Yesterday, the Centers for Medicare and Medicaid Services (CMS) released a pair of proposed regulations that will significantly impact the Medicaid program if finalized. The two notices of proposed rulemaking (NPRMs) jointly address a wide range of issues regarding access to and payment for Medicaid services. While there are positive components to the regulations, there are also several areas of concern for providers.

**The following analysis focuses on the Medicaid Access rule**, as it is the most impactful to the Medicaid Home and Community-Based Services (HCBS) program. **A subsequent NAHC Report will include a detailed analysis of the Managed Care Rule**, which was released in tandem with the Access rule.

Although this rule is described as “Access to Medicaid Services,” it also includes a wide range of other policies, such as:

* New HCBS Quality reporting requirements;
* Clarifications regarding HCBS assessments, reassessments, and plan of care updates; and
* A new mandate to establish an electronic incident reporting system.

Positive aspects of the rule include CMS addressing issues related to waiting lists for home and community-based services and delays in access to care; increasing transparency around provider payment rates; and requiring states to provide additional justification regarding their payment rate reductions. Unfortunately, the rule does not establish any minimum standards or requirements for Medicaid reimbursements. Instead, it establishes a threshold whereby states receive less scrutiny for proposed rate reductions. Exacerbating these concerns is a new proposal that would require no less than 80% of Medicaid payments be spent on compensation to direct care workers in three home-based care areas. Establishing this requirement without corresponding payment adequacy requirements is likely untenable for providers in many parts of the country.

Below, we provide more detailed information regarding key provisions in the rule. Additional information, analysis, and commentary will be disseminated as we continue to review the rule and discuss with our federal partners.

**Key Provisions in The Access Rule**

***HCBS Payment Adequacy***

This is the most impactful part of the rule for NAHC members and is also the most troubling part of the proposed regulation. In the NPRM, CMS proposes to require that no less than 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers for the following services: homemaker services, home health aide services, and personal care services. This requirement would apply to services delivered under sections 1915(c), (i), (j), (k), and 1115 of the *Social Security Act* as well as those delivered through managed care contracts. Notably, it would not apply to 1905(a) State plan personal care and home health services. The requirement would be effective 4 years after the effective date of the Final Rule, or the first managed care plan contracting period that begins on or after 4 years following the effective date of the Final Rule.

The rule would define “compensation” as:

* Salary;
* Wages;
* Other remuneration as defined by the *Fair Labor Standards Act*;
* Benefits (such as health and dental benefits, sick leave, and tuition reimbursement); and
* The employer share of payroll taxes for direct care workers.

Importantly, the definition does not include training and other related costs for workers and explicitly excludes nurses in supervisory or administrative roles who are not directly providing HCBS. These definitions and exclusions are likely to cause significant disparities in the applicability of the 80 percent threshold from state to state due to the wide variation in training requirements, as well as differences in provider oversight and quality management protocols, across the states.

***Payment Rate Transparency***

CMS proposes several requirements intended to increase transparency around each State’s Medicaid reimbursements. First, every state must maintain a website that is easily accessible to the general public which contains current fee-for-service fee schedule amounts for Medicaid services. The website must indicate whether there are variations in payment based on population or geographic differences and must clearly delineate each distinct payment amount in such instances.

States must also clearly delineate the different components of a bundled rate and the amount of payment attributable to those components. In the example CMS provides, a state that provides a bundled daily rate for day treatment would need to identify each separate service provided as part of day treatment and the portion of the daily rate that is allocated to that service.

***Payment Rate Disclosure***

The rule includes new requirements regarding comparative rate analyses that provide public information about the Medicaid payment rates beyond the fee schedule. For primary care, obstetrical and gynecological services, and outpatient behavioral health services, states must include a comparison between the most recently published Medicaid and Medicare fee-for-service rates.

For personal care, home health aide, and homemaker services, the state must clearly identify the average hourly payment rates by applicable category of service, including, if the rates vary, separate identification of the average hourly payment rates and any differences for:

* Individual providers and providers employed by an agency;
* Variations between pediatric and adult;
* Different provider types;
* Geographical locations.

The state must also identify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services.

Importantly, this rule does not require states to report on variations in populations served. There are instances where states vary rates for the same service based upon the targeted populations for the waiver(s) that services provided under. Such an analysis would identify potential access issues that arise when a state creates a disparity in payment rates for the same services but different recipient groups.

