# NASDDDS Review of Provisions in the CMS Draft ACCESS Rule

*February 26, 2024*

NASDDDS
National Association of State Directors of Developmental Disabilities Services

# CMS Proposed Rule: Ensuring ACCESS to Medicaid Services (Access NPRM) (CMS-2442-P)

*Federal Register* :: Medicaid Program; Ensuring Access to Medicaid Services

# ACCESS Rule Status

- NASDDDS submitted joint comments with the National Association of Medicaid Directors and ADvancing States in July 2023. Find @ State-Associations-Comments-on-Access-NPRM-HCBS-Provisions-FINAL.pdf (medicaiddirectors.org).
- Slated to be finalized spring 2024.
- If finalized, the HCBS requirements in this proposed rule, are intended to supersede and fully replace the reporting and performance expectations described in March 2014 guidance for section 1915(c) waiver programs.
- To ensure consistency and alignment across HCBS authorities, CMS proposes to apply the new HCBS requirements to section 1915(c) waiver programs and to section 1915(i), (j), and (k) state plan services, except where it is noted that a proposed requirement would only apply to certain services.
- In addition, except where noted, the proposed requirements would apply to services delivered through both FFS and managed care delivery services.

# ACCESS Rule Sections

- Person-Centered Planning
- Grievance in Fee-for-Service Systems
- Critical Incident Management Systems
- HCBS Payment Adequacy
- HCBS Payment Transparency
- Rate Provisions
- Website Transparency
- Timeliness of Access
- Waiver Waiting Lists lists
- HCBS Quality Measure Set

# Person-Centered Planning

# Person-Centered Planning

- Proposal to codify a minimum performance level for states to demonstrate that a reassessment of functional need, including changes in circumstances, is conducted annually for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.
- 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 the required reassessment of functional need every 12 months, for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.

**Proposed Effective Date — 3 years after the effective date of the final rule.**

# Percent of Beneficiaries Enrolled

- The rule proposes that states report annually on the percent of beneficiaries continuously enrolled in the state's HCBS programs for 365 days or longer for whom a reassessment of functional need was completed within the past 12 months.
- States would also be required to report on the percent 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 reassessment of functional need within the past 12 months.
- For both metrics, CMS proposes allowing states to report on a statistically valid random sample of beneficiaries, rather than for all individuals continuously enrolled in the state's HCBS programs for 365 days or longer.

**Proposed Effective Date — 3 years after the effective date of the final rule.**

# Medical Care Advisory Committees (MCAC)

# Advisory Committees

- CMS proposes to require both a Medicaid Advisory Committee (MAC) and a new Beneficiary Advisory Group (BAG).
- The MAC must include BAG members with lived experience, defined as current or previous beneficiaries or people with direct experience supporting beneficiaries.
- At least 25% of MAC membership would be reserved for BAG members.
- The MAC must also include state or local advocacy groups; clinical providers or administrators; managed care plans or plan associations as applicable; and other state agencies serving Medicaid beneficiaries as ex officio members. The exact proportion of these categories is left to state discretion.

# Advisory Committees

- MAC and BAG members would be appointed on a rotating and continuous basis. Members would serve for a defined time period, as selected by the state/territory.
- These committees must meet at least quarterly. At least two MAC meetings per year must be open to the public with time for public comment.
- BAG meetings must precede MAC meetings so the BAG members on the MAC are prepared for the latter meetings.
- Medicaid agency executive leadership (at least one member) must attend MAC and BAG meetings.
- The rule would expand the scope of MAC conversations to include both covered services and ability to access these services.

**Proposed Effective Date — 60 days after the effective date of the rule, with a one-year compliance timeline.**

# Grievance in Fee-for-Service Systems

# Grievance System

- The state must establish a procedure under which a beneficiary may file a grievance related to the state or a provider's compliance with person-centered planning (§§ 441.301(c)(1) through (3) and HCBS settings requirements §§ 441.301(c)(4) through (6).

# General Requirements (1 of 3)

(A) The beneficiary or a beneficiary's authorized representative, if applicable, may file a grievance. Another individual or entity may file a grievance on behalf of the beneficiary with the written consent of the beneficiary or authorized representative.

(B) The state must:

1. Base its grievance processes on written policies and procedures.
2. Provide beneficiaries reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes ensuring the grievance system is accessible to individuals with disabilities and persons who are limited English proficient, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
3. Ensure that punitive action is neither threatened nor taken against an individual filing a grievance.
4. Provide to the beneficiary the notices and information required under this subsection, including information on their rights under the grievance system and on how to file grievance.
5. Provide information about the grievance system to all providers and subcontractors approved to deliver services.

# General Requirements (2 of 3)

6. Allow the beneficiary to file a grievance with the state either orally or in writing.
7. Ensure that the individuals who make decisions on grievances were neither involved in any previous level of review or decision-making related to the grievance nor a subordinate of any such individual; and have the appropriate clinical and non-clinical expertise, as determined by the state.
8. Provide the beneficiary a reasonable opportunity, face-to-face (including through the use of audio or video technology) and in writing, to present evidence and testimony and make legal and factual arguments related to their grievance.
9. Provide the beneficiary their case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the state related to the grievance.

# General Requirements (3 of 3)

10. Allow a beneficiary to file a grievance at any time.
11. Review any grievance resolution with which the beneficiary is dissatisfied.
12. Establish a method to notify a beneficiary of the resolution of a grievance For notice of an expedited resolution, the state must also make reasonable efforts to provide oral notice.
13. Maintain records of grievances in a manner available upon request to CMS and must review the information as part of its ongoing monitoring procedures.

