HHS-CMS-CMCS
4/30/24
3:00 pm ET

Coordinator: Afternoon, and thank you for standing by. Your lines are in a listen-only mode until a question-and-answer session of today's conference. At that time, you may press star followed by the number one to ask a question. Please unmute your phones and state your name when prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time. It is now my pleasure to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you, and good afternoon, and welcome, everyone, to today's All-State Call and Webinar. I'll now turn to Dan Tsai, our Center Director, for opening remarks. Dan?

Dan Tsai: Hello. Thanks, Jackie. Good afternoon, everybody. Thanks for joining. We - it is rule season, apparently. Many of you, our state counterparts, have been deep in discussions with us through NAMD on these topics, so I hope you all know that last week, on Monday, we released three rules, two Medicaid rules, and one around nursing home staffing from the Centers for Clinical Standards and Quality.

On the Medicaid side, an access rule and a managed care rule that we've had quite a bit of discussion around and have a lot of work to do all together. So, today's all-state call, the team is going to be going through the various

provisions of what we finalized in the access rule. And next week, we will do another all-state call, and we'll be going through what's in the managed care rule. I just wanted to note a few things before I introduce and turn it to the team.

Number one, if you're on this call, you care about Medicaid, you care about making sure there's access, and whether it be around home and community-based services, which there's a big focus on in our access rules, or some of the things in the managed care rule to really think about appointment wait time, or how do we make sure that enrollees, members, consumers, beneficiaries have a stronger voice at the table, or a whole myriad of other really important provisions. I know we've had lots of discussions with lots of state partners on this.

We also know that there's a lot going on, and even where we've heard tremendous alignment around the policy principles and even the detailed provisions and what that means, a lot of folks are just recognizing and understanding there's a lot to do, and states have a lot of inequities.

And so we're highly cognizant of that, and so you'll see in the two rules that the implementation timeframes really stretch out across a multi-year period. In some cases, up to six to seven years, depending on which provisions across these various rules.

And we've been having very close dialog with NAMD and others on how - what sort of engagement process is the most efficient and important to really get at how to operationalize all this and partnership together. And so, much more to come on that, but I want to acknowledge that, given how much folks have in their place, state-level, federal-level plans, providers that are working with us, et cetera.

So, for today, on the access rule, Karen Llanos, who's our Group Director for the Medicaid Innovation Accelerator Program; Jen Bowden, who's our Division Director for the Medicaid Benefits and Health Programs Group; and Jeremy Silanskis, who is the Deputy Director of FMG, or Financial Management Group, will be going through various provisions of the rule. There are a lot of our team that have been really pouring themselves into this, and many of you all have engaged quite deeply on this over the past few years as well. So, thank you, and with that, I'm going to pass it over to Karen. Thank you.

Karen Llanos: Thanks, Dan. Next slide, please. Next slide. So, good afternoon, everyone. I am going to walk you through how we're going to spend the next 50 or so minutes of our time today. As Dan noted, we have a lot of different rules to cover, but for the purposes of today's conversation, and we'll be mainly focused on the ensuring access to Medicaid services. However, I will mention some highlights from the Managed Care Access, Finance, and Quality Rule, but as mentioned previously, more of that to come on May 7th.

Then we'll talk a little bit about how these rules fit into CMS's overall access strategy. Then we'll do a deeper dive into key provisions of the Ensuring Access to Medicaid Services or the access rule, and then we'll have some time for questions and answers.

Next slide, please. So, these rules were released on Monday - last Monday, as Dan said. We are sure that everyone has spent the weekend reading all of our rules and have lots of questions. But, again, we released two rules, and as Dan mentioned, these rules really support the administration's goals to ensure greater access to Medicaid and CHIP services for all eligible individuals.

Among the provisions, we focus on both - across the provisions, we focus both on enhancing care provided through managed care and through fee-for-service. And again, as Dan noted, we really listened to the comments that came in. And you'll hear us cover, at least for the Ensuring Access to Medicaid Services final rule today, talk about some applicability dates. We really thought about how to do this in a way that would allow states time to implement these changes in a well-thought-out way.

Next slide, please. So, I'll just briefly cover some of the key provisions across both rules, and again, this is just to give you some context for how these rules fit together. In the managed care rule, which we'll hear about on May 7th, that rule establishes national maximum standards for certain appointment wait times for managed care enrollees. The managed care rule also requires states to conduct independent secret shopper surveys of their Medicaid and CHIP managed care plans.

And these are the types of surveys that help assess compliance with appointment wait time standards and to identify inaccurate information that could be found in provider directories. Related to payment, you'll hear today about how the access rule creates new payment transparency requirements for states by requiring disclosure of provider payment rates and fee-for-service. And then you'll hear Jeremy talk more about how that other requirements in terms of - in comparison to Medicare rates for certain services and fee-for-service.

