Policy Update

CMS Releases Proposed Rule: Medicaid Program; Ensuring Access to Medicaid Services

Summary

On May 3, 2023 the Centers for Medicare & Medicaid Services (CMS) published the proposed rule Medicaid Program; Ensuring Access to Medicaid Services. The proposed rule seeks to increase transparency in payment rates, standardize data and monitoring, and create new opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care. The rule also has a particular focus on home and community based services (HCBS), including direct care worker compensation requirements, grievance process development, critical incident reporting definitions and HCBS quality reporting.

This proposed rule follows a request for information (RFI) that CMS released in 2022. That RFI examined challenges related to eligibility and enrollment; data availability to measure, monitor and support improvement efforts related to access to services; strategies for equitable and timely access to providers and services; and opportunities to use existing and new access standards to help ensure that Medicaid and Children's Health Insurance Program payments are sufficient to enlist enough providers.

The notice of proposed rulemaking has a 60-day comment period. Comments must be submitted to the *Federal Register* no later than July 3, 2023.

This rule was released in coordination with the proposed rule Medicaid Program; Managed Care Access, Finance, and Quality, which also has a 60-day comment period and addresses requirements related to Medicaid payment rate disclosures. Click here to read our analysis of that proposed rule.

Key Takeaways

The Medicaid; Ensuring Access to Medicaid Services proposed rule includes the following key proposals:

- Rescinding access monitoring review process (AMRP) requirements and instead requiring states to make all fee-for-service (FFS) Medicaid payment rates public and accessible on a state website
- Requiring states to conduct a comparative payment rate analysis between the state's Medicaid payment rates and Medicare rates for certain services
- Strengthening states use Medical Care Advisory Committees and creating a new Beneficiary Advisory Group
- Requiring that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead or profit)
- Requiring reporting on waiting lists in section 1915(c) waiver programs and service delivery timeliness for personal care, homemaker and home health aide services
- Enhancing HCBS quality reporting and timeliness.

Payment Rate Transparency

Key Takeaway: CMS would remove the AMRP requirements and instead require states to make all FFS Medicaid payment rates public and accessible on a state website. It would also require states to conduct a comparative payment rate analysis between their Medicaid payment rates and Medicare rates.

State Medicaid programs are required to ensure that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to beneficiaries at least to the extent as to the general population in the same geographic area. However, there are currently no specific requirements for how much a state Medicaid program is required to pay a provider. Moreover, in *Armstrong v. Exceptional Child Center*, the Supreme Court of the United States ruled that Medicaid providers and beneficiaries do not have a private right of action to challenge Medicaid payment rates in federal courts. As a result, there is significant variation across states in payment rates for services rendered. Medicaid payment rates are historically lower than Medicare payment rates across provider types.

Currently, there are no requirements for states to publicly post payment rate information, and if information is made available, it often is not easily accessible or understandable. States are required to conduct AMRPs to analyze data and supporting information to reach conclusions on sufficient access for covered services provided under fee-for-service. When states submit a state plan amendment to reduce or restructure provider payment rates, they must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid FFS payment rates on beneficiary access to care.

This proposed rule would rescind the AMRP requirements and instead require states to publish all Medicaid FFS payment rates in a clearly accessible location on a public website. The proposed rule would require Medicaid payment rates to be organized such that a member of the public could readily determine the amount that Medicaid would pay for a service and, in the case of a bundled or similar payment methodology, 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. If the rates vary, the state would be required to separately identify the Medicaid FFS payment rates by population (pediatric and adult), provider type (***e.g.***, physician, advanced practice nurse, physician assistant) and geographical location, as applicable. States also would have to date when the payment rates were last updated on the state Medicaid agency's website. States would be required to publish payment rates no later than January 1, 2026, including approved Medicaid FFS payment rates in effect as of January 1, 2026. (Of note, the Medicaid managed care rule that was released in coordination with this proposed rule includes requirements for publishing Medicaid managed care payment rates.)

States would be required to conduct a comparative payment rate analysis between their Medicaid payment rates and Medicare rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health services. This analysis would occur every other year. States would be required to analyze whether (and if so, how) their payments are consistent with "efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." CMS outlined methodology for conducting this analysis in the proposed rule.

