Centers for Medicare & Medicaid Services

Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule

July 2024

This page has been left blank for double-sided copying.

Contents

Tables

This page has been left blank for double-sided copying.

I. Introduction

On May 10, 2024, CMS published the Ensuring Access to Medicaid Services Final Rule, 89 FR 40542 (2024 Access Final Rule). The provisions of the 2024 Access Final Rule were organized into three main subsections: the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC); Home and Community Based Services (HCBS); and Documentation of Access to Care and Service Payment Rates. The guide focuses on the third of those subsections, "documentation of access to care and service payment rates," which is specific to fee-for-service (FFS) delivery systems and rates. Any reference within this guide to the requirements of the 2024 Access Final Rule should be construed as referring only to the provisions of that third subsection.

Please note that this guide is intended to consolidate and supplement information to help states meet the requirements of the 2024 Access Final Rule once the requirements are in effect. However, nothing in this guide is intended to conflict with or supersede any of the requirements in the 2024 Access Final Rule or statute, which should be regarded as the source of authority for these requirements.

A. Managed Care

As mentioned, the items discussed in this guide are specific to FFS delivery systems and rates. All states are required to comply with these requirements for services rendered through FFS, regardless of the quantity of services covered or delivered or beneficiaries enrolled in managed care.

Due to coverage transition periods, such as when an individual is Medicaid eligible but not yet enrolled in a managed care plan or benefits are covered retroactively, even states that generally enroll all beneficiaries into managed care plans pay for some services on a FFS basis that are not covered under the managed care plan contracts, and therefore, are expected to have Medicaid FFS fee schedule payment rates in effect. Such Medicaid FFS fee schedule payment rates are subject to the provisions finalized in this rule under § 447.203(b).

Rescission of Access Monitoring Review Plans (AMRP)

Reminder: The 2024 Access Final Rule rescinded the Access Monitoring Review Plan (AMRP) requirements previously in § 447.203(b)(1) through (8) and replaced these requirements with a streamlined and standardized process, described in § 447.203(b) and (c). Those former regulations required states to complete and make public AMRPs that analyzed and informed determinations of the sufficiency of access to care (which may vary by geographic location in the state) and were used to inform state policies affecting access to Medicaid services, including provider payment rates.

Starting the effective date of the 2024 Access Final Rule, states have no further or ongoing responsibility to meet the AMRP requirements, apart from any applicable records retention policies.

B. Applicability Dates

Regulation Section(s) in Title 42 of the CFR	Applicability Dates*
Payment Rate Transparency Publication § 447.203(b)(1)	July 1, 2026, then updated within 30 days of a payment rate change.
Comparative Payment Rate Analysis Publication § 447.203(b)(2) to (4)	July 1, 2026, then every 2 years
Payment Rate Disclosure § 447.203(b)(2) to (4)	July 1, 2026, then every 2 years
Interested Parties Advisory Group § 447.203(b)(6)	The first meeting must be held within 2 years after effective date of the final rule, then at least every 2 years.
Rate Reduction and Restructuring SPA procedures § 447.203(c)(1) and (2)	July 9, 2024

* In the 2024 Access Final Rule and this companion guide, we use the term "applicability date" to indicate when a new regulatory requirement will be applicable and when states must begin compliance with the requirements as specified in that regulation.

C. Accessibility

Longstanding legal requirements to provide effective communication with individuals with disabilities and the obligation to take reasonable steps to provide meaningful access to individuals with limited English proficiency also apply to the state's website containing Medicaid FFS payment rate information. Under Title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, and implementing regulations, qualified individuals with disabilities may not be excluded from participation in, or denied the benefits of any programs or activities of the covered entity, or otherwise be subjected to discrimination by any covered entity, on the basis of disability, and programs must be accessible to people with disabilities.[1] Individuals with disabilities are entitled to communication that is as effective as communication for people without disabilities, including through the provision of auxiliary aids and services.[2] Section 1557 of the Affordable Care Act requires recipients of Federal financial assistance, including state Medicaid programs, to take reasonable steps to provide meaningful access to their health programs or activities for individuals with limited English proficiency, which may include the provision of interpreting services and translations when reasonable.[3] These requirements apply to all state agency, contractor, or other third-party websites and any burden associated with meeting those Federal obligations is not created by policies finalized in this rule.

D. Privacy

We remind states of their obligations to comply with applicable Federal and state confidentiality, privacy, and security laws with respect to beneficiary information, such as the HIPAA Privacy Rule and Federal Medicaid requirements in section 1902(a)(7) of the Social Security Act and 42 CFR part 431, subpart F. We are not requiring states to publish any beneficiary-identifiable information in any of the requirements of the final rule. We expect states will ensure that any claims and Medicaid beneficiary data made publicly

[1] 29 U.S.C. 794; 42 U.S.C. 18116(a); 42 U.S.C. 12132; 28 CFR 35.130(a); 45 CFR 84.4 (a); 45 CFR 92.2(b).

[2] 28 CFR 35.160; 45 CFR 92.102; *see also* 45 CFR 84.52(d).

[3] 45 CFR 92.101; *see also* https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-vi/index.html.

available under these requirements have been de-identified in accordance with the HIPAA Privacy Rule at 45 CFR 164.514(b).

We strongly encourage states to have policies to ensure that all information, particularly claims and beneficiary data, published in their comparative payment rate analysis and payment rate disclosure is de-identified prior to publishing on July 1, 2026. Such policies should address circumstances in which the number of Medicaid-paid claims and/or Medicaid enrolled beneficiaries is small. For example, states may consider implementing a small cell size suppression policy for publishing data on the state's website, similar to CMS' cell size suppression policy that no cell (for example, admissions, discharges, patients, services, etc.) containing a value of 1 to 10 can be reported directly.[4] We invite states to reach out to CMS regarding any data privacy concerns that may impact a state's compliance with the comparative payment rate analysis or payment rate disclosure requirements.

Additionally, to address privacy concerns at the individual level, we would like to share the following resources for filing civil rights and HIPAA complaints with the Office for Civil Rights:

- Filing a civil rights complaint;[5] and
- Filing a health information privacy or security complaint.[6]

E. Ongoing Feedback

While we intend for this document to be both helpful and comprehensive, we understand states may require additional clarifications as they begin working to meet the new requirements of the 2024 Access Final Rule. For questions or comments on this guidance, including what would be helpful to include in any future implementation guidance CMS may produce, please contact MedicaidAccesstoCare@cms.hhs.gov. Questions on state plan amendment (SPA) submissions should be directed to your state lead.

[4] https://resdac.org/articles/cms-cell-size-suppression-policy.

[5] https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

[6] https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

This page has been left blank for double-sided copying.

II. Documentation of Access to Care and Service Payment Rates (§ 447.203(b))

As stated, this guide discusses the documentation of access to care and service payment rates section of the 2024 Access Final Rule, which is specific to FFS delivery systems and rates. The following sections describe, with illustrative examples, the payment rate transparency publication, the comparative payment rate analysis, and the payment rate disclosure requirements. We have also included a section on the interested parties advisory group established by the 2024 Access Final Rule; however, there is no illustrative example of a group recommendation that would be made by the interested parties' advisory group, as states and group members have broad flexibility in that regard.

In § 447.203(b)(5), if a state fails to comply with the payment rate transparency, comparative payment rate analysis, and payment rate disclosure requirements in paragraphs (b)(1) through (b)(4) of § 447.203, including requirements for the time and manner of publication, future grant awards may be reduced under the procedures set forth in 42 CFR part 430 subparts C and D, by the amount of federal financial participation (FFP) we estimate is attributable to the state's administrative expenditures relative to the total expenditures for the categories of services specified in paragraph (b)(2) of § 447.203 for which the state has failed to comply with applicable requirements, until such time as the state complies with the requirements. Unless otherwise prohibited by law, FFP for deferred expenditures would be released after the state has fully complied with all applicable requirements.

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

For the payment rate transparency publication, the initial publication of the Medicaid FFS payment rates shall occur no later than July 1, 2026, and include approved Medicaid FFS payment rates in effect as of July 1, 2026.

1. Scope

The scope of the payment rate transparency publication applies to Medicaid FFS fee schedule payment rates. For purposes of the payment rate transparency provision in § 447.203(b)(1), Medicaid FFS fee schedule payment rates are payment amounts made to a provider and known in advance of a provider delivering a service to a beneficiary by reference to a fee schedule, and subject to the requirements of § 447.203(b)(1)(i) through (vi). A fee schedule is a list, table, or similar presentation of covered services and associated payment amounts that are generally determined at the state's discretion. We also consider a state to use a fee schedule when the state has not organized its payment amounts into such a straightforward list, table, or similar presentation, but under the state's approved payment methodology, the state determines payment rates based on the application of a mathematical formula to another fee schedule or other reference rate stated as an amount certain. States that use the previously described formula-based methodology that may not currently publish these payment rates on a fee schedule will be required to publish the actual payment amounts as determined by their formula in the payment rate transparency publication.

Payment rates published under § 447.203(b)(1) must be inclusive of the payment amount from the Medicaid agency plus any applicable coinsurance and deductibles to the extent that a beneficiary is expected to be liable for those payments.

a. PPS Rates

Certain bundled payment rates[7] (see section below) and PPS rates for inpatient hospital, outpatient hospital, and nursing facility services are considered fee schedule payment rates subject to the payment rate transparency publication because these payment amounts are also known in advance of a provider delivering a service to a beneficiary and are stated (or can readily be stated) as a list, table, or similar presentation. PPS rates in Medicaid used to pay for services provided by inpatient hospitals, outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and nursing facilities are included in this requirement. In the context of payment rates to hospitals and nursing facilities, the term "encounter rate" or "per diem rate" can also be used to describe the PPS rate received by these providers. To the extent a state pays fee schedule payment rates for clinic services (as defined in § 440.90), dental services, and community mental health services that meet the previously stated description, those payment rates are subject to the payment rate transparency provisions in § 447.203(b)(1). Rates paid to federally qualified health centers (FQHCs) and rural health clinics (RHCs) are not subject to this requirement.

Bundled Payments: In the case of a bundled or similar payment methodology, where the bundled payment rate is based on fee schedule payment rates for each constituent service and under Medicaid FFS state plan authority, states 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. This requirement is applicable whether the bundled rate includes multiple units of service, multiple services within a single benefit category, or multiple services across multiple benefit categories. Bundled Payment rate methodologies that do not utilize fee schedule payment rates for each constituent service to create a single state-developed bundled payment rate to pay for a combination of services, are not subject to the bundled rate breakdown requirement in the payment rate transparency publication provision.

b. Value Based Purchasing (VBP) rates

A FFS VBP arrangement in which the minimum payment amount is calculable in advance based on the application of a mathematical formula to a fee schedule amount constitutes a fee schedule payment methodology subject to this requirement. We expect the state to use the minimum payment amount for purposes of the requirements of § 447.203(b), because this is the amount that a provider is assured to receive for furnishing the service. At state option, the state could also include information on the maximum payment amount the provider might receive under the FFS VBP payment methodology.

Payment rates that are not subject to the transparency provisions include those in which the minimum fee schedule payment is not known in advance of a provider delivering a service to a beneficiary because certain variables required for the payment calculation are unknown until after the provider has delivered the service. For example, cost-based and reconciled cost payment methodologies (including those that

[7] For additional information on bundled payments, please visit https://www.medicaid.gov/sites/default/files/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf.

involve interim payments) are not subject to the payment rate transparency provisions because actual cost is unknown until the end of the provider's reporting period.

Some states utilize more complex FFS VBP payment methodologies (including episodes of care and integrated care models) that depend on quality and cost measures to determine the provider's unique payment amount. Providers who participate in one of these complex VBP payment arrangements generally report quality and cost data to the state at the end of the provider's reporting period and then the state uses that data to determine the provider's payment amount after the provider has furnished services. As these measures are generally unknown until after the provider's reporting period has ended, the state does not know a provider's payment in advance. Therefore, complex VBP payment methodologies as previously described are not fee schedule payment methodologies within the meaning of the final rule that are subject to the payment rate transparency provision.

c. Advanced Payment Methodologies

An advanced payment methodology, as described in SMDL 20-004,[8] could also utilize fee schedule payments. For example, a state could calculate an advanced payment of $10,000 for a provider that is expected to furnish 1,000 services and each service is paid at a fee schedule payment rate of $10. The advanced payment amount was originally determined by a fee schedule payment rate, which is known in advance of a provider delivering a service to a beneficiary, and therefore these rates would appear to be covered by this requirement. However, there are also features of certain advanced payment methodologies that could place them outside the scope of this requirement. For example, an advanced payment methodology that permits states to include risk adjustments and quality performance adjustments to the advanced payment amount, and/or requires the state to perform a reconciliation to the actual number of claims, could mean that the Medicaid payment amount that the provider could expect to receive could not be known in advance. States should review advanced payment methodologies on a case-by-case basis to determine if the methodology is subject to this requirement. CMS is available to discuss or review future advanced payment methodologies on a case by case basis to determine applicability.

d. Miscellaneous

Self-directed models with service budget[9] payment rates are not subject to the payment rate transparency publication requirement in § 447.203(b)(1).

Manually priced payment methodologies that utilize the manufacturer's suggested retail price (for example, durable medical equipment) to result in a payment amount that is not known in advance of a provider delivering a service or item to a beneficiary is not a fee schedule payment methodology subject to the payment rate transparency publication requirements.

---

[8] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.

[9] Self-directed services are paid for using an individualized budget. States are required to describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization, define a process for making adjustments to the budget when changes in participants' person-centered service plans occur, and define a procedure to evaluate participants' expenditures. https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html.

Payment rate variations based on patient acuity are also not explicitly required in the payment rate transparency publication. Payment adjustments for patient acuity generally are limited to institutional settings (for example, inpatient hospitals and nursing facilities). Should a state opt to delineate its payment rates by patient acuity, to the state should use the minimum payment amount for purposes of the requirements of § 447.203(b), because a provider is assured to receive at least this amount for furnishing the service to any patient. At state option, the state could also include additional payment rate breakdowns the provider might receive for other levels of patient acuity.

Payment rate variations by site of service are not required, but states have flexibility to include this optional payment rate breakdown in the payment rate transparency publication. While not required in the 2024 Access Final Rule, should a state opt to break down their payment rates by site of service, the state should use the minimum payment amount for purposes of the requirements of § 447.203(b), because a provider is assured to receive at least this amount for furnishing the service at any site of service. At state option, the state could also include additional payment rate breakdowns a provider might receive at other sites of service in the state (for example: office, inpatient hospital, school, mobile unit, urgent care facility, nursing facility).

States are not required to publish claims data or data about actual payments made to providers under the payment rate transparency publication provision.

2. Publication Requirements

The language in § 447.203(b)(1) that requires states to "publish all Medicaid [FFS] payment rates on a website that is accessible to the general public," allows states to utilize a contractor to develop fee schedules. A state may also utilize a contractor's (or other third party's) website to publish the payment rate transparency publication so long as the state publishes a readily accessible link on its state-maintained website to the required content and ensures on an ongoing basis that the linked content meets all applicable requirements of the final rule. . In addition, § 447.203(b)(1)(ii), states that the "website where the state agency publishes its Medicaid [FFS] payment rates must be easily reached from a hyperlink on the state Medicaid agency's website."

The payment rate transparency publication has limited formatting requirements, and therefore we expect many states that already publish at least some of their Medicaid FFS fee schedule payment rates directly on fee schedules posted on the state agency's website would only need to make minor revisions or updates (if any) to comply with the new requirements with respect to these already-published payment rates. States are not required to create new fee schedules if their published payment rate information is already organized in such a way that a member of the public can readily determine the amount that Medicaid would pay for each covered service, consistent with § 447.203(b)(1). States can determine what organizational and formatting structure is most suitable for organizing rates in a manner that will be easily understood by providers and beneficiaries.

