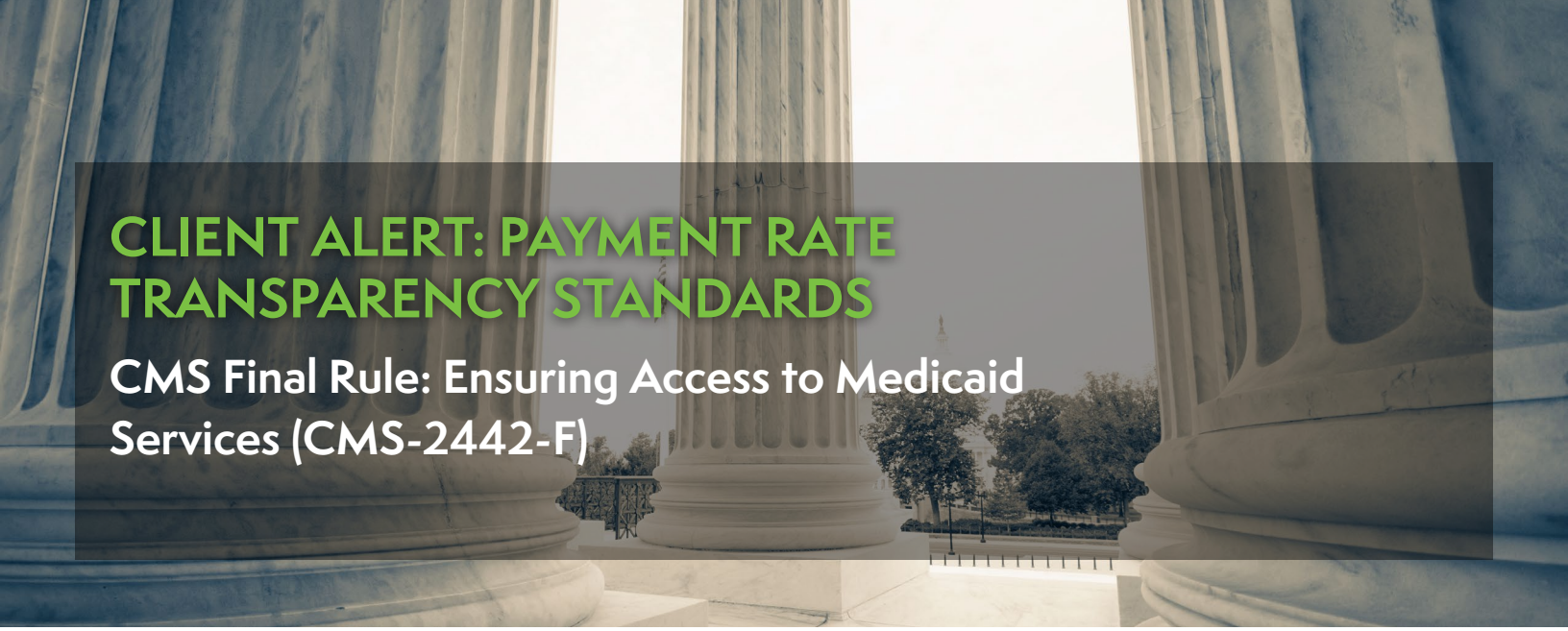

CLIENT ALERT: PAYMENT RATE TRANSPARENCY STANDARDS

CMS Final Rule: Ensuring Access to Medicaid Services (CMS-2442-F)

On May 10, 2024, the Centers for Medicare & Medicaid Services (CMS) published a final rule titled: *Medicaid and Children's Health Insurance Program (CHIP) Ensuring Access to Medicaid Services (CMS-2442-F).* The final rule rescinds the existing access monitoring review plan (AMRP) requirements at 42 CFR § 447.203(b) and replaces it with new requirements around Medicaid fee-for-service (FFS) payment rate transparency.

