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Agenda

- Background
- Access Rule: Key Components
- Next Steps
- Questions

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Background

- Three major regulations released on April 22nd:
  - Access Rule
  - Managed Care Rule
  - Nursing Home Staffing Rule
- All three in tandem represent a significant overhaul of Medicaid policy and operations, as well as in Long-term Care Service Delivery
- Today's presentation will focus on the Access rule

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Medicaid Catalysts Regarding "Access"

March 2015: Armstrong vs Exceptional Child Center
Removed Private Right of Action for State Payment Rates

October 2015: Original "Access" regulation
Required State Medicaid "Access Monitoring Plans"

July 2019: Proposed Rule
Would rescind original Access regulation

February 2022: Access Request for Information
Broad request covering Access issues including payment, wages, eligibility, Managed Care

April 2023: Proposed Access Rule
A wide range of policy changes to Medicaid and LTSS proposed

April 2024: Access Final Rule
Access rule is final with policies discussed today

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ACCESS RULE: Key Components

- HCBS Payment Adequacy
- Payment Rate Transparency
- Justification Required for Certain Rate Restructures
- Requirement to Create an Interested Party Advisory Council
- Waiver Waiting List Reporting
- Reporting on Delays or Gaps in Accessing HCBS
- HCBS Quality Reporting
- HCBS Grievance System
- HCBS Incident Management System

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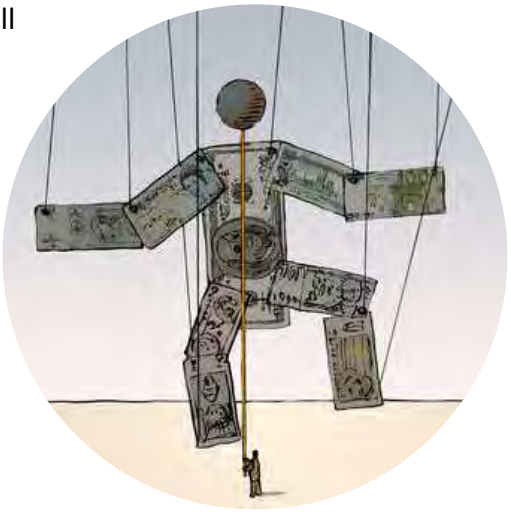
HCBS Payment Adequacy

- Would require states to "assure" that at least 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers
- Limited scope of services:
  - Homemaker;
  - Home Health Aide; and
  - Personal Care.
- Applied to following parts of Medicaid:
  - 1915(c)
  - 1915(i)
  - 1915(j)
  - 1915(k)
  - 1115
- NOT applied to 1905(a) [State plan].
- Becomes effective 6 years after the publication of the final rule → July 9, 2030



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Worker Definition

- Workers who:
  - Provide nursing services
  - Assist with ADLs and IADLs
  - Provide behavioral supports, employment supports, or other services to promote community integration.
- Specifically includes:
  - Nurses (RNs, LPNs, NPs, Clinical Nurse Specialists)
  - Licensed or certified nursing assistants
  - Direct support professionals
  - Personal care attendants
  - Home health aides
  - "Other individuals" paid to directly provide Medicaid services that address ADLs/IADLs, behavioral supports, employment supports, or other services to promote community integration, including nurses and other staff providing clinical supervision

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Compensation Definition

- Salary;
- Wages;
- Other remuneration as defined by the Fair Labor Standards Act;
- Benefits:
  - Health and dental benefits;
  - life and disability insurance;
  - paid leave;
  - retirement;
  - Tuition reimbursement; and
- The employer share of payroll taxes for direct care workers, specifically including FICA taxes, unemployment insurance, and worker compensation.

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New Policy: Excluded Costs

Costs not included in the calculation at all (i.e. not in the 80 or the 20)

Includes:

- 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
- Costs of personal protective equipment for direct care workers.

Example calculation:

- $30 state reimbursement
- $20 "total compensation" to worker

Component	Old Calculation	New Calculation
Wage	$20	$20
Administration	$5	$5
Travel, PPE, & Training	$5	$5
Percentage	20/30 = 66%	20/25 = 80%

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New Policy: Small Provider Exception

States are allowed, but not required, to establish a definition of "small provider" and establish an "Alternative Threshold" (ie: separate percentage) established through a transparent process

Definition of small provider must be based on "reasonable, objective criteria through a transparent process to identify small providers" that would be eligible for the separate threshold.

Alternative threshold must also be "based on reasonable, objective criteria" that is established through a transparent process

Further, if a state establishes a separate threshold for small providers, it must provide an annual report to CMS:

- The criteria used to define small providers;
- The pass-through requirement applied to these providers;
- The percentage of provider agencies that qualify for the small-provider exemption; and
- A plan, subject to CMS review and approval, for small providers to meet the standard 80% pass-through requirements.

Annual report is waived if less than 10% of providers qualify

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New Policy: Hardship Exception

States are allowed, but not required, to establish a process to exempt providers due to "extraordinary circumstances" that prevent compliance.

States must develop, "reasonable, objective criteria through a transparent process" to identify providers eligible for the exemption.

Only a "reasonable" number of providers should qualify for the exemption; however, there is no clarification regarding what a reasonable number would entail.

States that establish a hardship exemption must report, annually, on:

- The State's hardship criteria;
- The percentage of providers of services 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.