There are minimal qualities that the website containing the payment rate transparency publication necessarily must include, such as being able to function quickly and as an average user would expect; requiring minimal, logical navigation steps; taking reasonable steps to provide meaningful access to individuals with limited English proficiency; and ensuring accessibility for persons with disabilities in

accordance with section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. An example of this includes a single webpage clearly listing the names of the state's published fee schedules (such as Physician Fee Schedule, Rehabilitation Services Fee Schedule, etc.). as links that transport the user to the relevant state fee schedule file, which file should be in a commonly accessible file format that generally can be viewed within a web browser without requiring the user to download a file for viewing in separate software. In this example, there is no unnecessary burden (including requiring payment (a paywall), creation of an account and/or password to view the webpage, or need to install additional software to view the files) on the individual to trying to view the published fee schedules.

If the rates vary, the state must separately identify the Medicaid FFS payment rates by population (pediatric and adult), provider type, and geographical location, as applicable. States are not required to report separate Medicaid and Children's Health Insurance Program (CHIP) payment rate information within the pediatric population payment rate reporting. States that pay varying Medicaid FFS payment rates by population (pediatric and adult), provider type, and geographical location, as applicable, those states would need to separately identify their Medicaid FFS payment rates in the payment rate transparency publication by each grouping or multiple groupings, when applicable to a state's program so that a member of the public be readily able to determine the payment amount that will be made, accounting for those circumstances. For a state that varies its Medicaid FFS payment rates by any combination of these groupings, then the payment rate transparency publication must reflect these multiple groupings.

Some state plans specify certain provider payments as a percentage of the state's fee schedule rate. If the Medicaid FFS payment rates vary by provider type, the Medicaid FFS payment rates in each applicable situation must be separately identified as Medicaid FFS payment rates in the state's payment rate transparency publication with the actual amount, regardless of whether the state has individually specified each amount certain in its approved payment schedule.

A state that pays a single statewide rate regardless of population, provider type, or geographical location would only need to list the single statewide rate in its payment rate transparency publication. We also encourage states to disclose the age range the state's Medicaid program uses in the payment rate transparency publication for transparency purposes, as states define pediatric differently (such as, 18 years old or younger, 19 years old or younger, and 21 years old or younger).

States have flexibility to:

1. organize and format their publication, so that they can use existing fee schedule publications for compliance (assuming all requirements in § 447.203(b)(1) are met);
2. utilize contractors or other third party websites to publish the payment rate transparency publication on (however, we remind states that they are still required to publish the hyperlink on the state Medicaid agency's website that directs to the website where the publication is located as required in § 447.203(b)(1)(ii) of the final rule); and
3. for the initial publication, if necessary historical information about bundled payment rates is unavailable to the state, then the state does not need to include the bundled payment rate breakdown as required in § 447.203(b)(1)(iv) of the final rule (however, we remind states that upon

approval of a SPA that revised the bundled payment rate, the state will be required to update the publication to comply with § 447.203(b)(1)(iv)).

The single state agency must include the date the payment rates were last updated on the state Medicaid agency's website.

a. Bundled Payments

In the case of a bundled or similar payment methodology (or rate determined by a similar payment methodology where a single payment rate is used to pay for multiple services), where the bundled payment rate is based on fee schedule payment rates for each constituent service, states 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.

States have flexibility in determining the assumptions regarding the type, quantity, intensity, and price of the constituent services that they factor into the initial development of a bundled rate.[10] However, states have flexibility in determining how best to allocate the bundled payment rate to each constituent service in scenarios where historical data are unavailable. For example, a state may have a bundled payment rate that includes five constituent services, which the state knows was calculated by summing the undiscounted fee schedule payment rates for each of the five constituent services. Today, the state may be unable to locate the fee schedule amount for one of the constituent services. In this instance, we would expect the state to reasonably deduce the allocated rate for the fifth constituent service by summing the four known rates for the four constituent services and subtracting that amount from the total bundled payment rate. If a state can reasonably calculate missing rates, we expect them to do so for the purposes of completing the bundled payment rate allocation. If a state cannot calculate a missing portion of a bundled payment rate, they may use current fee schedule rates. For example, a state may have a bundled payment rate, but it does not have historical information about how the bundled payment rate was originally calculated from the constituent services. In this instance, we would expect the state to use the current fee schedule rates for the constituent services included in the bundle to allocate the bundled payment rate for the payment rate transparency publication.

One example of how to allocate a bundled payment rate to each constituent service under the state's bundled payment methodology, a state might pay a $480 bundled rate for assertive community treatment, based on the application of a small discount factor to the fee schedule payment rates for all the constituent services (assessments, care coordination, crisis intervention, therapy, and medication management). In this scenario, the state's fee schedule payment rates might be $50 for an assessment, $30 for care coordination, $200 for crisis intervention, $200 for 2 hours of individual therapy, and $20 for medication management. Separately, the state would pay a total of $500 for all of these services; however, the state might determine that a provider likely would realize efficiencies from providing the services together in a coordinated fashion, and so might reduce the bundled payment rate by 4 percent to account for these expected savings. Thus, the state's bundled payment rate would be $480, which would

[10] For new bundled rates, CMS requests information on how States developed the rates, including: assumptions regarding the type, quantity, intensity, and price of the component services typically provided to support the economy and efficiency of the rate. https://www.medicaid.gov/sites/default/files/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf.

be allocated as follows: $480 * ($50/$500) = $48 for assessment; $480 * ($30/$500) = $28.80 for care coordination; $480 * ($200/$500) = $192 for crisis intervention; $480 * ($200/$500) = $192 for 2 hours of individual therapy; and $480 * ($20/$500) = $19.20 for medication management. In this example, the state would identify each of these constituent services and use these allocation amounts to meet the requirements finalized in § 447.203 (b)(1)(iv).

Regardless of the approach states utilize to allocate the bundled payment rate to the constituent services, we expect states to include a description of how the bundled payment rate was allocated in the payment rate transparency publication to ensure that a member of the public can readily determine the amount that Medicaid would pay for the bundled service and understand how the state has accomplished a reasonable allocation of this amount to each constituent service included in the bundle, as required in § 447.203(b)(1)(iii).

For scenarios that cannot be addressed with these methods, we invite states to reach out to us for technical assistance on how to comply with § 447.203(b)(1)(iv) on a case-by-case basis.

b. Updates to Published Payment Rates

As stated in § 447.203(b)(1)(vi), "[t]he 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 SPA, section 1915(c) HCBS waiver amendment, or similar amendment revising the provider payment rate or methodology, or the effective date of the approved amendment." This language accounts for states submitting SPAs with prospective effective dates as the proposed regulatory language would have required State to publish payment rates in the payment rate transparency publication that were approved, but not yet effective.

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 no later than 1 month after the effective date of the most recent update to the payment rate.

For those states that set their Medicaid payments rates as a percentage of a Medicare payment rate, we expect the state to already be monitoring changes in Medicare rates in accordance with their approved payment methodology and §§ 430.10 and 430.20 and part 447, subpart B, which require states to pay the approved state plan payment rates in their state plan effective on or after the approved effective date of the state plan provision. Therefore, if a state's approved state plan pays a rate based on the most current Medicare payment rate for a particular service, then payment of any rate outside of the approved state plan methodology would result in a state plan compliance issue. We expect that states with such payment methodologies routinely are monitoring Medicare payment rates to ensure that their Medicaid payment rates are updated according to the approved methodology.

The requirement to include the date the rates were last updated refers to a date for the website publication. In other words, the date should provide assurance that the rates on the website are current as of the specified date. We do not expect states to examine historical records to find the dates every rate was last updated. However, if a state wishes to include that information for all or a subset of published rates, it can.

B. Payment Rate Transparency Publication: Sample Documentation

Table 1a. Sample of Payment Rate Transparency Documentation

Cpt/Hcpcs Codes	Population Group	Provider Type	Geographical Location	Other Payment Factors	Explanation of Other Payment Factors	Medicaid Payment Rate	Rate Effective Date
90834	Child	Physician	County 1	N/A	N/A	$65.81	07/01/2024
90834	Child	Physician	County 2	N/A	N/A	$62.43	07/01/2024
90834	Adult	Physician	County 1	N/A	N/A	$72.35	10/01/2023
90834	Adult	Physician	County 2	N/A	N/A	$65.81	07/01/2024
90834	Adult	Nurse Practitioner	County 1	N/A	N/A	$68.20	07/01/2024
90834	Adult	Nurse Practitioner	County 2	N/A	N/A	$66.51	07/01/2024
90834	Adult and Child	Licensed Clinical Social Worker	County 1	N/A	N/A	$64.30	07/01/2024
90834	Adult and Child	Licensed Clinical Social Worker	County 2	N/A	N/A	$62.40	07/01/2024
99214	Adult and Child	Physician	All counties	N/A	N/A	$81.76	01/01/2022
99214	Adult	Physician Assistant	County 1	N/A	N/A	$48.90	01/01/2022
99214	Adult	Physician Assistant	County 2	N/A	N/A	$48.90	01/01/2022
99214	Adult	Nurse Practitioner	County 1	N/A	N/A	$47.90	01/01/2022
99214	Adult	Nurse Practitioner	County 2	N/A	N/A	$47.90	01/01/2022
99446	Adult	Physician Assistant	County 1	N/A	N/A	$38.50	07/01/2024
99446	Adult	Physician Assistant	County 2	N/A	N/A	$35.76	07/01/2024
99446	Adult	Physician	County 1	N/A	N/A	$82.47	07/01/2024
99446	Adult	Physician	County 2	N/A	N/A	$80.35	07/01/2024
99446	Adult	Nurse Practitioner	All counties	N/A	N/A	$30.50	07/01/2024
99474	Child	Physician	All counties	N/A	N/A	$20.45	01/01/1999
99474	Adult	Physician Assistant	All counties	N/A	N/A	$15.96	01/01/1999
99474	Adult	Physician	County 1	N/A	N/A	$20.45	01/01/1999
99474	Adult	Physician	County 2	N/A	N/A	$19.58	01/01/1999
99474	Adult	Nurse Practitioner	All counties	N/A	N/A	$14.12	01/01/1999

Table 1b. Bundled Payment Rate Breakdown

Name of Service Bundled	Constituent Services Included in Service Bundle	Fee Schedule Payment Rate Outside of Bundle	Summation of Fee Schedule Payment Rates Outside of Bundle for Constituent Services	Bundled Payment Rate	Allocation of Bundled Payment Rate (Bundled Payment Rate * (Fee Schedule Payment Rate Outside of Bundle/Summation of Fee Schedule Payment Rates Outside of Bundle for Constituent Services))
Assertive Community Treatment	Assessment	$50.00	$500.00	$480.00	$48.00 = $480 * ($50/$500)
	Care Coordination	$30.00			$28.80 = $480 * ($30/$500)
	Crisis Intervention	$200.00			$192.00 = $480 * ($200/$500)
	Individual Therapy (2 hours)	$200.00			$192.00 = $480 * ($200/$500)
	Medication Management	$20.00			$19.20 = $480 * ($20/$500)

C. Comparative Payment Rate Analysis

Under § 447.203(b)(2) through (3), states are required to develop and publish a comparative payment rate analysis of Medicaid payment rates for certain specified services. Specifically, for each of the categories of services in paragraphs (b)(2)(i) through (iii), each state agency must develop and publish a comparative payment rate analysis of Medicaid payment rates as specified in § 447.203(b)(3). States must publish their first comparative payment rate analysis by July 1, 2026, for CY 2025 rates.

We expect to provide states with approximately 1 full calendar year of access to the CMS-published list of evaluation and management (E/M) Current Procedural Terminology (CPT)[11]/Healthcare Common Procedure Coding System (HCPCS) codes and Medicare non-facility payment rates as established in the annual Medicare Physician Fee Schedule (PFS) rule for a calendar year to provide states with sufficient time to develop and publish their comparative payment rate analyses as described in § 447.203(b)(4). Medicare publishes its annual PFS final rule in November of each year and the Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year are effective the following January 1. States are required to use the Medicare non-facility payment rates as established in the Medicare PFS final rule for calendar year 2025 for purposes of the initial comparative payment rate analysis to be published by July 1, 2026. The comparative payment rate analysis is required to be updated no less than every 2 years and by no later than July 1 of the second year following the most recent update, therefore, the second comparative payment rate analysis would be for calendar year 2027, the third analysis would be for calendar year 2029, so on and so forth. Each comparative payment rate analysis would use the respective year's CMS published list of E/M CPT/HCPCS codes which will be updated by CMS approximately one full calendar year before the due date of the next comparative payment rate analysis and the list will include changes made to the American Medical Association (AMA) CPT Editorial Panel and the Medicare PFS based on the most recent Medicare PFS final rule.

CMS will publish the first CMS-published list of the E/M CPT/HCPCS codes that actually will be subject to the comparative payment rate analysis requirements by July 1, 2025 for CY 2025, to facilitate states' publication of their comparative payment rate analyses by the applicability date of July 1, 2026. See additional information in the Publication Requirements section. The code list included in Appendix A is an example of the code list we would have provided if the requirements were in effect currently.

1. Scope

The comparative payment rate analysis requirements apply to all categories of services listed in subparagraphs (b)(2)(i) to (iii): primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services. States must use the Medicare non-facility payment rate as established in the annual Medicare PFS final rule for a calendar year in the comparative payment

[11] CPT codes, descriptions and other data only are copyright 1995 — 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association (AMA).

rate analysis.[12] Only codes included on the CMS-published list of E/M CPT or HCPCS codes are subject to the analysis.

The Medicaid FFS fee schedule payment rates should be representative of the total computable payment amount a provider would expect to receive as payment in full for the provision of Medicaid services to individual beneficiaries. Section 447.15 defines payment in full as "the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual." Therefore, the state's Medicaid base payment rates used for comparison should be inclusive of total base payment from the Medicaid agency plus any applicable coinsurance and deductibles to the extent that a beneficiary is expected to be liable for those payments. If a state Medicaid fee schedule does not include these additional beneficiary cost-sharing payment amounts, then the Medicaid fee schedule amounts would need to be modified to align with the inclusion of expected beneficiary cost sharing in Medicare's non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year.[13]

The payment rates that states must include in the comparative payment rate analysis are Medicaid FFS fee schedule payment rates, which as discussed previously are FFS payment amounts made to a provider and known in advance of a provider delivering a service to a beneficiary by reference to a fee schedule. We would also consider bundled payment rates to be Medicaid FFS fee schedule payment rates for the purposes of the comparative payment rate analysis.

a. Exclusions

Codes outside of this list, including services that Medicaid pays for, but Medicare does not, are not subject to the comparative payment rate analysis requirement. Rates paid to FQHCs and RHCs are not subject to the comparative payment rate analysis requirements in § 447.203(b)(2) through (3). Mental health services provided in a facility-based setting, such as FQHC, RHC, Certified Community Behavioral Health Clinic, or clinics (as defined in § 440.90) are likewise excluded from the comparative payment rate analysis.

PPS rates for services provided in inpatient hospitals, outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and nursing facilities are effectively excluded from the comparative payment rate analysis. States are also not required to disaggregate each of their PPS rates (including encounter, per diem, per visit, and provider-specific rates) and services covered in each rate to compare to Medicare's PPS rates when Medicare pays a PPS rate for the same service.

States do not need to publish the methodology used to determine its payment rates.

b. Code Selection

We identified E/M CPT/HCPCS codes to be included in the comparative payment rate analysis based on the following criteria: the code is effective for the same time period of the comparative payment rate analysis; the code is classified as an E/M CPT/HCPCS code by the AMA CPT Editorial Panel; the code is

[12] The Medicare non-facility payment rate, is described by CMS as "… the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office." See https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf.

[13] According to the Medicare PFS Guide, for most codes, Medicare pays 80 percent of the amount listed and the beneficiary is responsible for 20 percent.

included on the Berenson Eggers Type of Service (BETOS) code list effective for the same time period as the comparative payment rate analysis and falls into the E/M family grouping and families and subfamilies for primary care services, obstetrics and gynecological services, and outpatient behavioral services (now called outpatient mental health and substance use disorder services in the final rule); and the code has an A (Active), N (Non-Covered), R (Restricted), or T (Injections) code status on the Medicare PFS with a Medicare established relative value unit (RVU) and payment amount for the same time period of the comparative payment rate analysis.[14] The example list included in this guidance defines the services that would be subject to the comparative payment rate analysis through the identification of specific E/M CPT/HCPCS codes that are in effect for CY 2023.