You'll also hear about how, in the access rule, we establish additional transparency and interested party engagement requirements for setting Medicaid payment rates for HCBS, and Jen will do a deeper dive into those provisions as well.

Next slide. Across both rules, we really focus on putting the beneficiary at the forefront. So, for example, in the access rule, we create timeliness of access measures for HCBS. We also talk about how states can strengthen their use of the newly formed or former medical care advisory committees, and I'll be talking more about that in just a little bit.

In the managed care rule, which you'll hear more about on May 7th next week, you'll hear how we are requiring states to conduct enrolling experience surveys on an annual basis for each managed care plan as a way to gather input directly from enrollees.

And then finally, you'll also hear the managed care team talk about how that rule establishes a framework for states to implement a Medicaid and CHIP quality rating system, or the one-stop shop for enrollees to compare Medicaid and CHIP managed care plans based on a variety of different dimensions, including quality of care, access to providers, covered benefits, and so on.

So, across these two rules, we really are packing a punch to ensure that our Medicaid and CHIP beneficiaries have access to Medicaid and CHIP services. Next slide. And we're actually going to skip that slide and go straight into the access strategy background.

So, we'll take a quick step back in terms of how these two rules fit into CMS's broader access strategy. We know that Medicaid and CHIP provide essential healthcare coverage for 85 million people. Beneficiaries get their care in a variety of different ways, including managed care, fee-for-service, and we know that previous regulations addressing access may not have been as comprehensive or consistent across payment systems and programs.

We wanted to address and impact access in a way that really took a

programmatic view of our portfolio of Medicaid and CHIP. And it also took into account an access framework that we had developed that really thought about how a Medicaid and CHIP beneficiary engages with the healthcare system.

So, we know that we wanted to remove barriers for eligible people when enrolling. And once they were enrolled, to make sure that we were taking steps to ensure equitable access for Medicaid - two Medicaid-covered health care services and support. And then while they were still enrolled, trying to maintain that coverage.

So, really wanted to mimic our goals with the life cycle of someone of access, so it's not just about getting access, but it's also ensuring that you have the ability to get enrolled and stay enrolled and maintain that coverage. And we did that through the three different rules, the Eligibility and Enrollment Rule, which was released in March, the rule that we're going to talk about today, ensuring access to Medicaid services, and then the rule that will be highlighted in the May 7th off-date call managed care final rule.

Next slide. This is just another kind of visualization of how we use a regulatory strategy across both rules. You'll hear us talk today a lot about how we are really trying to empower the beneficiary voice for a variety of different areas, but I'll be talking about it as it relates to the Medicaid Advisory Committee.

Then you will hear Jen talk about how we are promoting transparency, standardized reporting, and enhanced accountability in HCBS. Finally, Jeremy will talk about state rate transparency and access monitoring and fee-for-service. And again, that May 7th call is really going to be focused on that managed care access, finance, and quality final goal.

Next slide. So, these are the three topics that we'll talk about today. Next slide, please. So, the first area that we're going to talk about, that I'll talk about, is the Medicaid Advisory Committees, formerly known as the Medical Care Advisory Committees. This is a longstanding statutory provision. When we took a look at these regulations, we knew that they required states to establish these MCACs, or Medical Care Advisory Committees. We also knew that through the time that this requirement had existed, these committees tended to be limited to, in practice, to medical topics and didn't always put the beneficiary at the forefront or people with lived Medicaid experience.

And going into this, we knew that we wanted to make sure that beneficiaries' perspectives were central to operating a high quality and equitable healthcare coverage, and we knew that updating and revising the Medical Care Advisory Committee regulations would certainly be one vehicle to do that. When we looked at how states were currently operating their Medical Care Advisory Committees, we knew that there was wide variation.

The existing provisions were really limited in detail and requirements for how states operate and function their MCAC. So, we saw this as an opportunity to finalize more robust requirements to ensure that all Medicaid agencies using these committees could really optimize them in a way that could bring different types of experience - Medicaid experiences around the table with the beneficiary at the forefront.

Next slide. So, on this slide, I put the - all of the provisions within the section 431.12. I will only be talking about those in bold, which is basis and purpose, CAC membership and composition, Beneficiary Advisory Council, and annual report, and that's just for the sake of time. I note in the box to the right are applicability dates, so except noted for two areas, C1 and I3, all of the

requirements under Section 431.12, A through J are applicable as of July 9, 2025.