***Justification Required for Certain Rate Restructures***

CMS proposes to create a two-tiered process for the level of information and data required to accompany a proposal to reduce or restructure payment rates. The first instance applies if the following three criteria are met:

* After the reduction/restructure, aggregate payment rates for the impacted services would be at or above 80% of the comparable Medicare rate;
* Aggregate payment reduction for the impacted benefit category would be less than or equal to 4%; and
* Public input processes resulted in no concerns or concerns that the state can reasonably mitigate.

In this case, the state must provide documentation that it meets these criteria and must also demonstrate that it will monitor access and continue to meet the three criteria on an ongoing basis.

In instances where those three criteria are not met, CMS requires substantial documentation to accompany the request for the payment restructure/reduction. States would be required to submit:

* A summary of the proposed payment change, including:
  1. The State’s reason for the proposal and a description of any policy purpose for the proposed change,
  2. 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;
* Information about Medicaid payment rates in the aggregate (including base and supplemental payments) before and after the proposed reduction or restructuring for each benefit category affected, including:
  1. A comparison of aggregate Medicaid payment before and after the payment change to the most recently published Medicare payment rates for the same or comparable services
  2. A comparison 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.
* The number of actively participating providers of services in each affected category for each of the prior 3 years;
* The number of Medicaid beneficiaries receiving services through the FFS delivery system in each affected category;
* The number of Medicaid services furnished through the FFS delivery system for each of the prior 3 years as well as estimates of the anticipated effect on the number of Medicaid services in each affected category.
* 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 impacted service(s).

The regulation includes an additional provision stating that failure to provide required information and/or unresolved access to care concerns would be grounds for disapproving the rate reduction/restructure.

***Requirement to Create an Interested Party Advisory Council***

Under the rule, States would be required to create an interested parties’ advisory group to advise and consult on fee-for-service rates specifically targeted to HCBS. The advisory group would focus on rates paid to direct care workers providing self-directed and agency HCBS, at a minimum for personal care, home health aide, and homemaker services. Unlike other portions of this rule that exclude 1905(a), this council would consult on rates paid for all homemaker, home health aide, and personal care services that are delivered in sections 1905(a), 1915(c), (i), (k), (k) and 1115 of the Social Security Act.

The advisory group would meet at least every 2 years to evaluate and comment on current and suggested payment rates and the sufficiency of these rates to ensure access to HCBS. The Medicaid agency would be required to publish the recommendations of the interested parties’ advisory group and should consider, but not be required to adopt, those recommendations. Similarly, the state is not required to consult with the group prior to implementing any rate modifications.

Although the group is advisory in nature, CMS notes that its input and recommendations would be considered in instances where additional justification is needed for a state to receive approval of changes to its reimbursements, as discussed in the previous section.

***Waiver Waiting List Reporting***

The regulation would require, for the first time, that states report on the waiting lists for the HCBS waiver. States would be required to report information including:

* Whether the state screens individuals for eligibility prior to placing them on the waiting list and, if applicable, whether and how often the individuals are re-screened;
* The number of people on the waiting list;
* The average amount of time that individuals wait prior to enrollment.

This represents a significant change from prior practice and further transparency regarding waiting list practices and timelines could, potentially, lead to additional Olmstead lawsuits on the basis of delaying community-based care.

***Reporting on Delays or Gaps in Accessing HCBS***

In the proposed rules, CMS also establishes a new requirement that would mandate states report on the average amount of time that lapses between when certain HCBS are authorized and when services begin. This specifically applies to homemaker, home health aide, and personal care services that are delivered in sections 1915(c), (i), (k), (k) and 1115 of the Social Security Act, as well as under managed care delivery models. States would also be required to report on the percentage of authorized hours that are actually delivered for those same three service categories. For both reporting requirements, states would be allowed to use a statistically significant sample size of individuals to evaluate the delays or gaps in care.

***HCBS Quality Reporting***

Graphical user interface

Description automatically generatedThe proposed rules would revamp the existing HCBS Quality reporting system for all HCBS provided under sections 1915(c), (i), (k), (k) and 1115 of the Social Security Act, as well as under managed care delivery models, which would align the oversight and reporting requirements for comprehensive HCBS programs regardless of the authority under which it is provided. Notably, CMS did NOT apply the requirements to State plan homecare services authorized under 1905(a), including personal care, home health, and case management services, but requests comments on whether they should consider including them in the final rule.