The CMS-published list of E/M CPT/HCPCS codes subject to the comparative payment rate analysis will classify each E/M CPT/HCPCS code into a corresponding category of service as described in § 447.203(b)(2)(i) through (iii). We are cognizant that codes with N (Non-Covered), R (Restricted), or T code statuses have limited or no Medicare coverage; however, Medicare may establish RVUs, and payment amounts for these codes. Therefore, when Medicare does establish RVUs and payment amounts for codes with N (Non-Covered), R (Restricted), or T (Injections) code statuses on the Medicare PFS, we include these codes in the comparative payment rate analysis to ensure the analysis includes a comprehensive set of codes, that are commonly provided services that fall into the categories of service in § 447.203 (b)(2)(i) through (iii) and delivered primarily by physicians and NPPs in an office-based setting.

The Medicare PFS is published through annual notice and comment rulemaking and takes effect January 1 of the upcoming calendar year. Medicare may issue a correction to the Medicare PFS after the final rule is in effect, and this correction may impact our published list of E/M CPT/HCPCS codes. We may issue a correction to the Medicare PFS after the final rule is in effect, and this correction may impact our published list of E/M CPT/HCPCS codes, and we may add or remove an E/M CPT/HCPCS code from the published list, as appropriate.

2. Publication Requirements

Section 447.203 (b)(2) requires states to separately identify the payment rates in the comparative payment rate analysis if the rates vary, by population (pediatric and adult), provider type, and geographical location, as applicable. These breakdowns of the Medicaid payment rates, similar to how payment rates are broken down in the payment rate transparency publication under § 447.203(b)(1), apply to all categories of services listed in subparagraphs (b)(2)(i) to (iii): primary care services, obstetrical and gynecological services, outpatient mental health and substance use disorder services.

In § 447.203 (b)(3)(i), for the categories of service described in paragraphs (b)(2)(i) through (iii), the state's analysis must compare the state's Medicaid FFS payment rates to the most recently published Medicare payment rates effective for the same time period for the E/M CPT/HCPCS codes applicable to the category of service. The comparative payment rate analysis of FFS Medicaid payment rates to FFS Medicare payment rates must be conducted on a code-by-code basis at the CPT/HCPCS code level using the most current set of codes published by us. To the extent there are differences in a state's rates based

[14] See https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup, and https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.

on population (pediatric and adult), provider type, and geographical location, the publication may need to have multiple CPT-level rate comparisons to account for each differing rate.

If a state does not use the exact code included in the CMS-published list of E/M CPT/HCPCS codes (for example, if a state amends existing CPT/HCPCS codes with additional numbers or letters for processing in their own claims system), then we expect the state to review the CMS-published list of E/M CPT/HCPCS codes and identify which of their codes are most comparable for purposes of the comparative payment rate analysis. States may need to review code descriptions as part of the process of identifying which codes on the CMS-published list of E/M CPT/HCPCS codes are comparable to the codes that states utilize.

In § 447.203 (b)(3)(i), the state's comparative payment rate analysis must meet the following requirements: (A) the analysis must be organized by category of service as described in § 447.203(b)(2)(i) through (iii); (B) the analysis must clearly identify the base Medicaid FFS fee schedule payment rate for each E/M CPT/HCPCS code identified by us 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 PFS 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 FFS fee schedule payment rate, that correspond to the Medicaid payment rates identified under paragraph (b)(3)(i)(B) including separate identification of the payment rates by provider type; (D) the analysis must specify the Medicaid payment rate identified under paragraph (b)(3)(i)(B) as a percentage of the Medicare payment rate identified under paragraph (b)(3)(i)(C) for each of the services for which the Medicaid payment rate is published under paragraph (b)(3)(i)(B); and (E) the analysis must specify the number of Medicaid paid claims within a calendar year for each of the services for which the Medicaid payment rate is published under paragraph (b)(3)(i)(B).

In § 447.203 (b)(3)(i)(C), the Medicare non-facility payment rates as established in the annual Medicare PFS final rule used for the comparison must be for the same geographical location as the Medicaid FFS fee schedule payment rate. For states that pay Medicaid payment rates based on geographical location (for example, payment rates that vary by rural or non-rural location, by zip code, or by metropolitan statistical area), the analyses must use the Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year for the same geographical location as the Medicaid FFS fee schedule payment rate to achieve an equivalent comparison. We expect states to review Medicare's published listing of the current PFS locality structure organized by state, locality area, and when applicable, counties assigned to each locality area and identify the comparable Medicare locality area for the same geographical area as the Medicaid FFS fee schedule payment rate.[15]

States that make Medicaid payment based on geographical location potentially do not use the same locality areas as Medicare. States have the flexibility to map their geographical areas to those used for Medicare payment for purposes of meeting the requirement that states break down their payment rates by geographical location, as applicable. We expect the state to determine an appropriate method to accomplish the comparative payment rate analysis that aligns the geographic area covered by each payer's rate as closely as reasonably feasible. For example, if the state identifies two geographic areas for

[15] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Locality.

Medicaid payment purposes that are contained almost entirely within one Medicare geographic area, then the state reasonably could determine to use the same Medicare non-facility payment rate as established in the annual Medicare PFS final rule in a calendar year in the comparative payment rate analysis for each Medicaid geographic area. As another example, if the state defined a single geographic area for Medicaid payment purposes that contained two Medicare geographic areas, then the state might determine a reasonable method to weight the two Medicare payment rates applicable within the Medicaid geographic area, and then compare the Medicaid payment rate for the Medicaid-defined geographic area to this weighted average of Medicare payment rates. States could also calculate the unweighted arithmetic mean of the two Medicare payment rates applicable within the Medicaid-defined geographic area.

For states that do not pay Medicaid payment rates based on geographical location, states must compare their Medicaid payment rates (separately identified by population, pediatric and adult, and provider type, as applicable) to the statewide average of Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year for a particular CPT/HCPCS code. The statewide average of the Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year for a particular CPT/HCPCS code would be calculated as a simple average or arithmetic mean where all Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year for a particular CPT/HCPCS code for a particular state would be summed and divided by the number of all Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year for a particular CPT/HCPCS code for a particular state. This calculated statewide average of the Medicare non-facility payment rates as established in the annual Medicare PFS final rule for a calendar year would be calculated for each CPT/HCPCS code subject to the comparative payment rate analysis using the non-facility price for each locality in the state as established in the annual Medicare PFS final rule for a calendar year.

In the next section, we direct states to the Excel file downloads of the "PFS Relative Value Files" which include the RVUs, geographic practice cost index (GPCIs), and the "National Physician Fee Schedule Relative Value File Calendar Year 2023" file which contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (for example, payment of assistant at surgery, team surgery, or bilateral surgery). We expect states to use the formula for the non-facility pricing Amount in "National Physician Fee Schedule Relative Value File Calendar Year 2023" file to calculate the "Non-Facility Price" using the RVUs, GPCIs, and conversion factors for codes not available in the Look-Up Tool.

If a state's base Medicaid FFS fee schedule payment rate varies by provider type for a particular code subject to the comparative payment rate analysis, then the payment rates must be separately identified by provider type, including, but not limited to, physician, nurse practitioner, and physician assistant, as specified in § 447.203(b)(3)(i)(B).

Under § 447.203 (b)(3)(i)(D), states must specify the Medicaid base payment rate identified under § 447.203(b)(3)(i)(B) as a percentage of the Medicare non-facility payment rate as established in the annual Medicare PFS final rule identified under § 447.203(b)(3)(i)(C) for each of the services for which the Medicaid base payment rate is published under § 447.203(b)(3)(i)(B). For each E/M CPT/HCPCS code that

we select, states are required to calculate each Medicaid base payment rate as specified in paragraph (b)(3)(i)(B) as a percentage of the corresponding Medicare non-facility payment rate as established in the annual Medicare PFS final rule specified in paragraph (b)(3)(i)(C). Both rates must be effective for the same time period of the comparative payment rate analysis. As previous components of the comparative payment rate analysis considered variance in payment rates based on population the service is delivered to (adult or pediatric), provider type, and geographical location to extract the most granular and accurate Medicaid and Medicare payment rate data, states are required to calculate the Medicaid base payment rate as a percentage of the Medicare non-facility payment rate as established in the annual Medicare PFS final rule in the comparative payment rate analysis to obtain an informative metric that can be used in the state's and our assessment of whether the state's payment rates are compliant with section 1902(a)(30)(A) of the Social Security Act (the Act).

The comparative payment rate analysis must include the number of Medicaid-paid claims (which may duplicate codes) 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 FFS fee schedule payment rate is published in the comparative payment rate analysis. For the initial comparative payment rate analysis, states will need to include their claims and beneficiary data for CY 2025 in the analysis to be published no later than July 1, 2026. This timing provides a 6-month period for claims run out.

States have flexibility to utilize contractors or other third-party websites to publish the comparative payment rate analysis. However, we remind states that they are still required to publish the hyperlink to the website where the publication is located on the state Medicaid agency's website and follow other requirements consistent with the publication requirements in § 447.203(b) (ii), which are the same for the payment rate transparency publication and the payment rate disclosure.

Under § 447.203(b)(4), the state agency must update the comparative payment rate analysis and payment rate disclosure no less than every 2 years, by no later than July 1 of the second year following the most recent update. States are required to use the Medicare non-facility payment rates as established in the Medicare PFS final rule for the applicable calendar year. The comparative payment rate analysis must be published consistent with the publication requirements described in § 447.203 (b)(1) introductory text, paragraphs (b)(1)(i) and (b)(1)(ii) of that section.

Approximately one full calendar year before the due date of the next comparative payment rate analysis, CMS will publish an updated list of E/M CPT/HCPCS codes for states to use for their comparative payment rate analysis updates through subregulatory guidance. The list included in this guidance is only an example. The updated list of E/M CPT/HCPCS codes will include changes made by the AMA CPT Editorial Panel (such as additions, removals, or amendments to a code definition where there is a change in the set of codes classified as an E/M CPT/HCPCS code billable for primary care services, obstetrics and gynecological services, or outpatient behavioral services) and changes to the Medicare PFS based on the most recent Medicare PFS final rule (such as changes in code status or creation of Medicare-specific codes).[16]

[16] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.

As stated previously, CMS may add or remove an E/M CPT/HCPCS code from the published list, as appropriate, depending on the change to the Medicare PFS. Depending on the nature of the change, we would expect states to accurately identify which code(s) are used in the Medicaid program during the relevant period that best correspond to the CMS-identified E/M CPT/HCPCS code(s) affected by the Medicare PFS correction.

3. Steps to Complete Sample Comparative Analysis

The code list, found in Appendix A, focuses on codes in the following service categories: (1) primary care, (2) behavioral health, and (3) obstetrics and gynecology (OB/GYN). An Excel version of the code list is available here. To develop the list, we reviewed and consolidated a couple of compendiums of E/M codes into a comprehensive, deduplicated spreadsheet:

- Berenson-Eggers Type-of-Service (BETOS) code list; and
- National Physician Fee Schedule Relative Value File, January release.

However, we note that, as needed in future years, we may also consult the following sources:

- Codes from the American Academy of Professional Coders (AAPC) Codify website;
- Healthcare Common Procedure Coding System (HCPCS) quarterly update; and/or
- HCPCS and Current Procedural Terminology (CPT) codes.

For primary care codes, we considered only codes pertaining to office visits and outpatient care. For OB/GYN codes, we included any codes whose descriptions contained outpatient services related to OB/GYN care. We used the same approach for behavioral health codes. We considered codes whose descriptions contained outpatient services related to behavioral health services for the behavioral health category.

In this section, we provide the steps states can take to complete its Comparative Payment Rate Analysis once the biennial code list is published. As stated previously, this first published list in Appendix A is an example list of codes that would have been subject to the comparative payment rate analysis if it were in effect for CY 2023; we will publish the initial list of E/M CPT/HCPCS codes subject to the comparative payment rate analysis no later than June 30, 2025, to provide states 1 full calendar year between the issuance of the CMS-published list of E/M CPT/HCPCS codes and the due date of the comparative payment rate analysis.

1. **Identify your state's Medicaid rate for each code included in the E/M code list (Appendix A).** If a state's payment rate varies by population (pediatric and adult), provider type, and geographical location, the state must include all applicable Medicaid rates in the comparative payment rate analysis. If a state does not pay varied rates and instead has a single statewide payment rate, the state must include its single statewide rate in the comparative payment rate analysis.

Example: The following table shows the 2022 non-facility reimbursement rates for code 99214 for North Carolina.

Fee Schedule Updated on: 8/10/2022			Medicaid Maximum Allowable			
PROCEDURE CODE	MODIFIE	PROCEDURE DESCRIPTION	FACILITY RATE	NON-FACILITY RA	Effective Date of Rate	FEE END DATE
99214		OFFICE/OUTPATIENT VISIT EST	$ 62.08	$ 81.76	1/1/2022	12/31/9999

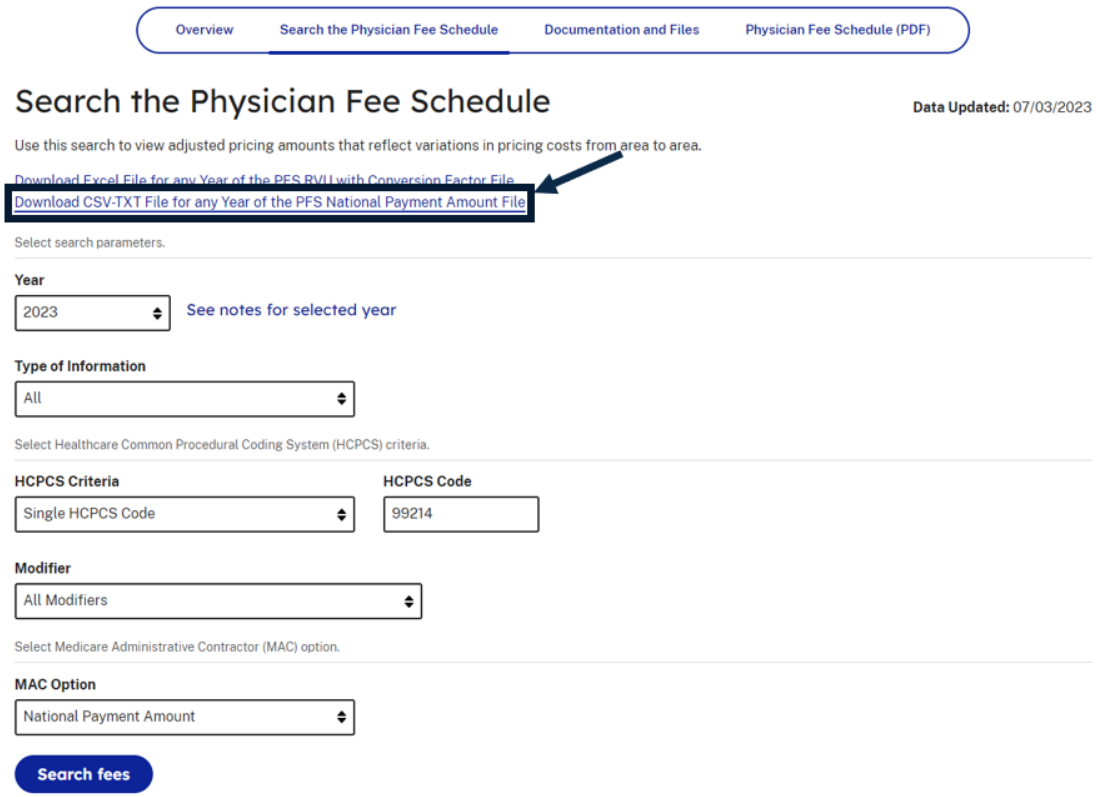
Source: NC Medicaid Division of Health Benefits website.