We also have been working on a toolkit for states, and that will be available later this year. Next slide, please. So, basis and purpose. Under paragraph A, we are renaming and expanding the use of the Medical Care Advisory Committees by - and creating a Beneficiary Advisory Council that would also share feedback and advise the state Medicaid agency.

So, as you can see in the table, this was an existing requirement that we were building off of. And we wanted to use this to really establish, not just redesign and overhaul the existing committee into the Medicaid Advisory Committee, but also add a Beneficiary Advisory Council that would also help and advise the Medicaid agency on matters of concern related to policy development and matters related to the effective administration of the Medicaid program.

And so, we did expand its purview, really focusing on policy - impacting policy development and providing feedback related to the program. We heard this through public comment that we really - our interested parties really wanted to make sure that states were leveraging these committees in ways that felt impactful.

We changed the name of the Beneficiary Advisory Group to the Beneficiary Advisory Council, also based on comment, and we note the bookability dates, July 9, 2025. We really wanted to give, again, based on comments, we really wanted to give states time to build and repurpose their existing MCAC committees, and we know that that takes time. So, we've built out a year's worth of ramp-up time to really give states time to be thoughtful in terms of how they reconfigure their existing committees and create the new Beneficiary Advisory Council.

Next slide. Next, I wanted to highlight Paragraph B, membership, MAC membership and composition. So, this is the paragraph that talks about two different types of members, well, actually more than that, but two different categories of members. The members, so we talk about how the membership of the MAC must be composed of certain representative categories of interested parties in the state. This was a prior requirement. As you can see under the prior requirement column, the previous regulations were very high level. Mention of consumer groups and beneficiaries, not too detailed.

And the other types of people that should be around the table as part of the MCAC memberships, again, not too much detail. What we wanted to do and what we accomplished in the final rule was to create a more robust description of the types of people that should be around the table. And that's D2, which I'll cover in just a second, but I wanted to start with D1, where we talk about a percentage of the MAC numbers must come from the back of the Beneficiary Advisory Council.

We call this, sometimes we refer to this as the back crossover on the MAC, but this is a way to have to ensure that the MAC membership has beneficiaries or caregivers and or family members as part of this broader membership. Important to note here is that based on comment, we heard that states wanted a more graduated approach to reaching that 25 minimum percent threshold. We did that, so we now have 10%, 20% and then 25%, you'll see the correct dates listed under applicability dates here. So, we're giving states the starting point of 10% for a year, moving to 20%, and then 25% thereafter, July 11, 2027.

Next slide. So the second part of the MAC membership and composition is who else should be around the table in addition to that crossover from the

Beneficiary Advisory Council. Again, this is an existing requirement that we fleshed out more. We created four main categories that we felt based on research and in speaking with our state partners that could be representative of the Medicaid community in most states.

So, we have, and I will note, we did not talk about numbers. We did mention that it should be at least one from each of the following categories to allow for maximum flexibility in terms of what your state looks like. So, in the interest of time, I won't run through the examples. I will note or I won't run through the categories. I will note that under D, other state agencies that serve Medicaid beneficiaries as ex-officio non-voting members, this was an existing category.

We tweaked it a little bit and we modified it to make sure that states had optimal flexibility in pulling in other sister agencies, such as, for example, the Department of Public Health, Foster Care, Behavioral Health, as expectation non-voting members.

So, we did change that a little bit for states that may not have a lot of managed care. They can take their managed care category because it is as applicable and include other types of associations representing the types of providers or provider associations in their state.

Next slide. Beneficiary Advisory Council, I wanted to just spend a quick minute here. This is the creation of a brand new requirement. We mentioned that this is, the Beneficiary Advisory Council has members that would sit, percentage of them that would sit on the broader Medicaid Advisory Committee, this is a brand new requirement.

This really focuses on creating an opportunity for the Beneficiary Advisory

Council, not just to advise the state regarding their experiences, but really as the central vehicle, or one of the central vehicles that the state can use to access, increase - have increased access the beneficiary perspective.

We say who can be part of this Beneficiary Advisory Council. We have individuals who are currently or currently have been Medicaid beneficiaries, as well as individuals with direct experience supporting Medicaid beneficiaries. These can be family members or paid or unpaid caregivers of those enrolled in Medicaid.

We also note that the BAC must meet separately from the broader committee on a regular basis and in advance of each MAC meeting, and this aligns with best practices and what we've heard across the country in terms of states that may already operate councils like this.

We want to make sure that this committee has an opportunity to speak freely and to share feedback freely, and that is why we want them to meet separately, but then have the opportunity to cross over on the broader membership. Major change here is that we've changed the name based on comments to the Beneficiary Advisory Council. We've also clarified that caregivers can be paid or unpaid. And I'll quickly move to my final slide, which is the annual report.

