CENTERS FOR MEDICARE & MEDICAID SERVICES

Access Rule – Financial Provisions
June 13, 2024

Fee-For-Service (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))

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.

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

Payment Rate Transparency (447.203(b)(1)(i) to (iv))

(b)(1) *Payment rate transparency.* The State agency is required to publish all Medicaid fee-for-service fee schedule payment rates on a website that is accessible to the general public.

- (i) For purposes of this paragraph (b)(1), the payment rates that the State agency is required to publish are Medicaid fee-for-service fee schedule payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through a fee-for-service delivery system.

- (ii) The website where the State agency publishes its Medicaid fee-for-service payment rates must be easily reached from a hyperlink on the State Medicaid agency's website.

- (iii) Medicaid fee-for-service payment rates must be organized in such a way that a member of the public can readily determine the amount that Medicaid would pay for a given service.

- (iv) In the case of a bundled payment methodology, the State must publish the Medicaid fee-for-service bundled payment rate and, where the bundled payment rate is based on fee schedule payment rates for each constituent service, must identify each constituent service included within the rate and how much of the bundled payment is allocated to each constituent service under the State's methodology.

Payment Rate Transparency (447.203(b)(1)(v) and (vi))

- (v) If the rates vary, the State must separately identify the Medicaid fee-for-service payment rates by population (pediatric and adult), provider type, and geographical location, as applicable.

- (vi) The initial publication of the Medicaid fee-for-service payment rates shall occur no later than July 1, 2026 and include approved Medicaid fee-for-service payment rates in effect as of July 1, 2026. The agency is required to include the date the payment rates were last updated on the State Medicaid agency's website and to ensure these data are kept current where any necessary update must be made no later than 1 month following the latter of the date of CMS approval of the State plan amendment, section 1915(c) HCBS waiver amendment, or similar amendment revising the provider payment rate or methodology, or the effective date of the approved amendment. In the event of a payment rate change that occurs in accordance with a previously approved rate methodology, the State will ensure that its payment rate transparency publication is updated no later than 1 month after the effective date of the most recent update to the payment rate.

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

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

2) Comparative payment rate analysis […]. The State agency is required to develop and publish a comparative payment rate analysis of Medicaid fee-for-service fee schedule payment rates for each of the categories of services in paragraphs (b)(2)(i) through (iii) of this section. If the rates vary, the State must separately identify the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable. […]

- (i) Primary care services.
- (ii) Obstetrical and gynecological services.
- (iii) Outpatient mental health and substance use disorder services.

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

(3) Comparative payment rate analysis […] requirements. The State agency must develop and publish, consistent with the publication requirements described in paragraphs (b)(1) through (b)(1)(ii) of this section, a comparative payment rate analysis […].

- (i) For the categories of services described in paragraph (b)(2)(i) through (iii) of this section, the comparative payment rate analysis must compare the State agency's Medicaid fee-for-service fee schedule payment rates to the most recently published Medicare payment rates effective for the same time period for the evaluation and management (E/M) codes applicable to the category of service. The State must conduct the comparative payment rate analysis at the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code level, as applicable, using the most current set of codes published by CMS, and the analysis must meet the following requirements:
  - (A) The State must organize the analysis by category of service as described in paragraphs (b)(2)(i) through (iii) of this section.
  - (B) The analysis must clearly identify the base Medicaid fee-for-service fee schedule payment rates for each E/M CPT/HCPCS code identified by CMS under the applicable category of service, including, if the rates vary, separate identification of the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable.
  - (C) The analysis must clearly identify the Medicare non-facility payment rates as established in the annual Medicare Physician Fee Schedule final rule effective for the same time period for the same set of E/M CPT/HCPCS codes, and for the same geographical location as the base Medicaid fee-for-service fee schedule payment rates, that correspond to the base Medicaid fee-for-service fee schedule payment rates identified under paragraph (b)(3)(i)(B) of this section, including separate identification of the payment rates by provider type.
  - (D) The analysis must specify the base Medicaid fee-for-service fee schedule payment rate identified under paragraph (b)(3)(i)(B) of this section as a percentage of the Medicare non-facility payment rate as established in the annual Medicare Physician Fee Schedule final rule identified under paragraph (b)(3)(i)(C) of this section for each of the services for which the base Medicaid fee-for-service fee schedule payment rate is published pursuant to paragraph (b)(3)(i)(B) of this section.
  - (E) The analysis must specify 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 for which the base Medicaid fee-for-service fee schedule payment rate is published pursuant to paragraph (b)(3)(i)(B) of this section.