The intended purpose of the new requirements is to ensure State compliance with the Section 1902 (a)(30)(A) of the Medicaid statute. Specifically, states must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[1]

The final rule requirements address this intent by:

- Increasing Medicaid FFS payment rate transparency, standardizing state data and information requirements, and decreasing state administrative burden though targeted rate review.
- Offering greater clarity into how Medicaid payment levels affect beneficiary access to care.
- Providing data to CMS to demonstrate that any provider rate reductions or restructuring will not harm beneficiary access to care.

How Myers and Stauffer can help

This section outlines the new payment transparency requirements, most of which must be met by July 1, 2026. There are new rate reduction and restructuring state plan amendment (SPA) procedures that apply beginning on the effective date of the final rule. To be compliant with payment transparency requirements, states may need assistance with disclosing their rate information, performing required comparative payment rate analysis, identifying potential deficiencies, and addressing CMS concerns. Our experienced rate-setting team will ensure compliance by drawing on our more than 45 years of Medicare and Medicaid knowledge to meet our clients' Medicaid policy and program objectives and promote the best use of limited public funds.

[1] Section 1902 (a)(30)(A) of the Social Security Act.

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The finalized rate transparency requirements cover seven primary topic areas identified by CMS:

- State agency publication of Medicaid FFS rates.
- Comparative payment rate analysis and payment rate disclosure requirements and timeline.
- Interested parties advisory group for rates paid for certain services.
- Rate reduction or restructuring analysis requirements.
- Mechanisms for ongoing beneficiary and provider input.
- Remediation of inadequate access to care.
- Compliance actions for access deficiencies.

State Agency Publication of Medicaid FFS Rates

Final 42 CFR § 447.203(b)(1)

1. States are required to publish all Medicaid FFS rates on a website developed and maintained by the state that is accessible to the general public from a hyperlink on the state Medicaid agency's website.
2. Rates effective as of July 1, 2026, must be published by July 1, 2026, on the public-facing website. Thereafter, when rates are changed, states must ensure the posted rates are updated no later than one month after CMS approval of the applicable SPA or waiver, or in the case of rates updated based on previously approved rate methods, no later than one month after the effective date of the rate update. The state must include the date the rates were last changed.
3. Rates must be organized in such a way that the public can easily determine what Medicaid would pay for a service. For bundled rates, the state must identify each service and how much of the bundled payment is allocated to each service.
4. If rates vary, such as by population (pediatric and adult), provider type, geographic location, or other differentiators, each rate must be identified.

Comparative Payment Rate Analysis and Payment Rate Disclosure Requirements and Timeline

Final 42 CFR § 447.203(b)(2)

1. States are required to develop and publish a comparative payment rate analysis of Medicaid payment rates for the following categories of service:
    a. Primary care services.
    b. Obstetrical and gynecological services.
    c. Outpatient mental health and substance use disorder (SUD) services.
2. If the rates vary, the state must separately identify the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable.
3. States will be required to develop and publish a payment rate disclosure of Medicaid payment rates for the following categories of service:
    a. Personal care, home health aide, homemaker, and habilitation services, as specified in § 440.180(b)(2) through (4), provided by individual providers and providers employed by an agency.

Final 42 CFR § 447.203(b)(3)