So, again, this is a brand-new requirement. We added this requirement to promote transparency and accountability. We know that some beneficiaries, and when we spoke to folks across the country as part of our research, we knew - ew heard that some beneficiaries were not always aware that their states had medical care advisory committees, and if they did, they weren't sure exactly what these committees did or discussed.

And by creating an annual report, we hope to really amplify that transparency

in terms of what these committees are discussing, the types of recommendations that are being considered, the types of, you know, how these recommendations are implemented.

In terms of notable changes, we added more time for states to finalize and post their first annual report. The applicability date here is noted on the right. So, this is July 9, 2026, to finalize the first annual report. And this is a way to acknowledge that the state will have time to ramp up their MAC and their BAC, hold meetings, and then finalize your first annual report. And with that, I'll turn it over to Jen Bowden to cover our HCBS.

Jen Bowden: Great. Thanks, Karen. And hi, everyone. Thanks so much for your time today. So, my name is Jen Bowden. I'm the Director of the Division of Community Systems Transformation in the Medicaid Benefits and Health programs Group. So, I'm going to talk to you about the Home- and Community-Based Services or HCBS provisions in the access final rule.

So, the HCBS provisions focus on specific challenges related to HCBS and among other things, they are intended to help address HCBS workforce shortages, to strengthen oversight and monitoring in order to improve quality and reduce risk of harm for people receiving HCBS, and address gaps in measurement and reporting and reduce disparities in HCBS programs.

Next slide, please. So, this slide includes a list of the key HCBS provisions and their associated regulatory citations I'm going to review the highlights of each of these provisions on the next several slides. And as I do that, I'll try to point out some of the places where we've made changes to the requirements from what was proposed in response to public comments.

And then one thing I just want to note, though, before we jump into each of

the provisions, is that to promote consistency across Medicaid HCBS authorities, the requirements in the HCBS section of the rule apply with certain exceptions to HCBS under Sections 1915C, I, J, and K authorities and to Section 1115 demonstrations that include HCBS. And they apply to HCBS delivered under both fee-for-service and managed care.

Next slide, please. So, first are the person-centered service planning and reporting requirements. So, what we're doing here is strengthening oversight of person-centered service planning by establishing new reporting requirements and minimum performance levels.

And specifically, we're requiring that states report annually and meet a minimum 90% performance level related to whether HCBS beneficiaries who have been continuously enrolled for at least a year have had a reassessment of functional needs within the past 12 months and whether their service plan was updated as a result of a reassessment of functional need within the past 12 months. These requirements are applicable in three years, and we finalized the requirements largely as proposed.

Next slide, please. So, you'll see on the next several slides related to incident management systems and critical incident reporting that we're requiring states to meet nationwide standards for monitoring their HCBS programs, and this includes, as you'll see on this slide, a requirement for for states to have a minimum standard definition of a critical incident. Oh, please go back one slide, please. Thanks.

So, this definition minimally states need to include in their definition of critical incidents, 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 and a

telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, hospitalization or death, or an unexplained or unanticipated death including but not limited to a death caused by abuse or neglect.

And this requirement for states to have a definition that minimally meets these requirements takes effect in three years, and we made only minor changes to this requirement from what was proposed.

Next slide, please. So, we're also requiring states to have electronic incident management systems, requiring provider reporting of critical incidents, and requiring states to use other data sources aside from provider reports, things like claims or adult protective service data to identify critical incidents.

These requirements are applicable in three years with the exception of a requirement for an electronic system, which we had proposed to also take effect in three years, but we have finalized that requirement, the electronic system requirement, as a five-year requirement. Other changes to these requirements from what was proposed were minor changes only.

Next slide, please. For states that refer critical incidents to other entities for investigation, we're also requiring information sharing between the state and investigative agencies on the status and resolution of incident investigations, and we're requiring states to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes.

We're also establishing new reporting requirements and minimum performance levels for latest critical incidents, and specifically, states are required to report annually and meet a 90% minimum performance level

related to whether critical incident investigations are initiated timely, whether the investigations are completed and resolved timely, and whether corrective actions are completed timely.

States also have to report every 24 months on an incident management system assessment. However, the frequency of the assessment may be reduced every 60 months for states determined to meet incident management system requirements. And these requirements that are showing in this slide are all applicable in three years, and we made only minor changes from what was proposed.

Next slide, please. For states that deliver HCBS through fee-for-service delivery systems, we are requiring that states established within two years grievance or complaint systems for those fee-for-service HCBS programs. And this is really to ensure that Medicaid beneficiaries receiving HCBS through fee-for-service delivery systems have the same opportunities as people enrolled in managed care to file complaints related to the state or provider's compliance with person-centered planning and HCBS settings requirements.