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

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

2) […]payment rate disclosure. […] The State agency is further required to develop and publish a payment rate disclosure of the average hourly Medicaid fee-for-service fee schedule payment rates for each of the categories of services in paragraph (b)(2)(iv) of this section, as specified in paragraph (b)(3) of this section. If the rates vary, the State must separately identify the payment rates by population (pediatric and adult), provider type, geographical location, and whether the payment rate includes facility-related costs, as applicable.

- […]
- (vi) Personal care, home health aide, homemaker, and habilitation services, as specified in § 440.180(b)(2) through (4) and (6), provided by individual providers and provider agencies.

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

(3) […] payment rate disclosure requirements. The State agency must develop and publish, consistent with the publication requirements described in paragraphs (b)(1) through (b)(1)(ii) of this section, a […] payment rate disclosure.

- (ii) For each category of services specified in paragraph (b)(2)(iv) of this section, the State agency is required to publish a payment rate disclosure that expresses the State's payment rates as the average hourly Medicaid fee-for-service fee schedule payment rates, separately identified for payments made to individual providers and provider agencies, if the rates vary. The payment rate disclosure must meet the following requirements:
  - (A) The State must organize the payment rate disclosure by category of service as specified in paragraph (b)(2)(iv) of this section.
  - (B) The disclosure must identify the average hourly Medicaid fee-for-service fee schedule payment rates by applicable category of service, including, if the rates vary, separate identification of the average hourly Medicaid fee-for-service fee schedule payment rates for payments made to individual providers and provider agencies, by population (pediatric and adult), provider type, geographical location, and whether the payment rate includes facility-related costs, as applicable.
  - (C) The disclosure must 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 for which the average hourly Medicaid fee-for-service fee schedule payment rates are published pursuant to paragraph (b)(3)(ii)(B) of this section.

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

Interested Parties Advisory Group (§ 447.203(b)(6)(i) and (ii))

(6) Interested parties advisory group for rates paid for certain services.

- (i) The State agency must establish an advisory group for interested parties to advise and consult on provider rates with respect to service categories under the Medicaid State plan, 1915(c) waiver, and demonstration programs, as applicable, where payments are made to the direct care workers specified in § 441.311(e)(1)(ii) for the self-directed or agency-directed services found at § 440.180(b)(2) through (4), and (6).

- (ii) The interested parties advisory group must include, at a minimum, direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties impacted by the services rates in question, as determined by the State.

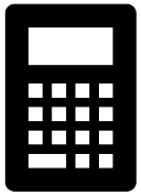
Interested Parties Advisory Group (§ 447.203(b)(6)(iii), (iv), and (v))

- (iii) The interested parties advisory group will advise and consult with the Medicaid agency on current and proposed payment rates, HCBS payment adequacy data as required at § 441.311(e), and access to care metrics described in § 441.311(d)(2), associated with services found at § 440.180(b)(2) through (4) and (6), to ensure the relevant Medicaid payment rates are sufficient to ensure access to personal care, home health aide, homemaker, and habilitation services for Medicaid beneficiaries at least as great as available to the general population in the geographic area and to ensure an adequate number of qualified direct care workers to provide self-directed personal assistance services.

- (iv) The interested parties advisory group shall meet at least every 2 years and make recommendations to the Medicaid agency on the sufficiency of State plan, 1915(c) waiver, and demonstration direct care worker payment rates, as applicable. The State agency will ensure the group has access to current and proposed payment rates, HCBS provider payment adequacy reporting information as described in § 441.311(e), and applicable access to care metrics as described in § 441.311(d)(2) for HCBS in order to produce these recommendations. The process by which the State selects interested party advisory group members and convenes its meetings must be made publicly available.

- (v) The Medicaid agency must publish the recommendations produced under paragraph (b)(6)(iv) of the interested parties advisory group consistent with the publication requirements described in paragraph (b)(1) through (b)(1)(ii) of this section, within 1 month of when the group provides the recommendation to the agency.

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

Rate Reduction and Restructuring SPA Analysis Procedures (§ 447.203(c)(1))

(c)(1) Initial State analysis for rate reduction or restructuring. For any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access where the criteria in paragraphs (c)(1)(i) through (iii) of this section are met, the State agency must provide written assurance and relevant supporting documentation that the following conditions are met as well as a description of the State's procedures for monitoring continued compliance with section 1902(a)(30)(A) of the Act, as part of the State plan amendment submission in a format prescribed by CMS as a condition of approval:

- (i) Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring would be at or above 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services.

- (ii) The proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the current State fiscal year, would be likely to result in no more than a 4 percent reduction in aggregate fee-for-service Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a State fiscal year.