1. The *comparative payment rate analysis* for primary care services, obstetrical and gynecological services, and outpatient mental health and SUD services must compare Medicaid FFS rates to the most recently published Medicare rates for the same period for evaluation and management (E/M) codes applicable to the category of service. Rates must be compared at the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code level.
2. The comparative payment rate analysis must:
    a. Be organized by category of service in 42 CFR § 447.203(b)(2)(i) through (iii), e.g., primary care services, obstetrical and gynecological services, and outpatient mental health and SUD services.
    b. Identify the Medicaid base payment rate by E/M, CPT, or HCPCS code, including, if the rates vary, separate identification by population (pediatric and adult), provider type, and geographical location, as applicable.
    c. Identify the Medicare non-facility payment rates effective for the same period for the same E/M, CPT, or HCPCS codes for the same geographical location as the Medicaid base payment rates and including, separate identification of the payment rates by provider type.
    d. Specify the Medicaid base payment rate as a percentage of the Medicare non-facility rate for each of the services for which a Medicaid base payment rate is published.
    e. Specify the number of Medicaid-paid claims and the number of Medicaid beneficiaries who received a service within a calendar year for each of the services for which the Medicaid base payment rate is published.
3. For personal care, home health aide, and homemaker services, the state is required to publish a payment rate disclosure that expresses the state's payment rates as the average hourly payment rates, separately identified for payments made to individual providers and to providers employed by an agency, if the rates vary. The payment rate disclosure must:
    a. Be organized by category of service in 42 CFR § 447.203(b)(2)(iv), e.g., personal care, home health aide, homemaker, and habilitation services.
    b. Identify the average hourly payment rates by category of service, including, if the rates vary, separate identification of the average hourly payment rates for payments made to individual providers and to providers employed by an agency, by population (pediatric and adult), provider type, and geographical location, as applicable.
    c. Specify the number of Medicaid-paid claims and the number of Medicaid beneficiaries who received a service within a calendar year for each of the services for which the average hourly payment rates are published.

Final 42 CFR § 447.203(b)(4)

States must publish their initial comparative payment rate analysis and payment rate disclosure for Medicaid rates in effect as of July 1, 2025, by July 1, 2026. Thereafter, states must update the analysis and disclosure no less than every two years, by July 1 of the second year after the latest update. Publication requirements are the same as the requirements for publication of Medicaid FFS rates § 447.203(b)(1).

Final 42 CFR § 447.203(b)(5) compliance with payment rate transparency, comparative payment rate analysis, and payment rate disclosure requirements.

If a state fails to comply with the payment rate, transparency, comparative payment rate analysis, and payment rate disclosure requirements, CMS may defer federal financial participation (FFP). CMS will estimate the amount of FFP attributable to the state's administrative expenditures relative to total expenditures for the categories of service for which the state has not complied. Deferred FFP will be released once the state is in compliance.

Interested-Parties Advisory Group for Rates Paid for Certain Services

Final 42 CFR § 447.203(b)(6) Interested parties advisory group for rates paid for certain services

1. States must establish an "interested parties advisory group" to advise and consult on provider rates under the state plan, 1915(c) waiver, and demonstration programs where payments are made to direct care workers. The group must include direct care workers, beneficiaries and their representatives, and other interested parties impacted by the rates.
2. The group will advise and consult with the state regarding payment rates, home and community-based services (HCBS) payment adequacy data, and access to care metrics to ensure rates are sufficient to ensure access, including an adequate number of direct care workers.
3. The first meeting must be held within two years of the effective date of the final rule and at least every two years after. The group will make recommendations to the state about the sufficiency of direct care worker payment rates. The state must publish the recommendations within one month of when the group makes a recommendation to the state. The state must make information available to the group regarding payment rates, HCBS provider payment adequacy minimum performance and reporting standards, and access to care metrics.

Rate Reduction or Restructuring Analysis Requirements

Final 42 CFR § 447.203(c)(1) Initial State analysis for rate reduction or restructuring

1. For any SPA that seeks to reduce payment rates, or restructure payment rates in a way that could result in diminished access, the state must provide written assurance and relevant supporting documentation that the following are met:
    a. Aggregate Medicaid payment rates (base and supplemental) for the service category after the proposed reduction or restructuring are at or above 80 percent of the most recently published Medicare rates for the same or comparable service.
    b. The proposed rate reduction or restructuring for the service, combined with any other rate reductions or restructurings in the state fiscal year, results in no more than a four percent reduction in aggregate Medicaid expenditures.
    c. The public process in § 447.203(c)(4) yields no significant access to care concerns from beneficiaries, providers, or other interested parties, or if there are concerns, the state can reasonably respond to or mitigate the concerns.

