Analysis: Ensuring Access to Medicaid Services Final Rule

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) has issued the final rule, *Ensuring Access to Medicaid Services* (Access Rule), which seeks to improve access to care and better address health equity issues in the Medicaid program. The date of publication is May 10, 2024.

Notably, CMS did not apply the proposed HCBS Payment Adequacy provision to habilitation services in the final rule.[1] Although there were modifications from the proposed rule, CMS did apply the 80% threshold to homemaker, home health aide, and personal care services with an effective date of 6 years from publication. Additionally, it expanded reporting requirements to these services *and habilitation services* which require states to begin reporting the percentage spent on direct care worker compensation within 4 years of publication.

CMS also finalized several provisions of the final rule which include promising opportunities to improve quality, transparency and consistency. Among others, these include provisions that require states to: publish fee-for-service payment rates, report when payment rates were last updated, report on key metrics related to waiting lists for home- and community-based services, adopt the HCBS Quality Measure Set in 1915(c) programs, and establish a critical incident tracking and reporting system.

Final Rulemaking

In late April, CMS released the text of the final Access Rule. The final rule includes performance standards and reporting requirements with different effective dates across services offered through 1915(c), (j), (k), and (i) waivers and managed care systems overseeing HCBS services. When access deficiencies are identified pursuant to the final rule, the state must, within 90 days after discovery, submit a corrective action plan with steps and timelines to address those issues with examples including increasing rates, improving outreach to providers, reducing barriers to enrollment, providing for telemedicine delivery and telehealth, or improving care coordination.

Modifications to HCBS Payment Adequacy in the Final Rule

The final rule requires that states meet the following minimum performance level, calculated as the percentage of total payment, not including excluded costs, to a provider for furnishing homemaker,

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[1] In the proposed rule, CMS requested comment on whether the 80% threshold should also be applied to residential habilitation services, day habilitation services, and home-based habilitation services for people with intellectual and developmental disabilities. Habilitation services are services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. In the final rule, CMS acknowledged habilitation services have direct and indirect costs which it lacked adequate data to assess and did not apply the 80% threshold.

home health aide, or personal care services as set forth at 42 C.F.R. § 440.180(b)(2) through (4), represented by the provider's total compensation to direct care workers.

- The State must ensure that each individual provider spends 80 percent of total payments the provider receives for services it furnishes on homemaker, home health aide, or personal care services on total compensation for direct care workers who furnish those services.

Direct care worker definition. In the final rule, direct care worker means any of the following individuals who may be employed or contracted by a provider, state agency, or third party, or delivering services under a self-directed services delivery model:

- A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid beneficiaries receiving home and community-based services pursuant to the rule;
- A licensed or certified 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, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid beneficiaries receiving home and community-based services pursuant to the rule, including nurses and other staff providing clinical supervision.

Compensation definition. In the final rule, compensation means:

- Salary, wages, and other renumeration as defined by the Fair Labor Standards Act and implementing regulations;
- Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and
- The employer share of payroll taxes for direct care workers delivering services authorized under 1915(c) of the Act.

Excluded costs. CMS has allowed the below costs in the final rule to be excluded from the Medicaid payment before the 80% threshold is applied for direct care compensation:

- Costs of required trainings for direct care workers (such as costs for qualified trainers and training materials);
- Travel costs for direct care workers (such as mileage reimbursement or public transportation subsidies); and
- Cost of personal protective equipment for direct care workers.

Exceptions and exemptions. In the final rule, CMS also introduces exceptions and exemptions in which providers delivering homemaker, home health aide, and personal care services may be excluded from the 80% threshold, including:

- Indian Health Service and Tribal health programs; and
- Self-directed service delivery models in which the beneficiary directing the services sets the direct care worker's payment rate.

CMS additionally offers states the option to develop a different payment adequacy percentage threshold for small providers:

- The state may develop reasonable, objective criteria through a transparent process to identify small providers to meet a separate percentage set by the state.
- States that establish a small provider minimum performance level must annually report to CMS its small provider criteria, the percentage of providers that qualify for the small provider level, and a plan, subject to CMS review and approval, for small providers to meet the 80% threshold within a reasonable period of time.

Lastly, CMS offers states the option to develop a limited hardship exemption:

- The state may develop reasonable, objective criteria through a transparent process to exempt a reasonable number of providers determined by the state to be facing extraordinary circumstances that prevent their compliance with the payment adequacy requirement.
- States that establish a hardship exemption must annually report to CMS its hardship exemption criteria, the percentage of providers that qualify for a hardship exemption, and a plan, subject to CMS review and approval, for reducing the number of providers that qualify for a hardship exemption within a reasonable period of time.

HCBS Payment Adequacy Reporting

Although CMS only applied the 80% threshold to homemaker, home health aide, and personal care services, it included habilitation services as part of required direct care compensation reporting.

- The state must report to CMS annually on the percentage of total payments (not including excluded costs) for furnishing homemaker services, home health aide services, personal care, and habilitation services that is spent on compensation for direct care workers.
- The state must report separately for each service and, within each service, must separately report services that are self-directed and services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.
- Reporting requirements begin 4 years from publication. One year prior, the state must report on its readiness to comply with these reporting requirements.

CMS also established access reporting for homemaker, home health aide, personal care, and habilitation services in which the state must report the average amount of time from when services are initially approved to when services began for individuals newly receiving services in the last 12 months and the percent of authorized hours for services provided within the past 12 months. This reporting requirement begins 3 years from publication.