One key change we made to this provision was to not finalized the proposed expedited grievance resolution requirements. And then we also made some changes to clarify that the beneficiary can file grievances related to the performance of person-centered planning and HCBS settings requirements to clarify the role of authorized representatives and to protect from punitive action authorized representatives and other individuals supporting beneficiaries with filing grievances. And as I noted earlier, where this requirement is applicable in two years.

Next slide, please. Related to compensation for direct care workers, we are

requiring that states report on the percent of Medicaid payments for certain HCBS that is spent on compensation for direct care workers. This provision begins in three years with a requirement that states report on their readiness to collect data regarding the percent of Medicaid payments for four services, homemaker, home health aid, personal care, and habilitation services that are spent on compensation to direct care workers. And this readiness reporting requirement is a new requirement compared to what was included in the proposed rule.

Next slide, please. In four years, states are required to report with certain exceptions on the percentage of Medicaid payments for those four services I mentioned on the previous slide, homemaker, home health aid, personal care, and habilitation services that are spent on compensation to direct care workers. And states are required to report separately on self-directed services and on facility-based services. Based on public comment, we have made a number of changes to this requirement from what was proposed.

And specifically, the major changes include adding habilitation as a service subject to the reporting requirement, exempting the Indian Health Service and certain tribal health programs from the reporting requirement, clarifying that clinical supervisors are included in the definition of direct care workers, excluding costs associated with travel, training, and personal protective equipment for direct care workers from the calculation of the percent of payment spent on compensation, requiring states to include data on self-directed services in which the beneficiary sets the direct care worker's payment rate and requiring states to report separately on facility-based services.

Next slide, please. So, in addition to the HCBS payment adequacy reporting requirements, we're also requiring that a minimum percentage of payments for

certain HCBS be spent on compensation for direct care workers. And specifically, this requirement kicks in, in six years, so states in six years will have to ensure a minimum of 80% of Medicaid payments for homemaker, home health aid, and personal care services be spent on compensation for direct care workers.

And the six-year applicability date for this requirement is a change from the four-year date that we had proposed. Similar to the payment adequacy reporting requirement, we also exempted the Indian Health Service and certain tribal health programs from the minimum performance requirement. We clarified that clinical supervisors are included in the definition of direct care workers.

We included costs associated with travel, training, and personal protective equipment for direct care workers from the calculation of the percent of payment spent on compensation. And we required states to exclude data on self-directed services in which the beneficiary sets the direct care worker's payment rate.

And then just to be clear, the ACDF payment adequacy reporting requirement applies to habilitation services, but for this requirement, the minimum performance requirement, we did not include habilitation services among the services that are subject to that requirement. Next slide, please.

So, the HCBS payment adequacy minimum performance requirement, we also added two new flexibilities for states. The first is to allow states to establish a hardship exemption for providers facing extraordinary circumstances. And any hardship exemptions must be based on a transparent state process and objective criteria.

And then the second flexibility we included is to allow states to establish a separate performance level for small providers that meet state-defined criteria. And similar to the hardship exemption, this small provider performance level must be based on the transparent state process and objective criteria.

States that take advantage of these options for a hardship exemption and a small provider performance level will be subject to some additional reporting requirements. For the hardship exemption, states will be required to report on the state's hardship criteria, the percentage of providers that qualify for a hardship exemption, and they'll also have to provide 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.

And then for the separate small provider performance level, states will have to report on the state's small provider criteria, the state's small provider minimum performance level, the percentage of providers that qualify for the small provider minimum performance level, and they'll also have to provide a plan subject to CMS review and approval for small providers to meet the 80% minimum performance requirement within a reasonable period of time.

However, for both the hardship exemption and the small provider performance level, we may waive the plan reporting requirements if the state demonstrates that it has applied the small provider minimum performance level or the hardship exemption to less than 10% of the state's providers.

Next slide, please. So, related to waiting lists and access reporting, we are requiring that states report annually on waiting lists in their Section 1915C waiver programs and Section 1115 demonstrations. And this includes requirements to report on how states maintain their waiting lists, the number of people on their waiting lists, and the average amount of time people newly

enrolled in a waiver in the past year were on the waiting list. And those requirements are applicable in three years, and they were finalized largely as proposed.

And then states also have to report annually on access to personal care, homemaker, home health aid and habilitation services, including how long it took from when services were approved to when individuals began receiving services, and the percent of authorized services that are provided annually. And those requirements are applicable in three years.

And I do want to apologize there is an error on the bottom row of the slide that we will try to correct before the slides are publicly posted. We did make one substantive change to those access reporting requirements from what was proposed. And that change was to apply the reporting requirements to habilitation services.