CMS may waive the reporting requirements if small provider or hardship exemption to less than 10 percent of the State's providers.

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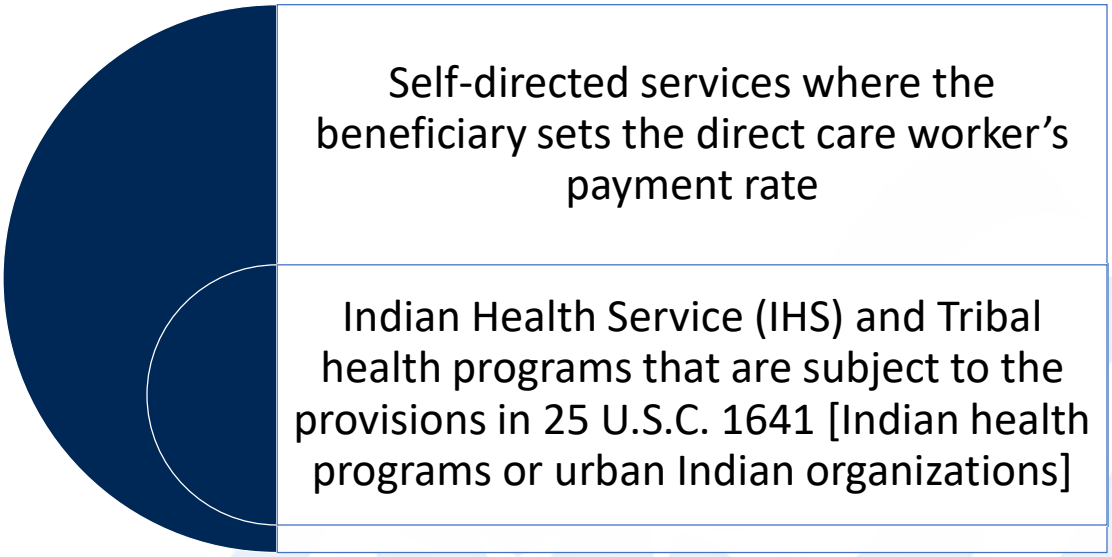
New Policy: Other Exemptions



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Reporting/Monitoring

- States would report annually on the percent of payments for homemaker, home health aide, personal care, and habilitation spent on compensation for direct care workers
  - Separate reports for each service category
  - Separate report on self-directed services for each category
  - Separate report on facility-based services
- Effective 4 years after issuance of final rule
  - 3 years after the issuance, states must report on readiness/ability to track

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Payment Rate Transparency

By July 1, 2026, every state must maintain an easily accessible website that contains current fee-for-service rates, including:

- Variations based on population
- 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.

For personal care, home health aide, homemaker, and habilitation services, the state must clearly identify the average hourly payment rates

Must also show any differences for:

- Self-directed and agency providers;
- Variations between pediatric and adult;
- Whether the rate includes facility costs;
- 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.

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Justification for Certain Rate Cuts/Restructures

Proposes a three criteria test:

1)Aggregate payment rates at or above 80% of the comparable Medicare rate;
2)Aggregate payment reduction ≤ 4%; and
3)Public input processes resulted in no concerns or concerns that the state can reasonably mitigate.

If all three are met, State must show that it meets these criteria and that it will monitor access and continue to meet the three criteria on an ongoing basis

If all three are not met, significant data reporting requirements to get approval

Services, including many HCBS, without corresponding Medicare services would always be subject to the higher reporting

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Requirement to Create an Interested Party Advisory Council

Required group to advise and consult on fee-for-service rates provider rates for habilitation, home health aide, homemaker, and personal care services..

Focus on to ensure access for the services in question, and to ensure adequate providers of self-directed personal care.

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.

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New Waiver Waiting List Reporting Requirements:

- 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

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Reports on Delays and Gaps in Care

- Beginning in 2027: report on the average amount of time that lapses between when certain HCBS are authorized and when services begin.
- Applies to:
  - Homemaker
  - Home health aide
  - Habilitation
  - Personal care services
- Additional reporting on the percentage of authorized hours that are delivered for those same three service categories.
- States allowed to use a statistically significant sample size of individuals

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New HCBS Quality Reporting System

Beginning 2028, states must report every alternating year on a subset of measures the HCBS Quality Measure Set

Announced in July 2022 State Medicaid Director Letter

Updated in April 2024

https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-quality/index.html

Every two years, HHS must hold a collaborative process to update the measures

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HCBS Grievance Systems

States must establish a new system to collect and track "grievances"

- Grievance defined as "an expression of dissatisfaction or a complaint"
- Minimum requirement to deal with issues related to:
  - State's or a provider's performance regarding person-centered planning and service plan requirements
  - The HCBS "settings" requirements that establish criteria for where HCBS may be provided

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HCBS Incident Management Systems

Requires States to operate and maintain an incident management system

- Core functions for system:
  - Identify
  - Report
  - Triage
  - Investigate
  - Resolve
  - Track
  - Trend
- 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.

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NAHC Advocacy: Next Steps

April 30, 2024: House Energy and Commerce Hearing

- Will consider HR8114 that would place a moratorium on CMS/HHS implementing 80-20 provision

Actively discussing Senate companion bill with potential sponsor(s)

Outreach to State Medicaid Agencies and Attorney Generals

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THANK YOU

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