- (iii) The public processes described in paragraph (c)(4) of this section and § 447.204 yielded no significant access to care concerns from beneficiaries, providers, or other interested parties regarding the service(s) for which the payment rate reduction or payment restructuring is proposed, or if such processes did yield concerns, the State can reasonably respond to or mitigate the concerns, as appropriate, as documented in the analysis provided by the State pursuant to § 447.204(b)(3).

Rate Reduction and Restructuring SPA Analysis Procedures (§ 447.203(c)(2)(i), (ii), and (iii))

(2) Additional State rate analysis. For any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access where the requirements in paragraphs (c)(1)(i) through (iii) of this section are not met, the State must also provide the following to CMS as part of the State plan amendment submission as a condition of approval, in addition to the information required under paragraph (c)(1) of this section, in a format prescribed by CMS:

- (i) A summary of the proposed payment change, including the State's reason for the proposal and a description of any policy purpose for the proposed change, including the cumulative effect of all reductions or restructurings taken throughout the current State fiscal year in aggregate fee-for-service Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a State fiscal year.

- (ii) Medicaid payment rates in the aggregate (including base and supplemental payments) before and after the proposed reduction or restructuring for each benefit category affected by proposed reduction or restructuring, and a comparison of each (aggregate Medicaid payment before and after the reduction or restructuring) to the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services and, as reasonably feasible, to the most recently available payment rates of other health care payers in the State or the geographic area for the same or a comparable set of covered services.

- (iii) Information about the number of actively participating providers of services in each benefit category affected by the proposed reduction or restructuring. For this purpose, an actively participating provider is a provider that is participating in the Medicaid program and actively seeing and providing services to Medicaid beneficiaries or accepting Medicaid beneficiaries as new patients. The State must provide the number of actively participating providers of services in each affected benefit category for each of the 3 years immediately preceding the State plan amendment submission date, by State-specified geographic area (for example, by county or parish), provider type, and site of service. The State must document observed trends in the number of actively participating providers in each geographic area over this period. The State may provide estimates of the anticipated effect on the number of actively participating providers of services in each benefit category affected by the proposed reduction or restructuring, by geographic area.

Rate Reduction and Restructuring SPA Analysis Procedures (§ 447.203(c)(2)(iv), (v) and (vi))

- (iv) Information about the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring. The State must provide the number of beneficiaries receiving services in each affected benefit category for each of the 3 years immediately preceding the State plan amendment submission date, by State-specified geographic area (for example, by county or parish). The State must document observed trends in the number of Medicaid beneficiaries receiving services in each affected benefit category in each geographic area over this period. The State must provide quantitative and qualitative information about the beneficiary populations receiving services in the affected benefit categories over this period, including the number and proportion of beneficiaries who are adults and children and who are living with disabilities, and a description of the State's consideration of the how the proposed payment changes may affect access to care and service delivery for beneficiaries in various populations. The State must provide estimates of the anticipated effect on the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring, by geographic area.

- (v) Information about the number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring. The State must provide the number of Medicaid services furnished in each affected benefit category for each of the 3 years immediately preceding the State plan amendment submission date, by State-specified geographic area (for example, by county or parish), provider type, and site of service. The State must document observed trends in the number of Medicaid services furnished in each affected benefit category in each geographic area over this period. The State must provide quantitative and qualitative information about the Medicaid services furnished in the affected benefit categories over this period, including the number and proportion of Medicaid services furnished to adults and children and who are living with disabilities, and a description of the State's consideration of the how the proposed payment changes may affect access to care and service delivery. The State must provide estimates of the anticipated effect on the number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring, by geographic area.

- (vi) A summary of, and the State's response to, any access to care concerns or complaints received from beneficiaries, providers, and other interested parties regarding the service(s) for which the payment rate reduction or restructuring is proposed as required under § 447.204(a)(2).

Administrative Match

- Under section 1903(a)(7) of the Social Security Act, federal payment is available at a rate of 50 percent for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 CFR 433.15(b)(7).
- Claims for Medicaid administrative federal financial participation (FFP) must come directly from the single state Medicaid Agency. In addition, the state must ensure that permissible, non-federal funding sources are used to match federal dollars.
- In order for Medicaid administrative expenditures to be claimed for federal matching funds, certain requirements must be met.
- States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested States should refer to 42 CFR Part 433, Subpart C (Mechanized Claims Processing and Information Retrieval Systems), for the specifics related to systems approval.

Questions?

- Medicaid state leads
- MedicaidAccesstoCare@cms.hhs.gov
- SchoolBasedServices@cms.hhs.gov (for administrative claiming questions)