Next slide, please. The access rule also includes requirements for states to report on a standardized set of HCBS quality measures known as the HCBS Quality Measure Set. And the final rule sets requirements for CMS to develop and update the measure set. So, first, the process to update the measure set.

So, in the rule, we did finalize a requirement for CMS to develop and update the HCBS Quality Measure Set through a process that will allow for public input and comment, including through the Federal Register. In the final rule, however, we 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. And we have required that CMS establish the measure set no later than December 31, 2026.

Next slide, please. So, states are required to report every other year on the

HCBS Quality Measure Set beginning in 4 years instead of 3 years as proposed, and states are also required to set performance targets for measures in the measure set and describe the quality improvement strategies that they'll pursue to achieve the performance targets.
This provision also allows states to report on additional voluntary measures and for CMS to report on certain measures on a state's behalf.

In the final rule, we also included phased-in requirements for states to stratify their data for certain measures by demographic and other factors in order to assess disparities and advance health equity. And consistent with the change to the applicability for reporting on the measure set, we have delayed the phase and schedule for the stratification requirements by one year, and we also removed tribal status as a stratification factor for alignment with the core set final rule.

And I also wanted to note that the dates on this slide are off by one year. Again, we will try to correct that before the slides are publicly posted. The reporting requirement is effective in 2028, and the phase and schedule for stratification is 25% in 2028, 50% in 2030, and 100% in 2032.

Next slide, please. And then, finally, I - is the Web site transparency requirements. So, we are promoting public transparency across all of the HCBS reporting requirements in the final rule by requiring states to publicly report the quality, performance, and compliance data they report to us. And then CMS will also publicly report the data and information across all states.

Those requirements begin to take effect in three years when states begin reporting data. And we made only minor changes to the Web site transparency requirements from what was proposed. Next slide, please. And I'm now going to hand it over to Jeremy to discuss the fee-for-service provision.

Jeremy Silanskis: Thank you, Jen. Good afternoon, everyone. This is Jeremy Silanskis. I'm the Deputy Director for the Financial Management Group. I'm going to keep this relatively brief, so we can get to your questions. By way of background, for fee-for-service, the provisions are rooted in statute.

The statute essentially says that rates need to be sufficient to provide access to care consistent with the general population in geographic areas. And while we continue to have a lot of spending in fee-for-service, we struggle with benchmarks for how we would create the standards to understand what a sufficient rate would be.

We did issue regulations in 2015 that required an access monitoring review plan that required data and analysis to demonstrate access. But in implementing that rule over the past several years, we've understood from states that the administrative burden was a bit much and also from providers and other stakeholders that the AMR piece really didn't give the level of information that they thought would be useful.

So, we set about with the new regulation that is really focused on transparency, comparisons to Medicare in order to understand and highlight where rates are. Next slide, please. So, the fee-for-service provisions break down into these five components. There's payment rate transparency, there's comparative payment rate analysis, there's payment rate disclosure, interested parties advisory group, and reproduction and restructuring spot analysis procedures.

Next slide, please. All right, payment rate transparency publication. So, in the final rule, we're requiring states to publish all Medicaid fee-for-service payment fee schedule rates made to providers delivering services through fee-

for-service on a Web site that is accessible to the general public and organized in a way that the public can readily determine applicable rates for services. We didn't make any changes from the proposed to final and states have to until July 1, 2026 to get that fee schedule process in place.

Slide please. The comparative payment rate analysis, this one requires states 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.

The analysis is done at the CPT code level, and we're working on guidance that will help states implement that provision if compared to Medicare rates. Again for this one we didn't really make any changes from the proposed to final and again states have until July 1, 2026 to publish the initial comparison and then they will do that every two years after.

Next slide please. Similar to the last provision there's a payment rate disclosure requirement that requires state to publish the average hourly rate paid to direct care workers delivering personal care, home health aid, homemaker, and habilitation service, and publish the disclosure every two years.

That 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 those services. The major change between proposed and final is that we added habilitation services into those that must be disclosed.

And just like the last provision, the deadline for the initial publication is July 1, 2026 and then every two years after. The difference between this one and

the last one is that obviously the sets of services in the last provision have comparative Medicare rates, whereas these services generally do not.

Next slide, please. All right, the Interested Parties' Advisory Group. This requirement will have states establish an advisory group for direct care workers, beneficiaries, beneficiary authorized representatives, and other interested parties. Those groups will meet every two years and advise and consult on payment rates paid to direct care workers for personal care, home health aid, homemaker, and habilitation services.

Just like with the last provision, the change here from the proposed to final is that we added habilitation services into the mix. And for this one, the group will meet within two years from the effective date of the final rule and then every two years after.