There are two main ways to merge your state's Medicaid rates with Medicare rates: (1) merge the Medicaid and Medicare rates using data analysis software (Steps 3 through 5 below) or (2) use the Medicare PFS website to identify the Medicare rate for each code (Steps 7 through 12).

a. Merging Medicaid and Medicare rates with data analysis software

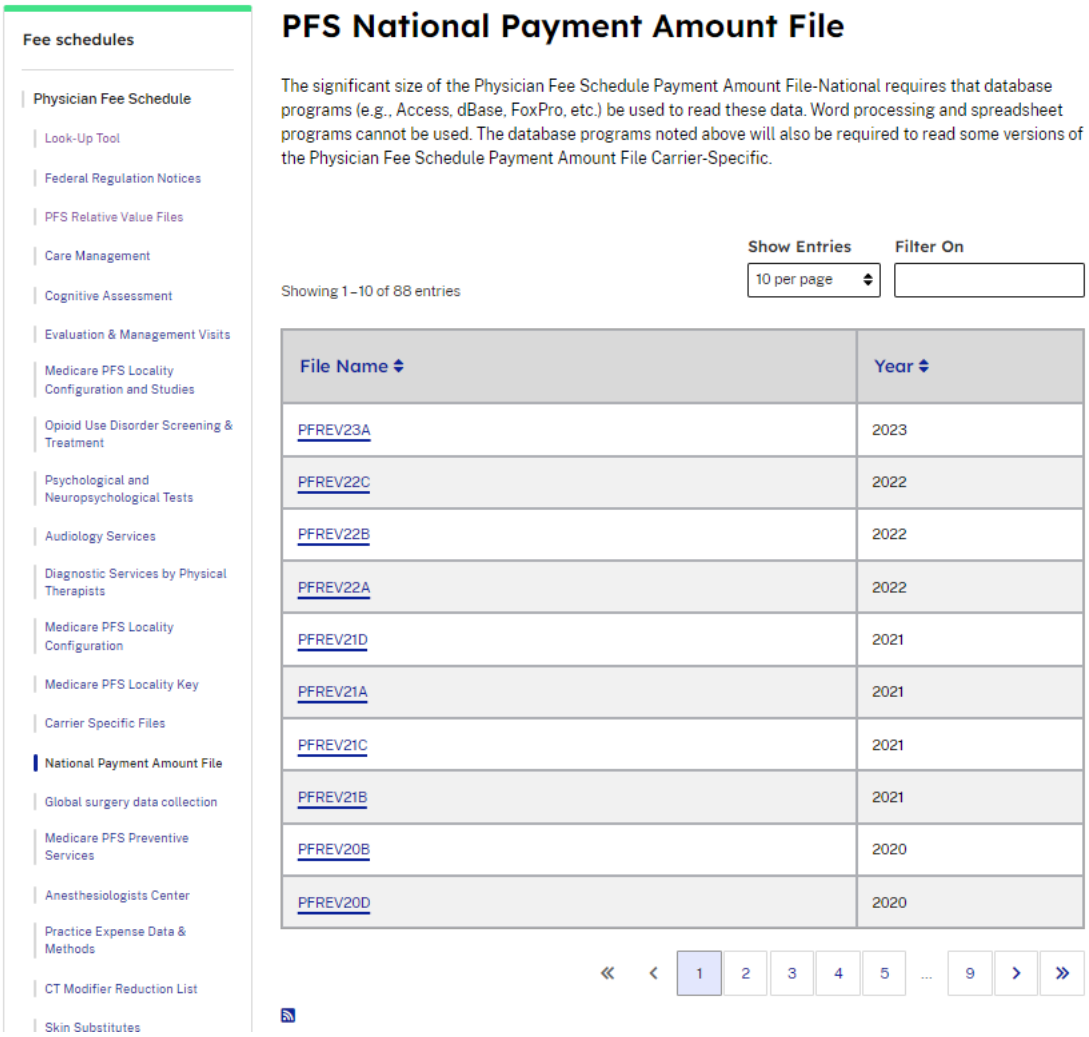
If possible, use software to merge the Medicare fee schedule with the E/M codes in this document, which will limit the Medicare fee schedule to the codes relevant to the payment rate comparison. This approach is much faster than using the Medicare PFS website to identify the Medicare rate for each code.

2. **To use the software method, visit the Centers for Medicare & Medicaid Services (CMS) Medicare PFS website[17] to download the full Medicare fee schedule.** Once you enter the site, select the option "Download CSV-TXT File for Any Year of the PFS National Payment Amount File."



[17] https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=3&H1=99214&M=5.

3. **Select the most recent PFS Payment Amount File.** Note that this selection is possible only after you are automatically redirected to another page after completing Step 2.



4. **Select the most recent PFREV file.** After you make this selection, you will be taken to a page where you can select the file for download in the "Downloads" box.

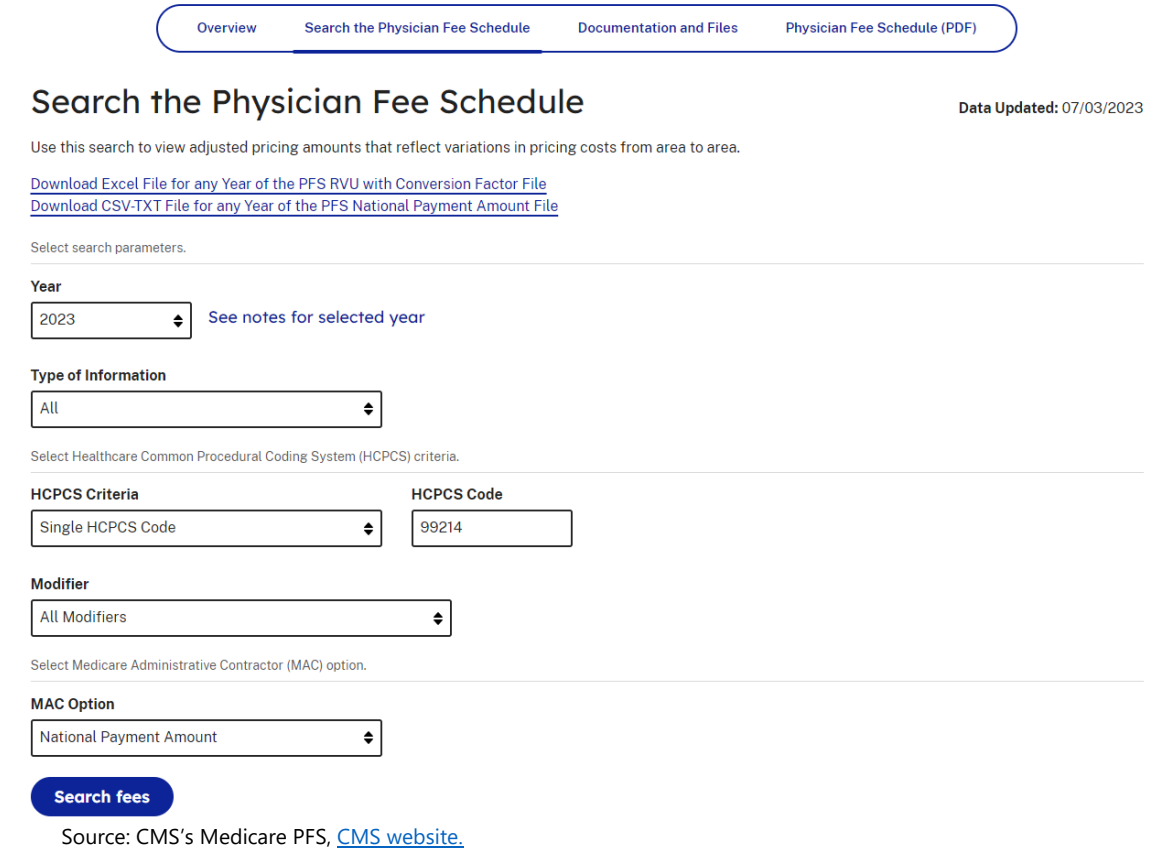
5. **Use your data analysis software to merge the Medicare fee schedule with the E/M code list in this document.** You can then merge the Medicare fee schedule rates and your state's rates at the code level. Finally, compare the rates by dividing your state's Medicaid rate by the Medicare rate for each code.

b. Using the Medicare PFS website to identify the Medicare rate for each code

Note: This is an alternative approach to Steps 2 through 5, not an additional approach. Please also note that this display tool is intended to be a helpful aid for physicians and nonpractitioners looking for a quick way to look up PFS payment rates. CMS makes no warranties, expressed or implied, regarding errors or omissions and assumes no legal liability or responsibility for loss or damage resulting from the use of information contained within. For the official and definitive CMS PFS payment files, please contact the local Medicare administrative contractor (MAC) in your payment jurisdiction.

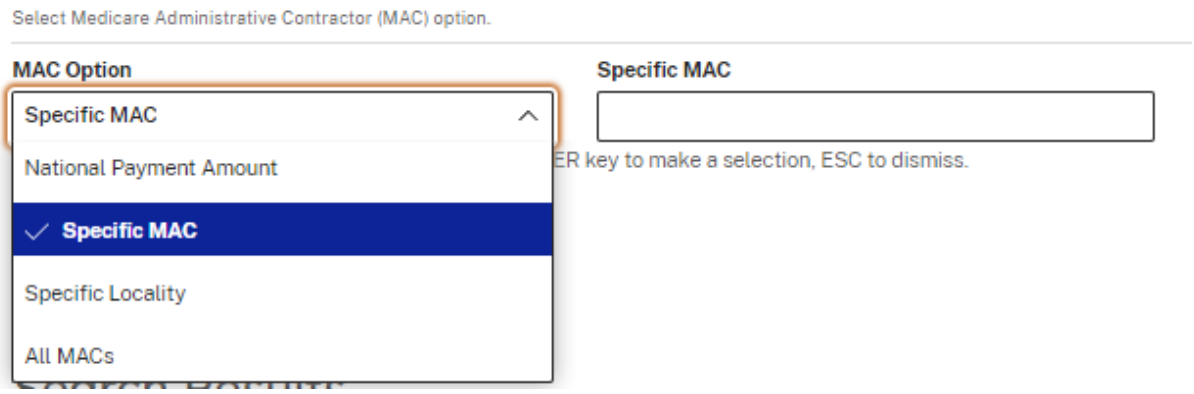
6. **Visit the CMS Medicare PFS website to identify the Medicare rate for each code.** We encourage each state to begin sourcing Medicare non-facility payment rates from the PFS Look-Up Tool and to use the PFS Guide for instructions on using this tool for the final rule; however, the state should first download and review the Medicare PFS Relative Value with Conversion Factor File. This is where you will find the necessary information for calculating Medicare non-facility payment rates, as established in the annual Medicare PFS final rule for each calendar year.

7. **Select the appropriate HCPCS criteria, including your code(s).** To ensure an appropriate comparison, do not apply any modifiers to the Medicare code.



Source: CMS's Medicare PFS, CMS website.

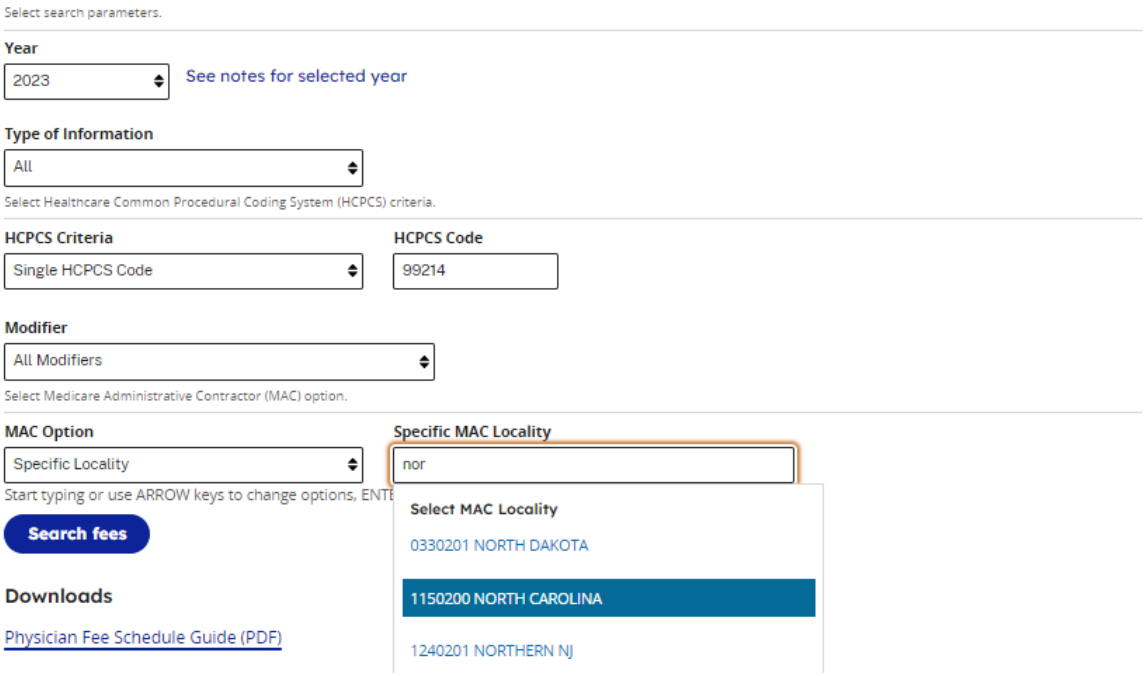
8. **Select the MAC option.** To select your state's data, choose the "Specific MAC" option.



Source: Medicare Physician Fee Schedule, CMS website.

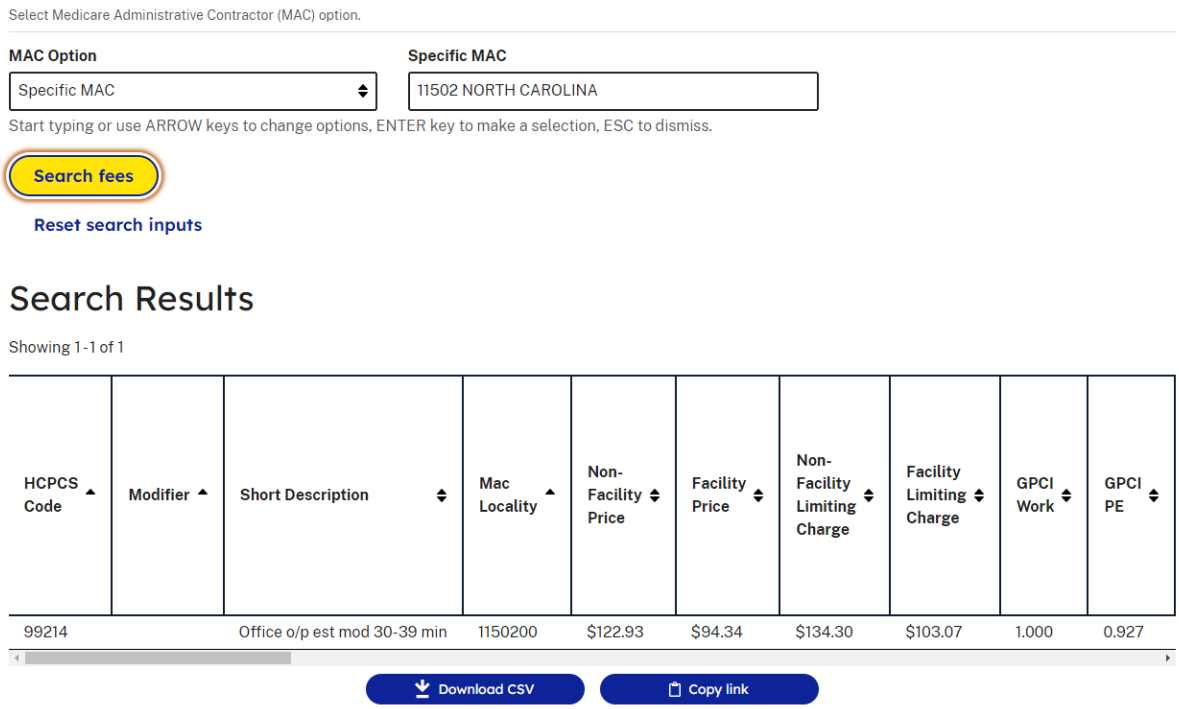
9. **Type your state name or the MAC locality ID in the "Specific MAC" box.** If your state does not use the same locality areas as Medicare to make Medicaid payments based on geographical location, select a method that most closely aligns with the covered geographic area of each payer's rate. For example, if within one Medicare geographic area your state identifies two geographic areas for Medicaid payment purposes, use the same Medicare non-facility payment rate listed in the Medicare PFS in the comparative payment rate analysis for each Medicaid geographic area. On the other hand, if there is a single geographic area used for Medicaid payments that contains two Medicare geographic areas, take a weighted approach to the two Medicare payment rates that are applicable in the Medicaid geographic area, and then compare the Medicaid payment rate to an unweighted average of the Medicare payment rates. If you prefer, your state can use a weighted arithmetic mean of the Medicare payment rates.