Final 42 CFR § 447.203(c)(2) Additional state rate analysis

1. For any SPA that seeks to reduce payment rates, or restructure payment rates in a way that could result in diminished access, if the three criteria in § 447.203(c)(1) are not met, the state must submit the items required in § 447.203(c)(1), plus:
    a. A summary of the proposed change, the state's reason for the change and the policy purpose, and the cumulative effective of all reductions or restructurings in the state fiscal year for the service.
    b. Aggregate Medicaid payment rates (base and supplemental) for the service category before and after the reduction or restructuring and a comparison of each (before and after) to the most recent Medicare rates, and if feasible, the most recent available payment rates of other payers in the state or geographic area for the same or comparable services.
    c. The number of actively participating providers of the impacted service(s) and observed trends in the number of providers for each of the three years preceding the SPA submission date by state-specified geographic area (e.g., county or parish), provider type, and site of service. Actively participating means participating in the Medicaid program and actively providing services or accepting new Medicaid patients.
    d. The number of Medicaid beneficiaries receiving services through FFS for the impacted service(s) and observed trends in the number of Medicaid beneficiaries for each of the three years preceding the SPA submission date by state-specified geographic area (e.g., county or parish), provider type, and site of service. The state must include information about beneficiary populations, including the number and proportion of children and adults living with disabilities and how the proposed payment changes may affect access for various populations. The state must provide an estimate on the anticipated effect on the number of Medicaid beneficiaries in FFS.
    e. The number of Medicaid services furnished through FFS for the impacted service(s) and observed trends in the number of Medicaid services for each of the three years preceding the SPA submission date by state-specified geographic area (e.g., county or parish), provider type, and site of service. The state must include information about Medicaid services, including the number and proportion of Medicaid services to children and adults living with disabilities and how the proposed payment changes may affect access for various populations. The state must provide an estimate on the anticipated effect on the number of Medicaid services in FFS.
    f. A summary of and the state's response to access-to-care concerns from beneficiaries, providers, and other interested parties.

Final 42 CFR § 447.203(c)(3) Compliance with requirements for state analysis for rate reduction or restructuring

1. A SPA to reduce or restructure payment rates in a way that could result in diminished access is subject to disapproval by CMS if the states does not provide the information and analysis under § 447.203(c)(1) and § 447.203(c)(2) to support approval.
2. If the state submits the required information, but there are unresolved access concerns, the SPA may be subject to disapproval.
3. If state monitoring of beneficiary access after the reduction or restructuring of payment rates takes effect shows reduced access to care, or if the state or CMS experience an increase in beneficiary or provider complaints about access, CMS may take compliance action under 42 CFR § 430.35 *Withholding of payment for failure to comply with Federal requirements.*

Mechanisms for Ongoing Beneficiary and Provider Input

Final 42 CFR § 447.203(c)(4)

States must have mechanisms for beneficiary and provider input on access to care (hotlines, surveys, ombudsman, review of grievance and appeals data, or an equivalent mechanism) and should promptly respond to public input with an appropriate investigation, analysis, and response. States must maintain a record of public input and the state's response and provide to CMS upon request.

Remediation of Inadequate Access to Care

Final 42 CFR § 447.203(c)(5)

When access to care deficiencies are identified, states must submit a corrective action plan within 90 days of discovery. The corrective action plan must have specific steps and timelines, with remediation occurring within 12 months.

Compliance Actions for Access Deficiencies

Final 42 CFR § 447.203(c)(6)

To remedy an access deficiency, CMS may take compliance action under 42 CFR § 430.35 *Withholding of payment for failure to comply with Federal requirements.*

FOR MORE INFORMATION

Myers and Stauffer is available to discuss any issues in the finalized rule. If you have questions or need assistance in assessing the impact of these changes or are in need of guidance in implementing required payment rate transparency changes, please contact the following members of our rate setting engagement team.

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