Next slide, please. Okay, and then this is the final provision that I'm going to talk about, and it's the rate reduction and restructuring SPA analysis procedures. So, after, you know, replacing the AMRP process, we needed something that we could use to evaluate rate changes when states come in to reduce or restructure their rates. We landed with a process that's really a two-tier approach.

One, largely implements policies that we put out in sub-regulatory guidance through the Medicaid Director's Letter, where states will look at how their rates compare to Medicare, if they're at least 80% of Medicare. That's one portion of a test, if the reductions are under 4% of spending within a benefit category and there are no public process responses, then states are free to submit information that, you know, essentially says, here's our best case for how, once we've reduced the rates, we'll still be in line with the statutory requirements for access to care.

However, states do not pass those three tests. Then we've laid out some structured data within the rule that we intend to issue a template for states to complete, and that will be how states will explain how their rates are sufficient to meet the statutory requirement.

We didn't make any major changes from the NPRM to the final rule for this one, and this one will be effective with the date of the final rule so that we will have information as states submit rate changes. Okay, next slide, please. I think we're going to open it up for questions.

Jackie Glaze: Thank you, Jeremy, Jen, and Karen. As Jeremy indicated, we're ready to take the states questions at this time. So, you can begin submitting your questions into the chat function, and then we'll follow by taking questions over the phone line. So, I'll turn now to you, (Krista), to start with the questions through the chat.

(Krista): Awesome. Thanks so much, Jackie, and thank you so much to the folks who presented. I did get a few questions just about the slides themselves and whether they will be sent out after the presentation, and I wanted to remind everyone that Medicaid and CHIP All-State Call slides are posted on medicaid.gov on the dedicated All-State Call page. So, these slides will be posted on medicaid.gov by the end of the week.

Aside from that, I am seeing a few technical questions here. The first is, does this effectively mean that the state no longer has to submit the previously required AMRP report, which was required every three years?

Jeremy Silanskis: That's correct.

(Krista): Thanks, Jeremy. Why was habilitation added to reporting requirements for payment transparency?

Jeremy Silanskis: We added the habilitation both in response to comments and then in addition because I think we wanted to be more representative of the overall Medicaid benefit package.

Jen Bowden: And hi, this is Jen Bowden. Habilitation was added in a couple of places in the rate transparency provisions that Jeremy talked about in the Payment Adequacy Provision. And in the - for the Payment Adequacy Provision, it was, you know, largely in response to public comment. And it's also in recognition of the importance of habilitation services specifically for people receiving -people with intellectual and developmental disabilities that are receiving HCBS.

Jackie Glaze: Thank you both. The next question is, how are we to calculate bundled rates?

Jen Bowden: I think that question is about the HCBS Payment Adequacy Provision, but it could also be, because we've gotten that question already, might also be about rate transparency. So, this is Jen Bowden, I'll start, and then Jeremy may want to jump in as well. So, you know, for the HCBS Payment Adequacy Provision, we do plan to issue sub-regulatory guidance to help to clarify this.

And so, I think we'll have more information to share specifically on kind of what the expectations are for when the services subject to the Payment Adequacy Provision are part of a bundled rate. Jeremy, do you want to jump in just around rate transparency?

Jeremy Silanskis: Yes. I mean, similar to what Jen said, you know, we intend to issue some implementation guidance to states to help you work through these questions.

You know, there is discussion within the preamble, the final rule that talks about, you know, breaking down services by their constituent parts.

So, I would direct you there initially to, you know, understand what that might look like. If there are additional questions, because this is probably going to be in some regards, state and service specific, our teams are very happy to work with you.

Jackie Glaze: Thank you both. The next question is, if there is a waiver service that is an in-home service, like personal care, but they have a habilitation component in the service definition, does this require the 80% payment to direct support workers or is it exempt?

Jen Bowden: So, I - we will address that through sub-regulatory guidance, and then we'll also work with states. We recognize that there's variability across states in terms of the specific names that they use for the services that they provide. And so, we'll provide some additional clarification around the specific services that are subject to the reporting requirements and to the minimum performance level.

Jackie Glaze: Great. Thank you so much. The next question is, will the HCBS quality measures replace the measures we are required to report on for our waivers or be in addition to?

Jen Bowden: Yes. So, the requirements in the rule, and I should have mentioned that as I was talking about the specific requirements, these requirements in the rule are really intended to replace the existing subassurance reporting requirements that states have for their 1915C waiver programs in Section 1915I. And we will be working with states to transition over to the new requirements, particularly for any states that would like to transition to the new requirements

earlier than the applicability dates that were included in the rule.

