue</th><th>Provision in the Final Rule</th><th>CHA Proposed Rule Comments</th><th>Compliance Date</th></tr>
<tr><td colspan="4">Fee-for-Service (FFS)</td></tr>
<tr><td>Payment Rate Transparency

(§ 447.203 (b))</td><td>States are required to publish all Medicaid fee-for-service (FFS) fee schedule payment rates on a website that is accessible and understandable to the public. This does not include supplemental payments.
• For bundled payments, states are required to publish the Medicaid FFS bundled payment rate and identify constituent services included within the rate and how much is allocated to each constituent service.
• States are required to identify payment rates by population (pediatric and adult), provider type, and geographical location, if the rates vary.</td><td>CHA supported this provision.</td><td>Beginning Jul. 1, 2026. Then, updates must be made within 30 days of a payment rate change.</td></tr>
<tr><td>Comparative Payment Rate Analysis

(§ 447.203 (b))</td><td>States are required to report on state Medicaid base payment rates relative to Medicare rates for primary care, obstetrical and gynecological, outpatient mental health, and substance use disorder services. States are also required to publish average hourly payment rates for personal care, home health aides, homemakers, and habilitation services. This analysis does not include supplemental payments.
• If the rates vary, states must separately identify the payment rates by population (pediatric and adult), provider type, geographical location, and if the payment includes facility-related costs.
• If states do not comply with the reporting, grants may be reduced.
• States are required to create an advisory group for interested parties to consult on provider rates for services under the 1915(c) waivers.
• To compare the Medicaid payment rates to Medicare payment rates, the Medicare payment rates must be effective for the same time period for the evaluation and management (E/M) codes applicable to the category of service. If the rates vary, identification of</td><td>CHA supported this provision. However, CHA noted that Medicare is not the perfect benchmark, especially for pediatric services.</td><td>Beginning Jul. 1, 2026. Then, an updated analysis must be published every other year.</td></tr>
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<td>population (pediatric and adult), provider type, and geographic location are needed. The categories of service that the state agency must compare are primary care, obstetrical and gynecological, and outpatient mental health and substance use disorder services.</td>
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<td>State Analysis for Rate Reduction or Restructuring

(§ 447.203 (c))</td>
<td>(1) CMS created a tiered state analysis process when a rate reduction or restructuring is proposed, to ensure access is maintained. States must provide documentation that certain conditions are met and a description of state procedures for monitoring continued compliance. For CMS approval, states must show:
Aggregate Medicaid payment rates, including base and supplemental payments, from the proposed reduction or restructuring would be at or above 80% of the most recently published Medicare payment rates for comparable Medicare-covered services.
The restructuring or reduction would result in no more than a 4% reduction in aggregate FFS Medicaid expenditures within a state's fiscal year for the relevant benefit category.
The reductions created no significant access to care concerns from beneficiaries, providers, or other interested parties. If such concerns were made, states can reasonably respond to the concerns.
(2) If the conditions above are not met, additional analysis is needed - states are required to provide the following to CMS:
A summary of the proposed payment change, including the reason.
Medicaid payment rates in the aggregate, including base and supplemental payments, before and after the proposed reduction or restructuring.
States must also include a comparison of each of the most recently published Medicare payment rates to comparable Medicare-covered services and the most recently available payment rates of other health care payers in the geographic area for comparable services.
The number of actively participating providers of services in each benefit category affected by the proposal.
An actively participating provider is someone participating in the Medicaid program and providing services to</td>
<td>CHA supported this provision. However, CHA did note that it would be beneficial to increase the additional analysis requirements to be at least 100% of Medicare.</td>
<td>Beginning on Jul. 9, 2024.</td>
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	Medicaid beneficiaries. o States must provide the number of actively participating providers of services in each effected benefit category for the 3 years following the state plan amendment submission date. These numbers must include geographic area, provider type, and site to service. o States are required to document trends in the number of participating providers and provide estimates of the anticipated effect on the number of participating providers in each benefit category affected. • The number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposal. o States are required to report the number of beneficiaries receiving services in each affected benefit category for the 3 years following the state plan amendment submission date. o States must report observed trends in the number of individuals receiving services. States are required to provide information on the beneficiary population, including the number of beneficiaries who are adults and children and individuals living with disabilities. o States must provide an estimate on the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposal. • The number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposal. o States must provide the number of Medicaid services furnished in each affected benefit category for 3 years following the state plan amendment submission date. o States must report observed trends in the number of Medicaid services furnished. o States must provide information about the Medicaid services furnished, including the number of Medicaid services furnished to adults and children and who are living with disabilities. • A summary of and the state's response to any access to care concerns or complaints.		

	(3) States are required to comply with requirements for rate reduction or restructuring. • States that fail to provide the information and analysis to support the reduction or restructuring may be subject to state plan amendment disapproval. • States that submit all necessary information but fail to address unresolved concerns about access may be subject to state plan amendment disapproval. (4) States are required to have ongoing mechanisms for beneficiary and provider input on access to care. • States should respond to public input and cite specific access problems with investigation, analysis, and response. • States are required to maintain a record of data on public input and how the state responded. • States are required to submit a corrective action plan with steps and a timeline, 90 days after discovery.		