   If your state does not make Medicaid payments based on geographic location, you can calculate a simple average of all the Medicare non-facility payment rates listed in the Medicare PFS for your state for the CPT/HCPCS code of interest. To do this, take the sum of the payment rates and divide it by the number of Medicare geographic locations in your state.



Source: Medicare Physician Fee Schedule, CMS website.

10. **Click the "Search fees" button.** The results for your search will then be shown.



Source: Physician Fee Schedule, CMS website.

11. **Identify the appropriate Medicare rates.** Data in the fifth column reflect the non-facility price, whereas data in the sixth column reflect the facility price.

Completing the Medicaid-to-Medicare comparative analysis (after Steps 2 through 5 or Steps 6 through 11).

12. **Make adjustments for non-physician providers.** Under section 1833(a)(1)(O) of the Social Security Act, the payment amount for non-physician providers in Medicare is 85 percent of the amount that would be paid to a physician under the PFS. Calculate the Medicare rate for nonphysician providers by multiplying the Medicare rate for the code from the PFS rate by 0.85.
13. **Divide your state's Medicaid rate by the Medicare rate for the code to compare the rates.** Be sure to clearly identify the Medicare non-facility payment rate and specify the Medicaid base payment rate as a percentage of the Medicare non-facility payment rate.

    If your state does not make Medicaid payments based on geographical location, you can calculate a simple average of all the Medicare non-facility payment rates listed on the Medicare PFS for your state for the specific CPT/HCPCS code of interest by taking the sum of the payment rates and dividing it by the number of Medicare geographic locations within your state[18].

[18] For more guidance on mapping Medicaid geographical areas to Medicare for the purposes of completing the comparative analysis, see https://www.federalregister.gov/d/2023-08959/p-553.

D. Sample Comparative Payment Rate Analysis

Table 2. Sample Comparative Payment Rate Analysis

Evaluation and Management Code[a]	Service Category	Population Group	Provider Type	Geographical Location	Calendar Year 2024 Base Medicaid Fee-For-Service Fee Schedule Payment Rates	Calendar Year 2024 Medicare Non-Facility Payment Rates	Comparison of Medicaid to Medicare Payment Rates	Number of Medicaid-Paid Claims	Number of Medicaid Beneficiaries
90834	Outpatient Behavioral Health	Child	Physician	County 1	$65.81	$97.84	67.3%	28,234	9,199
90834	Outpatient Behavioral Health	Child	Physician	County 2	$62.43	$97.84	63.8%	1,875	2,542
90834	Outpatient Behavioral Health	Adult	Physician	County 1	$72.35	$83.16	87.0%	28,234	9,199
90834	Outpatient Behavioral Health	Adult	Physician	County 2	$65.81	$83.16	79.1%	1,875	2,542
90834	Outpatient Behavioral Health	Adult	Nurse Practitioner	County 1	$68.20	$68.77	99.2%	28,234	9,199
90834	Outpatient Behavioral Health	Adult	Nurse Practitioner	County 2	$66.51	$68.77	96.7%	1,875	2,542
90834	Outpatient Behavioral Health	Adult and Child	Licensed Clinical Social Worker	County 1	$64.30	$65.22	98.6%	28,234	9,199
90834	Outpatient Behavioral Health	Adult and Child	Licensed Clinical Social Worker	County 2	$62.40	$654.22	9.5%	1,875	2,542
99214	Primary Care	Adult and Child	Physician	All counties	$81.76	$122.93	66.5%	335,493	122,780

Evaluation and Management Code[a]	Service Category	Population Group	Provider Type	Geographical Location	Calendar Year 2024 Base Medicaid Fee-For-Service Fee Schedule Payment Rates	Calendar Year 2024 Medicare Non-Facility Payment Rates	Comparison of Medicaid to Medicare Payment Rates	Number of Medicaid-Paid Claims	Number of Medicaid Beneficiaries
99214	Primary Care	Adult	Physician Assistant	County 1	$48.90	$88.82	55.1%	335,493	122,780
99214	Primary Care	Adult	Physician Assistant	County 2	$48.90	$88.82	55.1%	22,749	26,919
99214	Primary Care	Adult	Nurse Practitioner	County 1	$47.90	$88.82	53.9%	335,493	122,780
99214	Primary Care	Adult	Nurse Practitioner	County 2	$47.90	$88.82	53.9%	22,749	26,919
99214	Obstetrical and Gynecological	Adult	Physician	County 1	$61.50	$104.49	58.9%	145,761	140,700
99214	Obstetrical and Gynecological	Adult	Physician Assistant	County 2	$51.50	$88.82	58.0%	90,648	85,974
99214	Outpatient Behavioral Health	Child	Physician	County 1	$70.42	$104.49	67.4%	50,834	40,963
99214	Outpatient Behavioral Health	Adult	Physician Assistant	County 2	$60.42	$88.82	68.0%	30,345	20,555
99446	Obstetrical and Gynecological	Adult	Physician Assistant	County 1	$38.50	$55.60	69.2%	28,890	15,469
99446	Obstetrical and Gynecological	Adult	Physician Assistant	County 2	$35.76	$55.60	64.3%	4,990	1,797
99446	Obstetrical and Gynecological	Adult	Physician	County 1	$82.47	$98.52	83.7%	28,890	15,469
99446	Obstetrical and Gynecological	Adult	Physician	County 2	$80.35	$98.52	81.6%	4,990	1,797
99474	Primary Care	Child	Physician	All counties	$20.45	$23.65	86.5%	335,493	80,798

Evaluation and Management Code[a]	Service Category	Population Group	Provider Type	Geographical Location	Calendar Year 2024 Base Medicaid Fee-For-Service Fee Schedule Payment Rates	Calendar Year 2024 Medicare Non-Facility Payment Rates	Comparison of Medicaid to Medicare Payment Rates	Number of Medicaid-Paid Claims	Number of Medicaid Beneficiaries
99474	Primary Care	Adult	Physician Assistant	All counties	$15.96	$21.89	72.9%	335,493	122,780
99474	Primary Care	Adult	Physician	County 1	$20.45	$25.62	79.8%	184,040	122,780
99474	Primary Care	Adult	Physician	County 2	$19.58	$25.62	76.4%	15,497	26,919
99474	Primary Care	Adult	Nurse Practitioner	County 1	$14.12	$21.89	64.5%	335,493	122,780
99474	Primary Care	Adult	Nurse Practitioner	County 2	$14.12	$21.89	64.5%	22,749	26,919

[a] Codes may be applicable to more than one service category. For example, CPT code 99214, which is used for an established patient office visit, could be used by a variety of provider types across primary care, behavioral health and obstetrics/gynecology. States should include entries for each applicable service category.

E. Payment Rate Disclosure

States are required to develop and publish a payment rate disclosure for certain HCBS. For each of the categories of services in § 447.203(b)(2)(iv), each state agency must develop and publish a payment rate disclosure of Medicaid payment rates as specified in § 447.203(b)(3). Under § 447.203(b)(4), for the payment rate disclosure, the initial disclosure must include Medicaid payment rates in effect as of July 1, 2025, and be published no later than July 1, 2026. The state agency must update the payment rate disclosure no less than every 2 years, by no later than July 1 of the second year following the most recent update.

1. Scope

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 are subject to a payment rate disclosure of Medicaid payment rates under § 447.203 (b)(2)(iv). § 447.203 (b)(3)(ii) describes the payment rate disclosure for the categories of service.

States are not required, under the payment rate disclosure provisions at § 447.203(b)(3)(ii) to collect and disclose wage, compensation (including benefits), or financial records and information from provider agencies or to publish information about the compensation the provider agency pays to its employee.

a. Services

The categories of services subject to the payment rate disclosure requirements described in § 447.203(b)(3)(ii) are personal care, home health aide, homemaker, and habilitation services provided under FFS state plan authority, including sections 1915(i), 1915(j), 1915(k) state plan services; section 1915(c) waiver authority; and under section 1115 demonstration authority. We anticipate states may need to review code descriptions of CPT and HCPCS codes for personal care, home health aide, homemaker, and habilitation services as part of the process of identifying which CPT and HCPCS codes are comparable to the codes that states utilize. We want to ensure the full scope of personal care, home health aide, homemaker, and habilitation services, and providers of these services, are included in the payment rate disclosure.

We note that § 447.203(b)(2)(iv) refers to "habilitation" services, without distinguishing between residential habilitation services, day habilitation services, and home-based habilitation services.

We want to note a state has the option to indicate when a habilitation service rate includes personal care services or otherwise provide further data nuances while meeting the requirements of the final rule.

b. Provider types

Individual providers in the context of the payment rate disclosure at § 447.203(b)(3)(ii) refers to individuals that are direct care workers and often self-employed or contract directly with the state to deliver services as a Medicaid provide; additionally, the individual provider bills the states directly and is paid directly by the state for services provided. "Individual providers" does not refer to providers delivering services through self-directed models with a service budget authorized under §441.545, as these are not

considered Medicaid FFS fee schedule payment rates for the purposes of the payment rate transparency publication, as well as the payment rate disclosure at § 447.203(b)(3)(ii).

Provider agency in the context of the payment rate disclosure at § 447.203(b)(3)(ii) refers to the agency contracted or enrolled with the state to deliver Medicaid services, and the agency in turn employs or contracts with direct care workers as employees of the agency, and that works directly with the state Medicaid agency to provide Medicaid services; additionally, the agency bills the state directly and is paid directly by the state for services their employees or contractors provide. Also,, to the extent a state pays a provider agency a Medicaid FFS fee schedule payment rate, then those payment rates are subject to the payment rate disclosure requirements at § 447.203(b)(3)(ii).

We are not specifying a Federal definition for provider type because of the variety of provider types a state could license and pay for delivering Medicaid services. We would like to ensure the full scope of providers of personal care, home health aide, homemaker, and habilitation services across states are included in the payment rate disclosure for transparency purposes.

c. Payment Rates

For purposes of the payment rate disclosure, as with the payment rate transparency provision in § 447.203(b)(1), Medicaid FFS fee schedule payment rates are FFS payment amounts made to a provider and known in advance of a provider delivering a service to a beneficiary by reference to a fee schedule. Likewise, for the payment rate disclosure in § 447.203(b)(3)(ii)(B), we would also consider bundled payment rates to be Medicaid FFS fee schedule payment rates for the purposes of the payment rate disclosure.

We are requiring states to calculate and publish the average hourly Medicaid FFS fee schedule payment rate that states pay to individual providers and provider agencies, if the rates vary. We expect states to review their Medicaid FFS fee schedule payment rates for the payment rate and unit the state uses to pay for each of category of service and calculate the Medicaid average hourly Medicaid FFS fee schedule payment rate for personal care, home health aide, homemaker, and habilitation services, separately by service and provider employment structure as well as for payments that include facility-related costs.

States have flexibility in operating their Medicaid programs to set payment rates and payment policies for services that cover a particular unit of time for delivering the service and, therefore, states currently pay for these services in a wide range of units, from minutes to hourly to daily to monthly units. We are requiring states publish their payment rates in a uniform and comparable format, that is, an average hourly Medicaid FFS fee schedule payment rate. States that pay for the categories of services specified in § 447.203(b)(2)(iv) in a unit other than an hourly payment rate are expected to calculate an hourly payment rate using the unit of the rate the state pays for the service and the number of hours covered by that unit. States must separately identify whether the average hourly Medicaid FFS fee schedule payment rate for services includes facility-related costs.

d. Exclusions

There is no comparison to Medicare payment rates requirement. Because the payment rate disclosure does not involve a comparison to Medicare (or other payer), the data need only reflect the state's specific circumstances. Different states have different methods of assigning payment rates to particular regions

and are therefore best situated to determine how rates must reflect their state-determined geographical designations.

While PPS rates for services provided in inpatient hospitals, outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and nursing facilities are subject to the payment rate transparency publication, these PPS rates are effectively excluded from the payment rate disclosure because the categories of services specified in § 447.203(b)(2)(iv), i.e. personal care, home health aide, homemaker, and habilitation services, are inherently delivered in a home or community setting, outside of an institutional facility.

Negotiated rates are not subject to the payment rate disclosure provision because these payment rates are not subject to the payment rate transparency publication, as negotiated rates are not Medicaid FFS fee schedule payment rates that are known in advance of a provider delivering a service to a beneficiary.

In addition, self-directed services delivery model payment rates are excluded from the disclosure requirement.

States are also not required to report payment rate variations by populations served (that is, populations receiving services under a waiver versus state plan authority).

2. Publication Requirements

Section § 447.203(b)(3)(ii) describes the payment rate disclosure for the categories of service described in paragraphs (b)(2)(iv): personal care, home health aide, homemaker, and habilitation services provided by individual providers and provider agencies.

Under § 447.203(b)(3)(ii), the state's 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); (B) the disclosure must identify the average hourly payment rates, including, if the rates vary, separate identification of the average hourly payment rates for payments made to individual providers and to provider agencies by population (pediatric and adult), provider type, and geographical location, as applicable; and (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 Medicaid base payment rate is published under § 447.203(b)(3)(ii)(B).

In § 447.203(b)(3)(ii)(A), states must organize their payment rate disclosures by each of the categories of services specified in § 447.203 (b)(2)(iv), that is, to break out the payment rates for personal care, home health aide, homemaker, and habilitation services provided by individual providers and provider agencies, separately for individual analyses of the payment rates for each category of service and type of employment structure.

While we encourage states to organize their payment rate disclosure on a code basis, when possible, for clarity and formatting consistency with the comparative payment rate analysis, states have flexibility in meeting the payment rate disclosure requirements to ensure each state's unique circumstances can be accounted for in the disclosure. States are not required to organize their payment rate disclosure by E/M CPT/HCPCS codes.

In § 447.203(b)(3)(ii)(B), we require states to identify in their disclosure the Medicaid average hourly payment rates by applicable category of service, including, if the rates vary, separate identification of the average hourly payment rates for payments made to individual providers and to provider agencies, as well as by population (pediatric and adult), provider type, and geographical location, as applicable. States must also separately identify the Medicaid FFS fee schedule payment rates for services that include facility-related costs.

As part of § 447.203(b)(3)(ii)(A), for each of the categories of services, one Medicaid average hourly payment rate would be calculated as a simple average (arithmetic mean) where all payment rates would be adjusted to an hourly figure, summed, then divided by the number of all hourly payment rates. Different states might pay for personal care services using 15-minute increments, on an hourly basis, through a daily rate, or based on a 24-hour period, and we expect states to calculate the hourly rate from those rates. Also, if, for example, a state pays for personal care, home health aide, homemaker, or habilitation services on a daily basis, we would expect the state to divide that rate by the number of hours covered by the rate.

For states that do not pay varied payment rates by population (pediatric and adult), provider type, or geographical location and pay a single statewide payment rate for a single service, the payment rate disclosure only needs to include the state's single statewide payment rate.

Under § 447.203(b)(3)(ii)(C), the state 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 Medicaid payment rate is published under paragraph (b)(3)(ii)(B). States must report the number of Medicaid-paid claims and number of Medicaid enrolled beneficiaries who received a service under the same breakdown as § 447.203 (b)(3)(ii), where the state provides the number of paid claims and number of beneficiaries receiving services from individual providers versus agency-employed providers of personal care, home health aide services, homemaker, and habilitation services. As with the comparative payment rate analysis, the claims volume data is limited to Medicaid-paid claims and the number of beneficiaries is limited to Medicaid enrolled beneficiaries who received a service in the calendar year of the payment rate disclosure, where the services fall into the categories of service for which the average hourly payment rates are published pursuant to § 447.203(b)(3)(ii)(B).