For HCBS, states would be required to include personal care, home health aide and homemaker services provided by individual providers and providers employed by an agency in the payment rate disclosures. CMS would require states to publish every other year the average hourly rate paid to direct care workers delivering these services. This information would separately compare rates for individual direct care providers and direct care providers employed by an agency. The proposed rule also would require the establishment of an

interested parties' advisory group to advise and consult with the state on payment rates for direct care workers. This group would include, at a minimum, direct care workers, beneficiaries and their authorized representatives, and other interested parties.

Finally, states would be required to conduct an "excess access review" if payment reduction or restructuring results in any of the following scenarios:

- Aggregate Medicaid payment rates are lower than 80% of the most recently published Medicare payment rates.
- Changes to Medicaid payment rates are more than a 4% reduction in aggregate FFS Medicaid expenditures for each affected benefit category during the state fiscal year.
- The public processes raise significant access-to-care concerns from beneficiaries, providers or other interested parties.

Medical Care Advisory Committees

Key Takeaway: The proposed rule would create new requirements for state Medical Care Advisory Committees and would create a separate Beneficiary Advisory Group (BAG).

Currently, states are required to have a Medical Care Advisory Committee (MCAC) in place to advise the state Medicaid agency about health and medical care services. However, current laws include very little specificity regarding how states should use MCACs to ensure the proper and efficient administration of the Medicaid program and promote beneficiary perspectives. As a result, MCAC membership, transparency, meeting frequency, and meeting structure varies significantly across states. The proposed rule seeks to increase transparency and uniformity while also improving committee effectiveness.

If finalized, the proposed rule would rename the MCAC to the Medicaid Advisory Committee (MAC) and create a separate Beneficiary Advisory Group (BAG). The MAC and BAG would serve as vehicles for bi-directional feedback between interested parties and the state on matters related to the effective administration of the Medicaid program. Federal matching funds for Medicaid administrative activities would remain available to states in the same manner as the former MCAC.

The goal is that the MAC and its corresponding BAG would advise the state on issues related to health and medical services, matters related to policy development, and the effective administration of the Medicaid program, consistent with the requirement that a state plan must meaningfully engage Medicaid beneficiaries and other low-income people in the administration of the plan.

Every state would vary in the size and make-up of its committees and the topics that would benefit from interested parties' feedback. Members of the MAC and BAG would be appointed by the state Medicaid director or higher state authority on a rotating, continuous basis. Under the proposed rule, MAC and BAG members would serve a specific amount of time, the length of which would be determined by each state and noted in its bylaws. After a member term was completed, the state would appoint a new member, thus ensuring that MAC and BAG memberships rotate continuously.

The rule proposes that the MAC and BAG must each meet at least once per quarter and hold off-cycle meetings as needed. CMS proposes that at least two MAC meetings per year must be opened to the public. CMS also proposes an administrative framework for the MAC and BAG to ensure transparency and a meaningful feedback loop with the public and among MAC and BAG members.

CMS also proposes that at least 25% of MAC members must be individuals from the BAG with lived Medicaid beneficiary experience (*e.g.*, they are currently or have been a Medicaid beneficiary or the family member/care giver of a Medicaid beneficiary). Thus, 25% of the MAC members would be members of the BAG. The rest of the MAC membership would be required to include representation from each of the following categories:

- Members of state or local consumer advocacy groups or other community-based organizations that

represent the interests of, or provide direct service, to Medicaid beneficiaries
- Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care
- Representatives from participating Medicaid managed care plans or the state health plan association representing such plans, as applicable
- Representatives from other state agencies serving Medicaid beneficiaries as *ex officio* members.

States would have one year to complete these requirements if this rule is finalized.

CMS specifically seeks comment on whether the requirement that 25% of the MAC membership be BAG members with lived Medicaid beneficiary experience should be a different percentage threshold, as well as the timeframe necessary to implement the changes. CMS also seeks comments whether one year is an appropriate length of time to implement these changes.

Home and Community Based Services

Compensation to HCBS Direct Care Workers

Key Takeaway: CMS would require that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead or profit).