Home and Community-based Services (HCBS)			
New HCBS Requirements (multiple citations across HCBS authorities)	**(1) Person-centered care:** The individual or the individual's authorized representative will lead the person-centered planning process. States must ensure the person-centered service plan for every individual is reviewed and revised, at least every 12 months. States are required to show that it meets the minimum performance levels.	CHA did not comment on this provision.	**(1) Person-centered care:** Beginning on Jul. 9, 2027.
	(2) Incident management system: States are required to operate an incident management system that identifies, reports, investigates, resolves, tracks, and trends critical incidents. States must incorporate a continuous quality improvement process including monitoring, remediation, and quality improvement. States are required to show that it meets the minimum performance levels.		**(2) Incident management system:** Beginning on Jul. 9, 2027, except for the incident management system, which begins on Jul. 9, 2029.
	(3) Grievance system: States are required to create a procedure under which a beneficiary may file a grievance related to the state or provider's performance. The performance relates to person-centered planning, service plan requirements, and minimum performance at the state level. The process for handling grievances includes acknowledging each grievance, providing an opportunity to present evidence, providing beneficiaries with language services, and allowing beneficiaries to file a grievance at any time.		**(3) Grievance system:** Beginning on Jul. 9, 2026.

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<td>HCBS Payment Transparency and Adequacy</td>
<td>States are required to ensure a minimum of 80% of Medicaid payments be spent on compensation for direct care workers (as opposed to administrative overhead or profit).
Compensation includes salary, wages, and other remuneration, benefits, and the employer share of payroll taxes.
States have the option to establish a hardship exemption based on objective criteria for providers facing extraordinary circumstances and a separate performance level for small providers meeting state-defined criteria based on objective criteria.</td>
<td>CHA supported the general goal of ensuring the direct care workforce is paid fairly but had concerns with the 80% minimum requirement. CHA feels this could further strain access to high quality agencies.</td>
<td>Beginning on Jul. 9, 2030.</td>
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<td>Access Reporting Requirements

(§§ 441.303(f)(6), 441.311(d), 441.474(c), 441.580(i), 441.745(a)(1)(vii))</td>
<td>Creates several new reporting requirements related to HCBS waiver waiting lists, timely access to HCBS, and utilization in programs under sections 1915(c), (i), (j), and (k).

(1) Waiting Lists
States must describe how the waiting list is maintained and a list of individuals waiting to enroll.

(2) Timely Access and Service Utilization
States must report the average amount of time that services are approved to when services began, for individuals receiving services in the past 12 months.</td>
<td>CHA supports accountability as it relates to waiting lists.</td>
<td>Beginning on Jul. 9, 2027, for compliance reporting and access reporting.

Beginning on Jul. 9, 2028. for reporting on the HCBS Quality Measure Set and HCBS payment adequacy reporting.</td>
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<td>HCBS Quality Measures

(§§ 441.311(c), 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v))</td>
<td>CMS creates a new framework for HCBS quality measures that would govern CMS's efforts to update the HCBS Quality Measure Set.

States are required to report every other year on all measures.</td>
<td>CHA supports accountability as it relates to quality measures.</td>
<td>HHS Secretary will begin identifying quality measures no later than Dec. 31, 2026, and no more frequently than every other year.</td>
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Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)			
Advisory Committee Requirements **(§ 431.12)**	States are required to establish a public Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Committee (BAC) They must meet separately. MACs must be compromised of mostly diverse stakeholders, while BACs must be compromised of people with lived experiences with the Medicaid program. (1) **MAC Membership and Composition** • MAC membership and composition will include a phased in approach from Jul. 9, 2024, to Jul. 10, 2026. A certain percentage of MAC members must come from the BAC. • Must include at least one member from each of the following categories – state or local consumer advocacy groups, clinical providers or administrators, participating Medicaid MCOs, PIHPs, PAHPs, PCCM entities, or PCCMS, and other state agencies that serve Medicaid beneficiaries. (2) **BAC Membership and Composition** • Must be comprised of individuals who are currently or have been Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries. The BAC membership must also include other state agencies that serve Medicaid beneficiaries. (3) **MAC and BAC Administration** • States are required to publish bylaws for governance on the State website, including a list of members. • States are required to post meeting minutes from past MAC and BAC meetings. • States must publish MAC and BAC recruitment and selection, and leadership selection. • States must publish a regular meeting schedule. MAC and BAC must meet once per quarter. • Two MAC meetings per year must be open to the public, with a dedicated time during the meeting for the public to make comments. • States must offer a variety of meeting attendance options and ensure the meeting times and locations are selected to maximize attendance. • States must ensure that meetings are accessible to people with disabilities.	CHA recommended that CMS ensures that families of children currently enrolled in Medicaid, especially those with medical complexities, are included and represented on each MAC and BAC as those with lived experience. CHA stated that families should be appropriately compensated for their participation.	**Establishment of MAC and BAC:** Beginning on Jul. 9, 2025. **BAC crossover on MAC:** BAC members must comprise 10% of the MAC from July 9, 2024 through and July 9, 2025; 20% for July 10, 2025 through July 9, 2026; and 25% thereafter. **Annual Report:** States have until Jul 9, 2026, to finalize the first annual report. After the report is finalized, states have 30 days to post the report.