Section 447.203 (b)(4) requires states to publish the payment rate disclosure required under § 447.203 (b)(1). The payment rate disclosure must be published consistent with the publication requirements described in § 447.203(b)(1) introductory text, (b)(1)(i) and (b)(1)(ii) of that section. Section 447.203 (b)(1) requires the website be developed and maintained by the single state agency to be accessible to the general public. States must utilize the same website developed and maintained by the single state agency to publish their payment rate disclosure that they use for their Medicaid FFS payment rates and their comparative payment rate analysis.

F. Sample Payment Rate Disclosure

Table 3. Sample Payment Rate Disclosure

Service Category	Population Group	Provider Agencies And Individual Providers	Provider Type	State-Specified Geographic Location	Average Hourly Payment Rate Non-Facility	Average Hourly Payment Rate Facility	Number Of Medicaid-Paid Claims	Number Of Medicaid Beneficiaries
Personal Care	Adult and Child	Provider Agencies	Personal Care Assistant	Statewide	$12.54	N/A	20,973	16,991
Personal Care	Adult and Child	Individual Providers	Personal Care Assistant	Statewide	$72.96	N/A	6,862	2,754
Home Health Aide	Adult and Child	Individual Providers	Nurse	Statewide	$59.17	N/A	10,371	4,457
Home Health Aide	Adult and Child	Individual Providers	Licensed Practical Nurse	Statewide	$50.06	N/A	6,759	2,253
Homemaker	Adult and Child	Provider Agencies	Personal Care Assistant	Statewide	$10.78	N/A	2,756	1,842
Homemaker	Adult and Child	Individual Providers	Personal Care Assistant	Statewide	$25.98	N/A	1,789	874
Habilitation	Adult and Child	Provider Agencies	Direct support Professional	Statewide	$16.36	$16.50	25,980	15,660
Habilitation	Adult and Child	Individual Providers	Direct support Professional	Statewide	$14.60	N/A	18,005	9,335

G. Interested Parties Advisory Group

Section 447.203(b)(6) requires states to establish an interested parties advisory group to advise and consult on provider FFS rates where payments are made to direct care workers providing self-directed and agency-directed for personal care, home health aide, and homemaker services as described in § 440.180(b)(2) through (4) and (6); states may choose to include other HCBS. The group must consult on rates for the service categories under the Medicaid state plan, section 1915(c) waiver and demonstration programs, as applicable, where payments are made to individual providers or providers employed by an agency for, at a minimum, the previously described types of services provided under sections 1905(a), 1915(i), 1915(j), and 1915(k) state plan authorities, section 1915(c) waivers, and section 1115 demonstrations. The state may choose to have the group consult on provider payment rates in managed care delivery systems if desired. The interested parties advisory group must 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 homemaker services, home health aide services, personal care, 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.

The interested parties advisory group is required to include, at a minimum, direct care workers, beneficiaries and their authorized representatives, and other interested parties. Representation from each type of individual specified on this list is required. "Direct care workers" is defined at § 441.311(e)(1)(ii).[19] "Authorized representatives" refers to individuals authorized to act on the behalf of the beneficiary, and other interested parties may include beneficiary family members and advocacy organizations. We encourage states, when recruiting members, to consider the composition of members that would best satisfy the goals of this group and identify where there is a need for technical expertise, sufficient representation, etc., and work to establish the group in a manner that promotes its efficient functioning and meaningful contribution to Medicaid policies in the state. The inclusion of "other interested parties" affords states the flexibility to do so.

To the extent a state's MAC established under § 431.12 meets the requirements of the interested parties advisory group, the state can use the MAC for this purpose. If a MAC has membership that includes direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties impacted by the services and rates of focus in the interested parties' advisory group, then a state may include the remit of the interested parties' advisory group in the work of the MAC under the flexibility given to states and their MACs under § 431.12(g)(8), which permits "[o]ther issues that impact the

[19] A direct care worker can be a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid-eligible individuals receiving HCBS; a licensed nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist; a direct support professional; a personal care attendant; a home health aide; or other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living directly to Medicaid-eligible individuals receiving HCBS available under part 441, subpart G. A direct care worker may be employed by a Medicaid provider, State agency, or third party; contracted with a Medicaid provider, State agency, or third party; or delivering services under a self-directed service model.

provision or outcomes of health and medical care services in the Medicaid program as determined by the MAC, BAC, or state." States potentially also could establish the interested parties advisory group as a subgroup of the MAC, similar to the BAC, consistent with the requirements of the final rule. States will have the discretion to determine if the groups and/or their meetings need to be kept distinct in order best to fulfill the obligations of each. However, please note the roles of the MAC under § 431.12 and the interested parties advisory group under § 447.203(b)(6) are distinct. The cadence of required meetings, focus, and work products of the interested parties advisory group are distinct from the MAC, and states wishing to utilize their MAC will need to take adequate steps to ensure the MAC is meeting the regulatory requirements for both entities.

The interested parties advisory group must meet at least every 2 years under § 447.203(b)(6)(iv) 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. This is a minimum requirement, and a state may find that more frequent meetings would be necessary or helpful for the advisory group to provide meaningful and actionable feedback. The 2-year cadence could require the group to convene its first meeting and produce a recommendation before the HCBS payment adequacy data as required under § 441.311(e), and access to care metrics under § 441.311(d)(2), will be available. **Please note the group is not required to advise and consult on the HCBS payment adequacy data as required under § 441.311(e), and access to care metrics under § 441.311(d)(2), until such a time as those data are available under the newly established requirements.** States can use the requirement to produce the group's first recommendation by July 9, 2026, as an opportunity to refine operational practices on a narrower scope of topics. States also have the flexibility to convene the group within a shorter timeframe to adjust the future cadence to align with other publication schedules, if desired.

The state agency must ensure the group has access to current and proposed payment rates, HCBS provider payment adequacy minimum performance and reporting standards as described in § 441.311(e), and applicable access to care metrics for HCBS as described in § 441.311(d)(2) to produce these recommendations. These materials must be made be available with sufficient time for the advisory group to consider them, formulate recommendations, and transmit those recommendations to the state. If the state has asked the group to consider a proposed rate change, the state would need to provide the group with sufficient time to review and produce a recommendation within the state's intended rate adjustment schedule. The group's recommendation would be considered part of the interested parties input described in §§ 447.203(c)(4) and 447.204(b)(3) when the recommendation addresses a proposed rate change, which states must consider and analyze.

The process by which the state selects its advisory group members and convenes meetings must be made publicly available. The final rule leaves states free to establish conflict of interest policies applicable to the members of the interested parties advisory group, which we expect states will do in a manner that protects the integrity of the group while not unduly restricting input from individuals with perspectives the final rule is intended to ensure are heard. Other matters, such as the tenure of members or removal for cause, would be left to the state's discretion. The Medicaid agency must also publish the recommendations of the interested parties advisory group, under § 447.203(b)(6)(v), and consistent with the publication requirements described in § 447.203(b)(1) for payment rate transparency data, within 1

month of when the group provides the recommendation to the agency. We intend that states would consider, but not be required to adopt, the recommendations of the advisory group.

States will be responsible for giving appropriate guidance to the group so that it understands its role and responsibilities in producing recommendations. We defer to states on how to best communicate this information to the group. We also want to emphasize for states that the information they provide the group can be expected to shape the nature of the group's recommendations. As such, although we are not requiring the state to explain if and how inflation has factored in to a proposed rate, for example, or provide information to the group on costs imposed on providers beyond what is required under the payment adequacy metrics required under § 441.311(e), it would benefit a state to provide as much context as possible to the group so that it can produce the strongest, best-informed, most useful recommendations. Because the group's recommendations must be published publicly, interested parties such as state legislators and HHS will be able to see and review any recommendations.

This page has been left blank for double-sided copying.

III. State Analysis Procedures for Rate Reduction or Restructuring (§ 447.203(c))

Section 447.203(c) details the process for state access analyses that states must perform, document, and submit concurrently with the submission of rate reduction and rate restructuring SPAs, with additional analyses required in certain circumstances due to potentially increased access to care concerns. The process involves a two-tiered approach. The first tier of this approach, § 447.203(c)(1), sets out three criteria for states to meet when proposing payment rate reductions or payment restructurings in circumstances when the changes could result in diminished access. Where a state has met the criteria under paragraphs (c)(1)(i) through (iii), we consider that the proposed reduction would result in a nominal payment adjustment unlikely to diminish access below the level consistent with section 1902(a)(30)(A) of the Act and would approve the SPA, provided all other criteria for approval also are met, without requiring the additional analysis under § 447.203(c)(2). If all of the criterion in the first tier are not met, a second tier in § 447.203(c)(2) requires the state to conduct a more extensive access analysis in addition to providing the results of the analysis in the first tier. A state that fails to provide the required information and analysis or has unresolved access to care concerns following both of these analyses may be subject to SPA disapproval under § 430.15(c).

A. Overall

1. Scope

The requirements in § 447.203(c) are applicable to all Medicaid FFS services under the Medicaid state plan, including services furnished by FQHCs, and to home care services (including personal care and home health services) under Section 1905(a) of the Act and to those covered under section 1915 authorities, and demonstration payment rates, as applicable.

The provisions of the final rule in § 447.203(c) provide processes for rate reductions or restructurings, with the goal of determining when those changes could result in diminished access. In most instances, a performance-based incentive, innovative care models, or alternative payment models that restructure provider payments do so in a manner that would not result in diminished access and that we would not regard as a restructuring subject to § 447.203(c). We also note that other simple add-on payments for achievement of specified quality targets where there is no possibility of a reduction to any provider's payment would not be considered a restructuring subject to the requirements of § 447.203(c). However, to the extent that a state implements a performance-based incentive, withhold, or alternative payment model would reduce payment rates, such as models that involve down-side risk arrangements where provider payments could decrease from current levels in certain circumstances, these changes likely would have the potential to result in diminished access to care and therefore would be a restructuring that would fall under the requirements of § 447.203(c). If a state is unsure whether its proposed performance-based incentive, innovative care model, or alternative payment models contains a restructuring subject to § 447.203(c), they can engage with CMS prior to submission of a SPA. CMS can and may request § 447.203(c) analyses upon receipt of a proposal as well.

Lastly, like all state plan services for which the state proposes a rate reduction or restructuring in circumstances where the changes could result in reduced access, FQHC, RHC, clinic (as defined in § 440.90), dental, and community mental health services are subject to access analyses in § 447.203(c) for proposed rate reductions and restructuring.

To the extent that a state submits a SPA that updates coverage of a Medicaid service but does not amend Medicaid payment rates or the rate methodology in the Attachment 4.19A (for Medicaid inpatient services such as inpatient hospital services), 4.19B (for Medicaid non-institutional services such as physician services), or 4.19D (for Medicaid nursing facility services) state plan pages, CMS will not necessarily disapprove that SPA on the basis of insufficient Medicaid payment rates as the payment rates were not submitted along with the corresponding coverage and benefit changes for our consideration. States certainly can submit payment rate information to CMS of the state's own volition or upon request during review of a coverage SPA; however, CMS provides states in this situation (where the SPA would amend state plan coverage, but not payment, pages) with an option to instead defer review of the payment rate compliance issue through a mechanism called a "companion letter," as noted in the 2010 SMDL #10-0020.[20] Even in the absence of a SPA, the corrective action plan process under § 447.203(c)(5) (which we are recodifying from § 447.203(b)(8)) is available for CMS to take compliance action where it is aware of an access problem due to insufficient rates.

a. Restructuring

A rate restructuring is a payment action where a state amends its methodology for an interrelated set of rates whereby individual rates may increase, decrease, or remain the same, which the state typically undertakes to achieve some programmatic purpose, such as achieving more efficient payment for services that frequently are furnished together. While a rate restructuring potentially could include rate increases, if increasing rates is the only effect of the rate restructuring, then we generally would not expect these to be circumstances when the changes could result in diminished access, and the requirements of § 447.203(c)(1) through (3) would not have to be met.

A change in supplemental payments that reduces the total amounts that providers receive or shifts funds from one provider to another could result in access to care issues and is one example of a payment restructuring that could negatively impact access to care.

In most instances, a performance-based incentive, innovative care models, or alternative payment models that restructure provider payments do so in a manner that would not result in diminished access and that we would not regard as a restructuring subject to § 447.203(c). To the extent that a state implements a performance-based incentive, withhold, or alternative payment model would reduce payment rates, such as models that involve down-side risk arrangements where provider payments could decrease from current levels in certain circumstances, these changes likely would have the potential to result in diminished access to care and therefore would be a restructuring that would fall under the requirements of § 447.203(c).

[20] SMDL #10-020, "Revised State Plan Amendment Review Process." Published October 1, 2010. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD10020.pdf.

2. Link to Template

The link for the template states must use to provide the required analyses, as applicable, is available here: https://www.medicaid.gov/medicaid/access-care/downloads/rate-reduction-template.xlsx.

Note: Until the template is approved as part of the Paperwork Reduction Act process, use of this template is optional.

We are not including an example of a completed template for the rate reduction or restructuring SPA requirements due, in part, to the complexity of displaying a completed template in this guide. We have included the detailed instructions for completing the template in the sections below and are available to assist with any questions states may have when completing the template. After the requirement is in effect, we will assess where and how we can share best practices based on actual experiences working with the template.

B. Initial State Analysis

1. General Requirements

Under § 447.203(c)(1)(i), the state must provide a supported assurance that 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. Under § 447.203(c)(1)(i), "benefit category" refers to all individual services under a category of services described in section 1905(a) of the Act for which the state is proposing a payment rate reduction or restructuring.

Comparing the payment rates in the aggregate would involve first performing a comparison of the Medicaid to the Medicare payment rate on a code-by-code basis, meaning CPT, CDT, or HCPCS as applicable, to derive a ratio for individual constituent services, and then the ratios for all codes within the benefit category would be averaged by summing the individual ratios then dividing the sum by the number of ratios. For example, if the state is seeking to reduce payment rates for a subset of physician services, the state would review all current payment rates for all physician services and determine if the proposed reduction to the relevant subset of codes would result in an average Medicaid payment rate for all physician services that is at or above 80 percent of the average corresponding Medicare payment rates. For supplemental payments, we are relying upon the definition of supplemental payments in Section 1903(bb)(2) of the Act, which defines supplemental payments as "a payment to a provider that is in addition to any base payment made to the provider under the state plan under this title or under demonstration authority . . . [b]ut such term does not include a disproportionate share hospital payment made under Section 1923 [of the Act]." With the inclusion of supplemental payments, states would need to aggregate the supplemental payments paid to qualifying providers during the state fiscal year and divide by all providers' total service volume (including service volume of providers that do not qualify for the supplemental payment) to establish an aggregate, per-service supplemental payment amount, then add that amount to the state's fee schedule rate to compare the aggregate Medicaid payment rate to the corresponding Medicare payment rate. As this supported assurance in § 447.203l(1)(i) is expected to be

provided with an accompanying SPA, we noted that CMS may ask the state to explain how the analysis was conducted if additional information is needed as part of the analysis of the SPA.

When considering geography in rate analyses, we expect states to conduct a code-by-code analysis of the ratios of Medicaid-to-Medicare provider payment rates for all applicable codes within the benefit category, either for each of the GPCIs within the state, or by calculating an average Medicare rate across the GPCIs within the state (such as in cases where a state does not vary its rates by region). In cases where a state does vary its Medicaid rates based on geography, but that variation does not align with the Medicare GPCI, we explained that the state should utilize the Medicare payment rates as published by Medicare for the same geographical location as the base Medicaid FFS fee schedule payment rate to achieve an equivalent comparison and align the Medicare GPCI to the locality of the Medicaid payment rates, using the county and locality information provided by Medicare for the GPCIs, for purposes of creating a reasonable comparison of the payment rates. To conduct such an analysis that meets the requirements of § 447.203(c)(1)(i), states may compare the Medicaid payment rates applicable to the same Medicare GPCI to each Medicare rate by GPCI individually, and then aggregate that comparison into an average rate comparison for the benefit category. To the extent that Medicaid payment rates do not vary by geographic locality within the state, the state may also calculate a statewide average Medicare rate based upon all of the rates applicable to the GPCIs within that state and compare that average Medicare rate to the average Medicaid rate for the benefit category.