CMS proposes to require that at least 80% of Medicaid payments for homemaker, home health aide and personal care services be spent on compensation for direct care workers provided through section 1915(c), (j), (k) and (i) authorities. This 80% includes but is not limited to base payments and supplemental payments. This proposal would apply to both Medicaid FFS and managed care delivery systems. Key areas in which CMS requests comments include the following topics:

- Whether the proposed percentage should be higher or lower
- Whether this requirement should also apply to other services (such as adult day health, habilitation, day treatment or other partial hospitalization services; psychosocial rehabilitation services; and clinic services for individuals with chronic mental illness)
- Whether this requirement should apply to section 1905(a) state plan personal care and home health services.

In the proposed rule, CMS defines compensation for direct care workers as salary, wages and benefits (health insurance, tuition assistance, *etc.*) Compensation would not include training for these workers. CMS requests comments on this proposed definition of compensation.

CMS proposes to define direct care workers to "include workers who provide nursing services, assist with activities of daily living (such as mobility, personal hygiene, eating) or instrumental activities of daily living (such as cooking, grocery shopping, managing finances), and provide behavioral supports, employment supports, or other services to promote community integration." This includes nurses, licensed or certified nursing assistants, direct support professionals, personal care attendants, home health aides and other workers serving individuals receiving HCBS. It also includes those providing self-directed care services. However, it does not include workers in supervisory roles or administrative roles.

States would be required to report annually, in the aggregate for each service, the percentage of payments for homemaker, home health aide and personal care services that are spent on compensation for direct care workers, and to separately report on payments for such services when they are self-directed. CMS proposes that these payment and transparency requirements would be effective four years after the effective date of the final rule for FFS, and would apply to the first managed care plan contract rating period that begins on or after the date four years following the final rule's effective date of the final rule.

HCBS Grievance Procedures

Key Takeaway: States would be required to establish a grievance process for HCBS beneficiaries to submit complaints.

This rule would require states to establish grievance procedures for Medicaid beneficiaries who receive section 1915(c) HCBS through an FFS delivery system. This requirement would not apply to Medicaid managed care delivery systems. The grievance process would give beneficiaries (or an authorized representative) an opportunity to file an "expression of dissatisfaction," or complaint, related to the state's or a provider's compliance with person-centered planning and service plan requirements and the HCBS settings requirements. The rule outlines requirements for the grievance procedures, including recordkeeping, timelines for acknowledgments and procedures, notices to beneficiaries and protocols for handling grievance submissions. CMS proposes to require that states comply with this requirement within two years after finalization of the regulation. However, CMS seeks comments on whether states would need more or less time to complete this requirement. CMS also requests comments on whether this grievance process should also apply to section 1915(i), (j) and (k) authorities, and section 1905(a) state plan personal care, home health and case management services.

Definition of Critical Incident

Key Takeaway: CMS proposes to establish a minimum definition of "critical incident" and minimum state performance and reporting requirements for investigation and action related to critical incidents.

CMS would establish a new 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." No such standardized federal definition currently exists.

CMS would require that states operate and maintain an electronic incident management system that identifies, reports, triages, investigates, resolves, tracks and trends critical incidents. CMS proposes to require that states report to agency every 24 months on the results of an incident management system assessment to demonstrate that they meet the new proposed incident management system requirements. States would also be required to have 1915(c) waiver providers report critical incidents.

States would need to identify critical incidents through required provider reporting and other data sources (*e.g.*, claims, Medicaid Fraud Control Units, Adult Protective Services, Child Protective Services, law enforcement) and have information sharing agreements with those entities for investigations.

CMS proposes that these requirements would be effective three years after the effective date of the final rule for FFS. For Medicaid managed care, the requirements would be effective for the first managed care plan contract rating period that begins three years after the effective date of the final rule.

HCBS Person-Centered Planning

Key Takeaway: The proposed rule includes new requirements to strengthen person-centered service planning for HCBS.

Currently, states must have a person-centered plan for services provided through section 1915(c) waiver programs. A person-centered plan includes six elements: level of care, service plan, qualified providers, health and welfare, financial accountability and administrative authority. States are required to conduct systemic remediation and implement a quality improvement project when they score below 86% on any of these performance measures. This rule proposes to increase the 86% minimum performance level to 90%.