Subregulatory Guidance and Technical Assistance

In its introduction to the final rule, CMS acknowledges the many questions associated with implementation of the HCBS Payment Adequacy provision and moreover declined to codify further definitions of homemaker, home health aide, and personal care services. Instead, CMS states it will "provide additional subregulatory guidance and technical assistance to aide in implementation of the HCBS payment adequacy requirements and may consider addressing in future rulemaking."

ANCOR will continue to work with CMS to ensure subregulatory guidance is responsive and informed by challenges identified by community providers.

Increasing Transparency & Consistency

The final rule also requires states to report to CMS on key metrics to ensure transparency and consistency in service utilization, authorization, and delivery.

Payment Rates

The final rule would require states to publish their fee-for-service Medicaid payment rates in a clearly accessible, public location on states' websites and must include the date the payment rates were last updated.

- Rates must be organized by category of service, disclosed as an average hourly payment, identify the number of Medicaid-paid claims, and enrolled beneficiaries who received the service within a calendar year alongside a comparative payment rate analysis with the equivalent Medicare service.
- Reporting begins July 1, 2026 and must be updated within 30 days of any payment rate changes.

The final rule would also require that for any state plan amendment that reduces or restructures provider payment rates, states must demonstrate that:

- Aggregate payment rates for each category would be at or above 80% of the Medicare equivalent;
- The proposed reduction or restructuring would likely result in no more than a four-percent reduction in expenditures for each benefit category; and
- A mandatory public comment period yielded no significant access concerns from beneficiaries, providers, or other interested parties.

The final rule would separately require states to establish Interested Parties Advisory Groups (IPAGs) to advise and consult on provider rates where payments are made to direct care workers for homemaker, home health aide, personal care, and habilitation services.

- The IPAG must be include, at minimum, direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties.
- The IPAG must be established in 2 years from publication and meet at least every 2 years to make recommendations on the sufficiency of State plan, 1915(c) waiver, and demonstration direct care worker payment rates.

Waiting Lists

The final rule would require states to report annually to CMS on metrics regarding the state's waiting list, including how the state maintains its list of individuals who are waiting to enroll in a section 1915(c) waiver program, the number of people on the waiting list, and the average amount of time that individuals newly enrolled in the waiver program were on the waiting list. This requirement begins in 3 years from publication.

HCBS Quality Measure Set

The final rule establishes standards for the Home and Community Based Services Quality Measure Set in 1915(c) waiver programs.

- Beginning December 31, 2026 and updated no more frequently every other year, CMS must identify the quality measures to be included in the HCBS Quality Measure Set.
- State reporting requirements on the HCBS Quality Measure Set begin in 4 years, although CMS may provide that mandatory reporting for certain measures and populations be phased in over a specified period of time.
- Providers are included as identified interested parties that CMS must consult with to identify priorities, measures to be added and removed, and ensure the measures are evidence-based, meaningful for states, and feasible.

Critical Incident Systems

The final rule standardizes a definition for critical incidents and requires states to operate and maintain an electronic incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

- Critical incidents at minimum include verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.
- The final rule requires states to report every 24 months on the result of critical incident management system assessments with 90% performance benchmarks for initiating investigations, completing an investigation, and ensuring corrective action.

Although critical incident reporting requirements begin 3 years from publication, states have five years to create the electronic incident management system.

MAC and BAC

The final rule establishes a Medicaid Advisory Committee (MAC), with 25% of membership dedicated to the Beneficiary Advisory Council (BAC), to advise the state on matters of concern related to Medicaid including:

- Additions and changes to services;
- Coordination of care;
- Quality of services;
- Eligibility, enrollment, and renewal processes;
- Beneficiary and provider communications by State Medicaid agency and Medicaid MCOs, PIHPs, PAHPs, PCCM entities or PCCMs;
- Cultural competency, language access, health equity, and disparities and biases in the Medicaid program;
- Access to services; and
- Other issues that impact the provision or outcomes of health and medical care services in the Medicaid program as determined by the MAC, BAC, or State.

The MAC must be formed by July 9, 2025 and, with support from the State, must submit an annual report describing its activities, topics discussed, and recommendations within 2 years of publication.

Additional Protections for Beneficiaries

Person-centered planning. The final rule sets minimum standards for person-centered plans to be reviewed and updated with a reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the beneficiary. States are also required to report on the percentage of beneficiaries, receiving HCBS for 365 days or longer, who had a plan updated within the past 12 months. There is a performance benchmark of 90%. This requirement begins 3 years after publication.

Grievances. The final rule requires states to establish grievance procedures under which a beneficiary may file a grievance expressing dissatisfaction or complaint related to the state's or a provider's performance in person-centered planning and HCBS settings compliance. The rule sets minimum standards and timeframes in which the state must resolve each grievance not to exceed 90 calendar days. This requirement begins 2 years after publication.

Ongoing beneficiary and provider input. The rule requires states to have mechanisms for beneficiary and provider input on access to care and provides examples of hotlines, surveys, ombudsman, review of grievance and appeals data, or other equivalent mechanisms.

Contact

Have questions? Want to share your perspective on the final rule? Email Lydia Dawson, Vice President of Government Relations, at ldawson@ancor.org.