The published Medicare payment rates means the amount per applicable procedure code identified on the Medicare fee schedule. The established Medicare fee schedule rate includes the amount that Medicare pays for the claim and any applicable co-insurance and deductible amounts owed by the patient. Medicaid fee-schedule rates should be representative of the total computable payment amount a provider would expect to receive as payment-in-full for the provision of Medicaid services to individual beneficiaries. Section 447.15 defines payment in full as "the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual." Therefore, state fee schedules should be inclusive of total base payments from the Medicaid agency plus any applicable coinsurance and deductibles to the extent that a beneficiary is expected to be liable for those payments. If a state Medicaid fee schedule does not include these additional beneficiary cost-sharing payment amounts, then the Medicaid fee schedule amounts would need to be modified to include expected beneficiary cost sharing to align with Medicare's fee schedule.

Medicaid benefits that do not have a reasonably comparable Medicare-covered analogue, and for which a state proposes a payment rate reduction or payment restructuring in circumstances when the changes could result in diminished access, are subject to the expanded review criteria in § 447.203(c)(2), because the state would be unable to demonstrate its Medicaid payment rates are at or above 80 percent of Medicare payment rates for the same or a comparable set of Medicare covered services after the payment rate reduction or payment restructuring. For identifying a comparable set of Medicare covered services, we expect to see services that bear a reasonable relationship to each other. For example, the clinic benefit in Medicaid does not have a directly analogous clinic benefit in Medicare. In Medicaid, clinic services generally are defined in § 440.90, as "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients." This can include a number of primary care services otherwise

available through physician practices and other primary care providers, such as nurse practitioners. Therefore, in seeking to construct a comparable set of Medicare covered services to which the state could compare its proposed Medicaid payment rates, the state reasonably could include Medicare payment rates for practitioner services, such as physician and nurse practitioner services, or payments for facility-based services that bear a reasonable similarity to clinic services, potentially including those provided in Ambulatory Surgical Centers. We would expect the state to develop a reasonably comparable set of Medicare-covered services to which its proposed Medicaid payment rates could be compared and to include with its submission an explanation of its reasoning and methodology for constructing the Medicare rate to compare to Medicaid payment rates.

In § 447.203(c)(1)(ii), states must provide a supported assurance that the proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the state fiscal year, would result in no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a single state fiscal year. The documentation will need to show the change stated as a percentage reduction in aggregate FFS Medicaid expenditures for each affected benefit category. The 4 percent threshold is limited to the cumulative percentage of rate reductions or restructurings applied to the overall FFS Medicaid expenditures for a particular benefit category affected by the proposed reduction(s) or restructuring(s) within each state fiscal year. During the SPA process, states are required to estimate the amount of the financial impact on their CMS form 179 and in their public notice as required by § 447.205(c)(2), which states that the public notice must "give an estimate of any expected increase or decrease in annual aggregate expenditures." Where states are unsure how they should demonstrate whether the proposed change meets the 4 percent threshold in § 447.203(c)(1)(ii), they should look to existing criteria and methodologies used to estimate financial impacts for the CMS form 179 and public notice under § 447.205.

In § 447.203(c)(1)(iii), states are required to provide a supported assurance that the public processes described in § 447.203(c)(4) yielded no significant access to care concerns or yielded concerns that the state can reasonably respond to or mitigate, as appropriate, as documented in the analysis provided by the state under § 447.204(b)(3). We generally consider "significant concerns" to mean those that are not easily resolvable through engagement with beneficiaries, providers, and other interested parties. The state's response to any access concern identified through the public processes, and any mitigation approach, as appropriate, would be expected to be fully described in the state's submission to us. For example, where providers are raising concerns about the level of payment they would receive under a state's new payment rate proposal, the state could discuss with interested parties other legislative initiatives underway or programmatic goals that might be considered as offsetting any decrease in provider payments that might be expected from the proposed rate action. When a state submits the SPA to us, § 447.204(b)(3) requires the state to also submit a specific analysis of the information and concerns expressed in input from affected interested parties. We would rely on this and other documentation submitted by the state, including under § 447.203(c)(1)(iii), (c)(2)(vi), and (c)(4), to inform our SPA approval decisions. We remind states that they are required to use the applicable public process required under section 1902(a)(13) of the Act, as applicable, and follow the public notice requirement in § 447.205, as well as any other public processes required by state law.

2. Instructions for Completing the Template – Initial Analysis

Consistent with §§ 447.203 and 447.204, the template provides space for a state to demonstrate compliance with FFS access-to-care requirements. As described in § 447.203(c)(1), for any SPA that proposes to reduce provider payment rates or restructure provider payments, the following three criteria must be met:

1. Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each affected benefit category 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.
2. The proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings done throughout the current state fiscal year, would be no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each benefit category affected by the proposed reduction or restructuring within a state fiscal year.
3. Public processes described in § 447.203(c)(4) of this section and § 447.204 yielded no significant access-to-care concerns from beneficiaries, providers, or other interested parties regarding the services for which the payment rate reduction or payment restructuring is proposed, or if such processes do 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).

The state is required to enter data on the three tabs of the template: (1) "I 80% Medicare" (2) "II 4% Aggregate", and (3) "III Public Process Attestation." The state will use the information in these tabs to demonstrate compliance with the three criteria required for any proposed rate reduction or restructuring.

The "I 80% Medicare" tab enables the state to demonstrate compliance with Criterion 1 in § 447.203(c)(1)(i): aggregate Medicaid payment rates are at or above 80 percent of the most recently published Medicare payment rates. The state will populate one row for each benefit category (such as primary care services, obstetrical and gynecological services, behavioral health outpatient services, and home and community-based services) with a proposed rate reduction or restructuring. The state must populate the tab with the requested information, including the name of the SPA, the date the SPA was submitted, the benefit category, Medicaid payment rates in aggregate, and Medicare payment rates. The template will auto-calculate the rate reduction or restructuring percentage.

The "II 4% Aggregate" tab enables the state to demonstrate compliance with Criterion 2 in § 447.203(c)(1)(ii): no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each benefit category. The state must populate the tab with the requested information, which includes the estimated expenditures and prior-year expenditures. The template will auto-calculate the comparison of expenditures.

The "III Public Process Attestation" tab enables the state to demonstrate compliance with Criterion 3 in § 447.203(c)(1)(iii): public processes yield no significant access-to-care concerns from beneficiaries, providers, or other interested parties regarding the services for which the payment rate reduction or payment restructuring is proposed. The state must read and attest to the statement on the tab.

C. Additional State Analysis

1. General Requirements

States are responsible to ensure that their proposed reduction or restructuring SPA submission includes all of the information required under § 447.203(c)(1) prior to submission. If the proposed reduction or restructuring SPA does not meet all of the paragraph (c)(1) requirements, then the state would need to provide the additional analysis required under § 447.203(c)(2).

In § 447.203(c)(2), we require states to document current and recent historical levels of access to care, including a demonstration of counts and trends of actively participating providers, counts and trends of FFS Medicaid beneficiaries who receive the services subject to the proposed payment rate reduction or payment restructuring; and service utilization trends, all for the 3 year period immediately preceding the submission date of the proposed rate reduction or payment restructuring SPA, as a condition for approval. Section 447.203(c)(2) requires that states conduct and provide to us a rigorous analysis of a proposed payment rate reduction's or payment restructuring's potential to affect beneficiary access to care. If we approve the state's proposal, the data provided would serve as a baseline for prospective monitoring of access to care within the state.

Section 447.203(c)(2)(i) requires states to provide 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 FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a state fiscal year. CMS will collect this information for SPAs that require a § 447.203(c)(2) analysis, but for those that meet the criteria under § 447.203(c)(1), we are not requiring 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 beyond that which is already provided as part of a normal state plan submission or as may be requested by CMS through the normal state plan review process.

Section 447.203(c)(2)(ii) requires states to provide 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. States should look to the nature of the service rather than, for example, the enrollment type of the provider, to identify a reasonably similar set of Medicare-covered services for comparison. For services for which a Medicare comparator is not available, the § 447.203(c)(2) analysis is required to be submitted by the state along with the SPA proposing to reduce or restructure provider payment rates as the state is unable to demonstrate compliance with § 447.203(c)(1).

Section 447.203(c)(2)(iii) requires states to provide 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 is required to provide the following data:

- Number of actively participating providers of services in each affected benefit category for each of the 3 years immediately preceding the SPA submission date, by state-specified geographic area (for example, by county or parish), provider type, and site of service.
- Observed trends in the number of actively participating providers in each geographic area over this period.
- 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.

Section 447.203(c)(2)(iv) requires states to provide 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 is required to provide the following data:

- Number of beneficiaries receiving services in each affected benefit category for each of the 3 years immediately preceding the SPA submission date, by state-specified geographic area (for example, by county or parish).
- Observed trends in the number of Medicaid beneficiaries receiving services in each affected benefit category in each geographic area over this period.
- 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.
- 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.

Section 447.203(c)(2)(v) requires 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 is required to provide the following data:

- Number of Medicaid services furnished in each affected benefit category for each of the 3 years immediately preceding the SPA submission date, by state specified geographic area (for example, by county or parish), provider type, and site of service.
- Observed trends in the number of Medicaid services furnished in each affected benefit category in each geographic area over this period.
- 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.

- 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.

Section 447.203(c)(2)(vi) requires 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).

2. Instructions for Completing the Template – Additional Analysis

If a state does not meet the three criteria required for all SPAs proposing rate reductions or restructuring, the state must show that its proposed payment rates and structure would be sufficient for enlisting enough providers to make covered services available to beneficiaries at least to the same extent as to the general population in the geographic area. To demonstrate this, the state must fill out five additional tabs for each benefit category affected by the proposed rate reduction or restructuring.

On the "IV. "Addl—Analysis" tab, the state will summarize its proposed payment change. The summary must include the reason for the proposal, a description of any policy purpose for the proposed change, and the cumulative effect of all reductions or restructuring for each benefit category affected by the proposed reduction or restructurings. The state will also provide more details on the aggregate rate changes in the proposed rate reduction or restructuring. The state must populate the requested information in the tab, which includes the benefit category, Medicaid payment rates in the aggregate (including base and supplemental payments) before rate reduction or restructuring, Medicaid payment rates in the aggregate (including base and supplemental payments) after rate reduction or restructuring, Medicare payment rate, and health care payer rate. The template will auto-calculate the comparison of Medicaid, Medicare, and health care payer rates.

On the "V. Addl—Providers" tab, the state will provide more details on the actively participating providers for each benefit category affected by the proposed reduction or restructuring. For this purpose, an "actively participating provider" is one who is participating in the Medicaid program and is actively seeing and providing services to Medicaid beneficiaries or is accepting Medicaid beneficiaries as new patients. The state must populate the requested information in the tab, which includes the state-specified geographic region, provider type, site of service, and number of actively participating providers for the three years preceding the proposed SPA. The template will auto-calculate any trends. The state must also describe the observed trends for each geographic area over the three-year period and estimate the anticipated effect of the rate reduction or restructuring on the number of actively participating providers.

On the "VI. Addl—Beneficiary" tab, the state will provide qualitative information about the beneficiaries who receive services furnished through an FFS delivery system for each benefit category affected by the proposed rate reduction or restructuring. The requested information includes the demographic characteristics of the beneficiary populations receiving services affected by the rate reduction or restructuring and how the proposed reduction or restructuring might affect access to care and service delivery for these populations. The state will also provide quantitative information on these beneficiary

populations. This information includes the state-specified geographic region, the total number of beneficiaries receiving services, the number of adult beneficiaries receiving services, the number of child beneficiaries receiving services, and the number of beneficiaries with disabilities who are receiving services. Beneficiary data must be provided for the three years preceding the proposed SPA. The template will auto-calculate the proportion of beneficiaries and beneficiary trends. The state must also describe the observed trends for each geographic area over the three-year period and estimate the anticipated effect of the rate reduction or restructuring on beneficiaries.

On the "VII. Addl—Services" tab, the state will provide qualitative information on any services furnished through the FFS delivery system that might be affected by the proposed reduction or restructuring for each benefit category. The requested information includes a description of services affected by the rate reduction or restructuring and how the proposed rate reduction or restructuring could affect access to care and service delivery. The state will also provide quantitative information on affected services furnished through the FFS delivery system for each benefit category. The state must specify the number of claims for the services subject to the proposed rate reduction or restructuring for each affected benefit category. Other required information includes the number of Medicaid services furnished (1) through FFS, (2) to adult beneficiaries, (3) to child beneficiaries, and (4) to beneficiaries with disabilities. Service data must be provided for the three years preceding the proposed SPA. The template will auto-calculate the proportion of services furnished to each population and trends in services over the three-year period. The state must also describe the observed trends for each geographic area over the three-year period and estimate the anticipated effect of the rate reduction or restructuring on the services furnished to each population.

On the "VIII. Addl—Concerns" tab, the state will summarize any access-to-care concerns or complaints received from beneficiaries, providers, and other interested parties regarding the services affected by the proposed payment rate reduction or restructuring, along with responses from the state.

D. Where to Obtain Data

To satisfy the requirements of § 447.203(c)(1) and § 447.203(c)(2), there are a number of data sources that states should consult when developing documentation for the Medicaid payment rate reduction or restructuring analysis. The chart below provides potential data sources for each provision of § 447.203(c), while the sections immediately following the chart provide detailed descriptions of the requirements of each of the provisions in the section.

Regulation	Summary of Requirement	Potential Data Sources
§ 447.203(c)(1)(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.	State Medicaid Fee Schedules State Plan Payment Methodologies Medicare Fee-for-Services Fee Schedules, including any necessary geographic data and adjustments [21] Medicaid Upper Payment Limit (UPL) demonstration, to the extent that the services have an applicable UPL demonstration.
§ 447.203(c)(1)(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 FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a state fiscal year.	Form CMS-64 Expenditure Data Estimated impact of the reduction, similar to the information provided with the form CMS 179 which is submitted with SPAs.
§ 447.203(c)(1)(iii)	Public processes 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.	State records, particularly summaries or copies of the public comments, and summaries or copies of the state's response to those comments.
§ 447.203(c)(2)(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.	Expenditure data from the form CMS-64. CMS-179 to estimate the budget impact of each current and/or prior SPA proposal.
§ 447.203(c)(2)(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.	State Medicaid Fee Schedules State Plan Payment Methodologies Medicare Fee-for-Services Fee Schedules, including any necessary geographic data and adjustments [22] Medicaid Upper Payment Limit (UPL) demonstration, to the extent that the services have an applicable UPL demonstration.

[21] https://www.cms.gov/medicare/payment/fee-for-service-providers.

[22] Ibid.

Regulation	Summary of Requirement	Potential Data Sources
§ 447.203(c)(2)(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.	State MMIS or T-MSIS data, organized by geographic area of the state over a 3-year period. National Plan and Provider Enumeration System (NPPES) and National Provider Identifier (NPI)
§ 447.203(c)(2)(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.	State claims systems, such as MMIS or T-MSIS data, organized by geographic area of the state over a 3-year period.
§ 447.203(c)(2)(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.	State claims systems, such as MMIS or T-MSIS data, organized by geographic area of the state over a 3-year period.
§ 447.203(c)(2)(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).	State records, particularly summaries or copies of the public comments, and summaries or copies of the state's response to those comments.

IV. Additional 2024 Access Final Rule Provisions

The following subsections of this section detail additional provisions of the 2024 Access Final Rule. These provisions did not create new reporting requirements and therefore for the purposes of this guidance document, we are just addressing them briefly.