Under the proposed rule, states would be required to demonstrate that an assessment of functional need is

conducted annually for at least 90% of individuals continuously enrolled in a state's HCBS programs. States would be required to demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of this required reassessment of functional need every 12 months, for at least 90% of individuals continuously enrolled in the state's HCBS programs.

The rule also proposes that states report on the percentage of beneficiaries continuously enrolled in the state's HCBS programs for 365 days or longer who had a service plan updated as a result of a re-assessment of functional need within the past 12 months. If finalized, these proposed new performance levels and reporting requirements would be effective three years after the effective date of the final rule. However, CMS requests comments on whether two years or four years to implement these standards would be more appropriate. These requirements would be applied across section 1915(c), (i), (j) and (k) waiver authorities. They would not apply to section 1905(a) "medical assistance" state plan personal care, home health and case management services. CMS seeks comments on the proposed new requirements and whether they should be extended to section 1905(a) state plan services.

HCBS Reporting

Key Takeaway: The proposed rule would require states to report on waiting lists in section 1915(c) waiver programs and on service delivery timeliness for personal care, homemaker and home health aide services.

States have the option to cap the number of people enrolled in HCBS waivers. As a result, there are often waiting lists for individuals to receive HCBS. The Kaiser Family Foundation reports that in 2021, 37 states had an HCBS waiting list, with a total of approximately 656,000 individuals on these lists. States are not currently required to report wait list information to CMS; Kaiser Family Foundation collects wait list data in a state survey.

CMS proposes to require states that have a limit on the size of their 1915 (c) waiver programs to describe the following annually to CMS:

- How the state maintains the list of individuals who are waiting to enroll in the waiver program, including whether the state screens individuals on the waiting list for eligibility for the waiver program
- Whether the state periodically re-screens individuals on the waiting list for eligibility, and if so, how frequently the re-screening occurs.

States would also be required to report the number of people on the waiting list and the average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list.

CMS proposes to report annually on the average amount of time from when services are initially approved to when those services begin.

CMS seeks comments on these access measures and the frequency of updating the reporting from the state to CMS.

HCBS Quality Measurement Set

Key Takeaway: CMS would require states to report every other year on the HCBS quality measure set.

The HCBS quality measure set is a set of nationally standardized quality measures for Medicaid-covered HCBS. CMS proposes to update the measure set at least every other year in consultation with states and other interested parties. In the proposed update process, the Secretary would solicit comments on the HCBS quality measure set in order to do the following:

- Establish priorities for the development and advancement of the HCBS quality measure set
- Identify newly developed or other measures that should be added, including to address gaps in the HCBS

quality measure set
- Identify measures that should be removed because they no longer strengthen the HCBS quality measures
- Ensure that all measures included in the HCBS quality measure set are evidence-based, meaningful for states, and feasible for state-level and program-level reporting as appropriate.

The Secretary would also develop a process for updating the HCBS quality measurement set, including the following steps:

- Identify all measures in the HCBS quality measure set, including newly added measures, measures that have been removed, mandatory measures, measures that the Secretary will report on states' behalf, measures that states can elect to have the Secretary report on their behalf, and measures for which the Secretary will provide states additional time to report
- Inform states how to collect and calculate data on the measures
- Provide a standardized format and schedule for reporting the measures
- Provide procedures that states must follow in reporting the measure data
- Identify specific populations for which states must report the measures
- Identify the subset of measures that must be stratified by race, ethnicity, Tribal status, sex, age, rural/urban status, disability, language or other factors as may be specified by the Secretary
- Describe how to establish state performance targets for each of the measures.

The requirements would be effective three years after the final rule's effective date, although reporting for certain measures would be phased in over time. CMS seeks comment on whether the timeframe for states to report on the measures in HCBS quality measure set is sufficient, whether reporting should be required more frequently (every year) or less frequently (every three years), and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

Conclusion

This summary represents our initial and high-level overview of the Ensuring Access to Medicaid Services proposed rule. There will be a 60-day comment period for the notice of proposed rulemaking, and comments must be submitted to the *Federal Register* no later than July 3, 2023. If you have additional questions about the rule or wish to comment on the rule, please contact the McDermottPlus team.