Jackie Glaze: Thank you. Next question. Can you confirm MMFP states have to report quality measure sets before non-MFP states?

Jen Bowden: Yep. That's correct. So, states, the 41 states and territories participating in the Money Follows a Person demonstration are required to report on a subset of the measures in the HCBS Quality Measure Set beginning in 2026. And we recently issued guidance on those requirements, and we also covered them on an all-state call as well as an MFP national quarterly call, as well as on some technical assistance calls.

If, you know, any MFP grant recipients have questions on those requirements, you know, I would encourage you to reach out to your CMS project officer, and we're happy to work through those with you. I will note, though, that MSP grant recipients can include the cost of implementing the HCBS Quality Measure Set in their MFP budget. And, you know, we're happy to work with states on, you know, identifying the specific cost that can be included in their budget to support implementation.

Jackie Glaze: Great. Thank you. Next question. If there is a waiver service that is an in-home service, like, personal care, you know what? I think this actually is a duplicate question from before, so let me just go on to the next one. How can we address value-based payments in our direct care worker wages?

Jen Bowden: We may need some clarification on that question. I don't know if it's kind of a general question about how do you address value-based payments or if it's a question that's sort of relative to the requirements in the rule and how, you know, they, the specific requirements in the rule apply. So, if the person asked that could provide some clarification, I think that would be helpful.

Jackie Glaze: Thanks. Next question here is whether and when we will be putting out sub-regulatory guidance and any tools or resources to support states.

Jen Bowden: So, Jeremy and Karen may want to jump in around the other provisions for HCBS. We are working to identify specific pieces of sub-regulatory guidance and technical assistance material that we think will be helpful for states, and we think are necessary to support implementation. We're not quite ready to share the schedule for that yet and to talk about that, but we are talking internally about it and hope to have more information available soon. Karen and Jeremy, anything you want to add?

Karen Llanos: Yes. Thanks, Jen. So, this is Karen. As I mentioned in my slides, we do have a toolkit that we are working to finalize that we'll release for states that will walk through some best practices related to the Medicaid Advisory Committees. We're also going to be rolling out a webinar series later in the fall. Jeremy?

Jeremy Silanskis: Yes, I think we're all in similar places there. You know, we're working on guidance to help these with the payment rate comparison. You know, a listing of CPT codes that could be used to make the Medicare comparison, you know, best practices on how to do that. So, you know, and I don't think that that's, you know, the end of our guidance either. Our intention is to get, obviously, the template that would guide the rate reduction out quickly too.

So, we're working through that. I don't have a timeline either, but, you know, I think it would be helpful if you all have a particular need, if we could hear from those as well, hear about those as well, in terms of like just our planning for the next couple years of implementation.

Jackie Glaze: Thank you, Jeremy. So, I think we'll transition to the phone lines now to see if we have any questions there. So, (Michelle), if you could please provide instructions for registering the questions, and then also if you can open the phone lines, please.

Coordinator: Thank you. At this time, if you would like to ask a question, you may press Star 1. If you'd like to withdraw your question, you can press Star 2. Please unmute your phones and state your first and last name when prompted. Again, that is Star 1 if you would like to ask any questions or have any comments. One moment, please. Again, you may press Star 1 if you have any questions. At this time, I am showing no questions.

Jackie Glaze: Thank you, Michelle. (Krista), I think we have time for one more question, if you have any more.

(Krista): Great. Yes. I do see one additional question here. Is the expectation that states will implement a grievance system for each HCBS waiver or one statewide system for grievances? Same question for MAC/BAC.

Jen Bowden: So, for fee-for-service, states have flexibility here, you know, we would encourage that coordinated and integrated approaches, but states do have flexibility and how they meet those requirements. Karen, do you want to respond for the other provision?

Karen Llanos, I'm not sure, I'm not - I completely followed. We don't have, I mean, it's up to the state to select the different types of topics in coordination with the Medicaid Advisory Committee and their Beneficiary Advisory Council in terms of the types of topics that we'll discuss. If they choose to use it as a way to discuss grievances, I think that's one thing, but it wouldn't be to replace a grievance system. Not sure I followed the question, but hopefully that gave

you enough feedback.

Jackie Glaze: Thank you, Karen, and thank you, Jen. So, in closing, I do want to thank our team for their presentations today. And also as a reminder, next week we will have another all-state call on May the 7th. And here we will focus on the managed care final rule.

So, if you do have questions before next week, please reach out to us or your state leads or bring your questions again to the all-state call next week. So, thank you again, everyone, for joining. We appreciate your participation, and we hope everyone has a great afternoon. Thank you.

Coordinator: Thank you. And this concludes today's conference call. You may go ahead and disconnect at this time.

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