A. Public Input Process § 447.203(c)(4)

Section 447.203(c)(4) provides beneficiaries with opportunities to raise their concerns through hotlines, surveys, ombudsman, grievance, and appeals processes that the state makes available, or other equivalent mechanisms offered by the state. This section is carried over from prior regulatory language at former § 447.203(b)(7). We note that § 447.203(c)(4)(iii) requires states to maintain a record of data on public input and how the state responded to this input, and the record of input and responses "will be made available to CMS upon request."

States are welcome to develop additional processes to facilitate beneficiary and provider feedback, as well as feedback from other interested parties.

B. Addressing access questions and remediation of inadequate access to care § 447.203(c)(5)

The steps states must take to respond to concerns about access raised through input pursuant to § 447.203(c)(4) are detailed in § 447.203(c)(5), which is a recodification from former § 447.203(b)(8). Section 447.203(c)(5) requires states to develop and submit a corrective action plan to CMS within 90 days of discovery of an access deficiency. The submitted action plan must aim to remediate the access deficiency within 12 months.

These remediation efforts can include but are not limited to: increasing payment rates; improving outreach to providers; reducing barriers to provider enrollment; providing additional transportation to services; or improving care coordination.

Beneficiaries, patient advocacy organizations, and providers raising plausible access concerns to state officials would be considered as identifying an access deficiency when raised to the state through appropriate state channels.

C. Compliance actions for access deficiencies § 447.203(c)(6)

We moved previous § 447.204(d) "To remedy an access deficiency, CMS may take a compliance action using the procedures described at § 430.35 of this chapter" to § 447.203(c)(6). The subject matter, compliance actions for an access deficiency, is better aligned to the changes in § 447.203. We did not finalize any changes to the remedy for the identification of an unresolved access deficiency.

D. Medicaid provider participation and public process to inform access to care § 447.204)

Section 447.204 contains conforming changes to reflect changes in § 447.203. These conforming edits are limited to § 447.204(a)(1) and (b). The remaining paragraphs of § 447.204 are unchanged.

Specifically, we updated the language of § 447.204(a)(1), which previously referenced § 447.203, to reference § 447.203(c). Because we finalized wholesale revisions to § 447.203(b) and the addition of § 447.203(c), the data and analysis referenced in the previous citation to § 447.203 would be located more precisely in § 447.203(c).

Previous § 447.204(b)(1) referred to the state's most recent AMRP performed under previous § 447.203(b)(6) for the services at issue in the state's payment rate reduction or payment restructuring SPA; we removed this requirement to align with the rescission of the AMRP requirements previously in § 447.203(b).

Previous § 447.204(b)(2) and (3) required the state to submit with such a payment SPA an analysis of the effect of the change in the payment rates on access and a specific analysis of the information and concerns expressed in input from affected interested parties; we noted our belief that the previous requirements are addressed in § 447.203(c)(1) and (2), as applicable. The continued inclusion of these § 447.204 (b)(2) and (3) would be unnecessary or redundant in light of § 447.203(c)(1) and (2). The objective processes under § 447.203(c)(1) and (2), which require states to submit quantitative and qualitative information with a proposed payment rate reduction or payment restructuring SPA, are sufficient for us to obtain the information necessary to assess the state's proposal with the same or similar information as previously required under § 447.204(b)(2) and (3).

With the removal of § 447.204(b)(1) through (b)(3), we revised § 447.204(b) to read, "[t]he state must submit to us with any such proposed SPA affecting payment rates documentation of the information and analysis required under § 447.203(c) of this chapter."

Finally, as described in the previous subsection, we removed and relocated former § 447.204(d), as we believed the nature of that provision is better suited to codification in § 447.203(c)(6).

V. Conclusion

This guide addressed the provisions located in the "documentation of access to care and service payment rates," section of the 2024 Access Final Rule.

As a reminder, for questions or comments on this guidance, including what would be helpful to include in any future implementation guidance CMS may produce, please contact MedicaidAccesstoCare@cms.hhs.gov.

States: For questions on the requirements and processes described in this guide and the 2024 Access Final Rule, contact your Medicaid state lead.

This page has been left blank for double-sided copying.

Appendix A.

Code List for State Comparative Rate Analysis, based on January 2023 Physician Fee Schedule[23]

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
59400	Routine obstetric care for vaginal delivery (with or without episiotomy and/or forceps), including antepartum and postpartum care	-	X	-	A (Active)	OBGYN	-	Yes
59409	Obstetrical care	-	X	-	A (Active)	OBGYN	-	Yes
59410	Obstetrical care	-	X	-	A (Active)	OBGYN	-	Yes
59510	Routine obstetric care for cesarean section delivery, including antepartum and postpartum care	-	X	-	A (Active)	OBGYN	-	Yes
59610	Routine obstetric care for vaginal delivery (with or without episiotomy and/or forceps) after cesarean delivery, including antepartum and postpartum care	-	X	-	A (Active)	OBGYN	-	Yes
59618	Routine obstetric care for cesarean delivery following attempted vaginal delivery after previous cesarean delivery, including antepartum and postpartum care	-	X	-	A (Active)	OBGYN	-	Yes

[23] This list uses the January 2024 release of the Physician Fee Schedule.

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
76801	Ob us < 14 wks single fetus	-	X	-	A (Active)	OBGYN	-	Yes
76801	Ob us < 14 wks single fetus	-	X	-	A (Active)	OBGYN	-	Yes
76802	Ob us < 14 wks addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76802	Ob us < 14 wks addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76805	Ob us >= 14 wks sngl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76805	Ob us >= 14 wks sngl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76810	Ob us >= 14 wks addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76810	Ob us >= 14 wks addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76811	Ob us detailed sngl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76811	Ob us detailed sngl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76812	Ob us detailed addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76812	Ob us detailed addl fetus	-	X	-	A (Active)	OBGYN	-	Yes
76813	Ob us nuchal meas 1 gest	-	X	-	A (Active)	OBGYN	-	Yes
76813	Ob us nuchal meas 1 gest	-	X	-	A (Active)	OBGYN	-	Yes
76814	Ob us nuchal meas add-on	-	X	-	A (Active)	OBGYN	-	Yes
76814	Ob us nuchal meas add-on	-	X	-	A (Active)	OBGYN	-	Yes
76815	Ob us limited fetus(s)	-	X	-	A (Active)	OBGYN	-	Yes
76815	Ob us limited fetus(s)	-	X	-	A (Active)	OBGYN	-	Yes
76816	Ob us follow-up per fetus	-	X	-	A (Active)	OBGYN	-	Yes
76816	Ob us follow-up per fetus	-	X	-	A (Active)	OBGYN	-	Yes
76817	Transvaginal us obstetric	-	X	-	A (Active)	OBGYN	-	Yes
76817	Transvaginal us obstetric	-	X	-	A (Active)	OBGYN	-	Yes
90785	Psytx complex interactive	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
90791	Psych diagnostic evaluation	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
90792	Psych diag eval w/med srvcs	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90832	Psytx w pt 30 minutes	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90833	Psytx w pt w e/m 30 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90834	Psytx w pt 45 minutes	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90836	Psytx w pt w e/m 45 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90837	Psytx w pt 60 minutes	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90838	Psytx w pt w e/m 60 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90839	Psytx crisis initial 60 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90840	Psytx crisis ea addl 30 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90845	Psychoanalysis	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
90846	Family psytx w/o pt 50 min	-	-	X	R (Restricted)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90847	Family psytx w/pt 50 min	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90849	Multiple family group psytx	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
90853	Group psychotherapy	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Group	Yes
90865	Narcosynthesis	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
90875	Psychophysiological therapy	-	-	X	N (Non-Covered)	Behavioral Health Services	No RBCS Family	Yes
90880	Hypnotherapy	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
90882	Environmental manipulation	-	-	X	N (Non-Covered)	Behavioral Health Services	No RBCS Family	Yes
90901	Biofeedback train any meth	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
90912	Bfb training 1st 15 min	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
90913	Bfb training ea addl 15 min	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96110	Developmental screen w/score	X	-	X	N (Non-Covered)	Behavioral Health Services	No RBCS Family	Yes
96112	Devel tst phys/qhp 1st hr	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96113	Devel tst phys/qhp ea addl	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96116	Nubhvl xm phys/qhp 1st hr	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96121	Nubhvl xm phy/qhp ea addl hr	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96125	Cognitive test by hc pro	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96127	Brief emotional/behav assmt	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96130	Psycl tst eval phys/qhp 1st	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96131	Psycl tst eval phys/qhp ea	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
96132	Nrpsyc tst eval phys/qhp 1st	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96133	Nrpsyc tst eval phys/qhp ea	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96136	Psycl/nrpsyc tst phy/qhp 1st	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96137	Psycl/nrpsyc tst phy/qhp ea	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96138	Psycl/nrpsyc tech 1st	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96139	Psycl/nrpsyc tst tech ea	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96146	Psycl/nrpsyc tst auto result	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96156	Hlth bhv assmt/reassessment	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96158	Hlth bhv ivntj indiv 1st 30	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Nongroup	Yes
96159	Hlth bhv ivntj indiv ea addl	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96164	Hlth bhv ivntj grp 1st 30	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96165	Hlth bhv ivntj grp ea addl	-	-	X	A (Active)	Behavioral Health Services	Psychotherapy - Group	Yes
96167	Hlth bhv ivntj fam 1st 30	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
96168	Hlth bhv ivntj fam ea addl	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
97129	Ther ivntj 1st 15 min	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
97130	Ther ivntj ea addl 15 min	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99202	Office o/p new sf 15 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - New	Yes
99203	Office o/p new low 30 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - New	Yes
99204	Office o/p new mod 45 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - New	Yes
99205	Office o/p new hi 60 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - New	Yes
99211	Off/op est may x req phy/qhp	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
99212	Office o/p est sf 10 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
99213	Office o/p est low 20 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
99214	Office o/p est mod 30 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
99215	Office o/p est hi 40 min	X	X	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
99381	Init pm e/m new pat infant	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99382	Init pm e/m new pat 1-4 yrs	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99383	Prev visit new age 5-11	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99384	Prev visit new age 12-17	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99385	Prev visit new age 18-39	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
99386	Prev visit new age 40-64	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99387	Init pm e/m new pat 65+ yrs	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99391	Per pm reeval est pat infant	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99392	Prev visit est age 1-4	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99393	Prev visit est age 5-11	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99394	Prev visit est age 12-17	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99395	Prev visit est age 18-39	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99396	Prev visit est age 40-64	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99397	Per pm reeval est pat 65+ yr	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99401	Preventive counseling indiv	X	-	X	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99402	Preventive counseling indiv	X	-	X	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99403	Preventive counseling indiv	X	-	X	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99404	Preventive counseling indiv	X	-	X	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99406	Behav chng smoking 3-10 min	X	-	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99407	Behav chng smoking > 10 min	X	-	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
99408	Audit/dast 15-30 min	X	-	X	N (Non-Covered)	Behavioral Health Services	No RBCS Family	Yes
99409	Audit/dast over 30 min	X	-	X	N (Non-Covered)	Behavioral Health Services	No RBCS Family	Yes
99412	Preventive counseling group	X	-	X	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99415	Prolng clin staff svc 1st hr	X	-	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99416	Prolng clin staff svc ea add	X	-	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99421	Ol dig e/m svc 5-10 min	X	X	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99422	Ol dig e/m svc 11-20 min	X	X	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99423	Ol dig e/m svc 21+ min	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99429	Unlisted preventive service	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99441	Phone e/m phys/qhp 5-10 min	X	X	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99442	Phone e/m phys/qhp 11-20 min	X	X	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99443	Phone e/m phys/qhp 21-30 min	X	X	X	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99446	Ntrprof ph1/ntrnet/ehr 5-10	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99447	Ntrprof ph1/ntrnet/ehr 11-20	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99448	Ntrprof ph1/ntrnet/ehr 21-30	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
99449	Ntrprof ph1/ntrnet/ehr 31/>	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99450	Basic life disability exam	X	-	-	N (Non-Covered)	Office/Outpatient Services	No RBCS Family	Yes
99451	Ntrprof ph1/ntrnet/ehr 5/>	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99452	Ntrprof ph1/ntrnet/ehr rfrl	X	X	X	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99453	Rem mntr physiol param setup	X	X	-	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99454	Rem mntr physiol param dev	X	X	-	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99455	Work related disability exam	X	-	-	R (Restricted)	Office/Outpatient Services	No RBCS Family	No
99456	Disability examination	X	-	-	R (Restricted)	Office/Outpatient Services	No RBCS Family	No
99457	Rem physiol mntr 1st 20 min	X	X	-	A (Active)	E/M - Miscellaneous	No RBCS Family	Yes
99458	Rem physiol mntr ea addl 20	X	X	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99473	Self-meas bp pt educaj/train	X	X	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99474	Self-meas bp 2 readg bid 30d	X	X	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99487	Cplx chrnc care 1st 60 min	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
99489	Cplx chrnc care ea addl 30	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
99490	Chrnc care mgmt staff 1st 20	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
99491	Chrnc care mgmt phys 1st 30	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
99492	1st psyc collab care mgmt	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99493	Sbsq psyc collab care mgmt	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99494	1st/sbsq psyc collab care	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
99495	Transj care mgmt mod f2f 14d	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
99496	Transj care mgmt high f2f 7d	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
99497	Advncd care plan 30 min	-	-	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99498	Advncd care plan addl 30 min	-	-	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
99484	Care mgmt svc bhvl hlth cond	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
D0150	Comprehensve oral evaluation	-	-	-	R (Restricted)	Office/Outpatient Services	No RBCS Family	No
D4355	Full mouth debridement	-	-	-	R (Restricted)	Office/Outpatient Services	No RBCS Family	No

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
G0076	Care manag h vst new pt 20 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0080	Care manag h vst new pt 75 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0081	Care man h v ext pt 20 mi	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0082	Care man h v ext pt 30 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0083	Care man h v ext pt 45 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0084	Care man h v ext pt 60 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0085	Care man h v ext pt 75 m	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G0101	Ca screen; pelvic/breast exam	X	X	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
G0102	Prostate ca screening; dre	X	-	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
G0396	Alcohol/subs interv 15-30mn	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0397	Alcohol/subs interv >30 min	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0402	Initial preventive exam	X	-	-	A (Active)	Office/Outpatient Services	Annual Wellness Visits	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
G0409	Corf related serv 15 mins ea	-	-	X	R (Restricted)	Behavioral Health Services	No RBCS Family	Yes
G0438	Ppps, initial visit	X	-	-	A (Active)	Office/Outpatient Services	Annual Wellness Visits	Yes
G0439	Ppps, subseq visit	X	-	-	A (Active)	Office/Outpatient Services	Annual Wellness Visits	Yes
G0442	Annual alcohol screen 15 min	X	-	-	A (Active)	Office/Outpatient Services	Annual Wellness Visits	Yes
G0443	Brief alcohol misuse counsel	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0444	Depression screen annual	X	-	-	A (Active)	Office/Outpatient Services	Annual Wellness Visits	Yes
G0445	High inten beh couns std 30m	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0446	Intens behave ther cardio dx	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0447	Behavior counsel obesity 15m	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0473	Group behave couns 2-10	-	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G0506	Comp asses care plan ccm svc	X	-	-	A (Active)	Care Management/ Coordination	Chronic and Transitional Care Management	Yes
G2011	Alcohol/sub misuse assess	X	-	X	A (Active)	Behavioral Health Services	No RBCS Family	Yes
G2082	Visit esketamine 56m or less	-	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
G2083	Visit esketamine, > 56m	-	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes

HCPCS_Code	Description	E/M Primary Care	E/M OBGYN	E/M Behavioral Health	Medicare Status	RBCS_Subcat_ Desc	RBCS_Family_ Desc	RVU/ Payment Rate Available
G2086	Off base opioid tx 70min	X	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
G2087	Off base opioid tx, 60 m	X	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
G2088	Off base opioid tx, add30	X	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
Q0091	Obtaining screen pap smear	X	X	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes
G2088	Off base opioid tx, add30	X	-	X	A (Active)	Office/Outpatient Services	Office E/M - Established	Yes
Q0091	Obtaining screen pap smear	X	X	-	A (Active)	Office/Outpatient Services	No RBCS Family	Yes