The new quality reporting system would shift focus to the following five priority areas:

* Person-centered planning;
* Participant health and welfare;
* Access;
* Beneficiary protections; and
* Quality improvement.

As part of the new Quality requirements, states would have to report every alternating year on the HCBS Quality Measure Set that was first established in a July 2022 [State Medicaid Director Letter.](https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf) States would be required to establish performance targets for a portion of the Measure Set. The rule establishes a process for regular updates to the measure set, as well as for identification of areas that require stratification or other deeper levels of analysis.

***Reassessment of Need and Person-Centered Plan Updates***

The rule would also contain a new requirement for States to demonstrate that a reassessment of functional need was conducted, and that person centered service plans were reviewed and revised (as appropriate) based on the results of the reassessment at least once every 12 months for at least 90 percent of individuals continuously enrolled in the waiver for at least 365 days. The regulations would not provide any “good cause exceptions” to this requirement, as CMS views the 90% threshold as a way to provide states with latitude for when good causes result in a delay to reassessment.

Importantly, the regulation clarifies that the HCBS regulations apply to services authorized under section 1115 demonstration waivers.

***HCBS Grievance System***

States must establish a new system to collect and track “grievances” related to a participant’s issues with certain components within the HCBS system. In the regulation, CMS defines a grievance as, “an expression of dissatisfaction or complaint” and ensures that this new system is distinct from the existing appeals processes within Medicaid. CMS only requires that states establish this new grievance system for issues related to the State’s or a provider’s compliance with person-centered planning and service plan requirements the HCBS “settings” requirements that establish criteria for where HCBS may be provided. States must allow participants to file grievances, and must collect and track information, regardless of whether the beneficiary requests any remedial action. This grievance system would apply to the same HCBS authorities as the Quality reporting requirements.

***HCBS Incident Management System***

Although CMS expects that states implement an effective incident management system, prior investigations, audits, and reports have demonstrated flaws and gaps in the oversight of these systems. In response, CMS is proposing to create a new regulatory requirement that specifically requires States to operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. The incident management system must be electronic and CMS encourages, but does not require, the system to meet interoperability standards in order to facilitate the effective exchange of information.

The requirement would also create, for the first time, a standardized federal minimum definition of critical incidents. Critical incidents would include standard definition of a critical incident to include, at a minimum:

* 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.

CMS proposes to require that HCBS providers report any critical incidents that occur during the delivery of HCBS specified in a participant’s person-centered service plan, or any critical incidents that are a result of the failure to deliver authorized services. States would also be required to use claims data, Medicaid Fraud Control Unit data, and data from other State agencies such as Adult Protective Services or Child Protective Services (to the extent permissible under applicable State law) to identify unreported critical incidents.

***Medicaid Advisory Committee and Beneficiary Advisory Group***

The rule proposes to revamp the existing Medical Care Advisory Committee requirements and rename it the Medicaid Advisory Committee. The rules would require that states establish a new Beneficiary Advisory Group, which would provide feedback and advice to the Medicaid Advisory Committee. This new Beneficiary Advisory Group would be comprised of individuals who either are currently or have been enrolled in Medicaid and individuals with direct experience supporting Medicaid beneficiaries (i.e. family members or caregivers).

The new Medicaid Advisory Committee would have more requirements regarding structure and membership than the prior rules. At least 25% of the committee must be comprised of members from the Beneficiary Advisory Group (ie: current or former Medicaid participants, their families, and/or their caregivers). There would be no percentage breakout requirements for the remainder of the Committee, but members must include representatives from at least the following categories:

* Consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries;
* Clinical providers or administrators familiar with the health and social needs of Medicaid beneficiaries;
* Representatives from participating Medicaid managed care plans or the State health plan association representing such plans (if applicable); and
* Representatives from other State agencies serving Medicaid beneficiaries, as ex-officio members.

The regulation includes suggestions, but not requirements, regarding the different types of providers and community-based organizations that would participate on the panel. The proposal also would require an annual report, with recommendations, that the state Medicaid agency must respond to and publish publicly.

***Repeal of Access Monitoring Plans***

The rule replaces the previous approach of requiring States to publish access monitoring review plans with the provisions discussed above. The regulatory requirements for these monitoring plans are repealed.