# Review Timelines

The state must resolve each grievance, and provide notice, as expeditiously as the beneficiary's health, safety, and welfare requires, within state-established timeframes that may not exceed the timeframes specified in this section.

The beneficiary may request expedited resolution of a grievance whenever there is a substantial risk that resolution within standard timeframes will adversely affect the beneficiary's health, safety, or welfare

(1) For standard resolution of a grievance and notice to the affected parties, the timeframe may not exceed 90 calendar days from the day the state receives the grievance.

(2) For expedited resolution of a grievance and notice to affected parties, the state must establish a timeframe that is no longer than 14 calendar days after the state receives the grievance.

(3) The states may extend the timeframes by up to 14 calendar days if —
    (1) The beneficiary requests the extension; or
    (2) The state documents that there is need for additional information and how the delay is in the beneficiary's interest.

**Proposed Effective Date — 2 years after the effective date of the final rule.**

# Waiver Waiting Lists

# Waiver Waiting Lists

States must report:

- A description of how the state maintains the list.
    1. Information on whether the state screens individuals on the list for waiver eligibility.
    2. Whether and how frequently the state periodically rescreens individuals on the list for eligibility.
    3. Number of people on the list.
    4. Average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the list.

# Timeliness of Access

The state must report:

(i) Average amount of time from when homemaker services, home health aide services, or personal care services are initially approved to when services began, for individuals newly approved to begin receiving services within the past 12 months. Can use a sample.

(ii) Percent of authorized hours for homemaker services, home health aide services, or personal care services, as that are provided within the past 12 months. Can use a sample.

**Proposed Effective Date — 3 years after the effective date of the final rule.**

# HCBS Quality

# HCBS Quality

- The proposed HCBS requirements in the rulemaking are intended to establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for section 1915(c) waiver programs.
- The priority areas are person-centered planning, health and welfare, access, beneficiary protections, and quality improvement.
- New reporting requirements to fully replace the 86% measure threshold from 2014 requirements.
- To ensure consistency and alignment across HCBS authorities, propose to apply the proposed requirements for section 1915(c) waiver programs to section 1915(i), (j), and (k) state plan services as appropriate.

# HCBS Quality Measure Set

The Secretary shall:

- In consultation with states, develop and update, at least every other year, the HCBS Quality Measure Set using a process that allows for public input and comment.
- Ensure that all measures included in the Home and Community-Based Services Quality Measure Set reflect an evidence-based process including testing, validation, and consensus among interested parties; are meaningful for states; are feasible for sate-level, program-level, or provider-level reporting as appropriate.
- Identify the specific measures for which reporting is mandatory from a mandatory HCBS Quality Measure Set as well as other quality measures selected by the state.
- Identify the subset of measures that must be stratified by race, ethnicity, sex, age, rural/urban status, disability, language, Tribal status, other.
- Identify the measures for which the Secretary will complete reporting on behalf of states and the measures for which states may elect to have the Secretary report on their behalf; and the measures, if any, for which the Secretary will provide states with additional time to report.

HCBS Measure Set SMDL (medicaid.gov)

# Critical Incident Management Systems

# New Assurance

- Assurance that the state operates and maintains an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

# New Definition

Defines critical incident to include, at a minimum —

1. Verbal, physical, sexual, psychological, or emotional abuse;
2. Neglect;
3. Exploitation including financial exploitation;
4. Misuse or unauthorized use of restrictive interventions or seclusion;
5. 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
6. An unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

# New Identification Requirements

The state must:

- Require providers to report to the state, within state-established timeframes and procedures, any critical incident that occurs during the delivery of services authorized under section 1915(c) of the Act and as specified in the waiver participant's person-centered service plan, or occurs as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the waiver participant's person-centered service plan.
- 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 critical incidents that are unreported by providers and occur during the delivery of services authorized under section 1915(c) of the Act and as specified in the waiver participant's person-centered service plan, or occur as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the waiver participant's person-centered service plan.
- Ensure that there is information sharing on the status and resolution of investigations, such as through the use of information sharing agreements, between the state and the entity or entities responsible in the state for investigating critical incidents.

# New Identification Requirements cont.

The state must:

1. Initiate an investigation, within state-specified timeframes, for no less than 90 percent of critical incidents;
2. Complete an investigation and determine the resolution of the investigation, within state-specified timeframes, for no less than 90 percent of critical incidents; and
3. Ensure that corrective action has been completed within state-specified timeframes, for no less than 90 percent of critical incidents that require corrective action.

Separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes ("intended to ensure that the failure to effectively share information between state agencies or other entities in the state responsible for investigating incidents does not impede a state's ability to effectively identify, report, triage, investigate, resolve, track, and trend critical incident").

# New Information System

1. Enables electronic critical incident data collection.
2. Tracking (including of the status and resolution of investigations).
3. Trending.

Requirements are effective three years after the date of enactment of this paragraph; and in the case of the state that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the MCO's, PIHP's, or PAHP's contract, the first managed care plan contract rating period that begins on or after three years after the date of enactment of this paragraph.

# New Reporting Requirements

1. The state must report, every 24 months, on the results of an incident management system assessment to demonstrate that it meets the requirements. CMS may reduce the frequency of reporting to up to once every 60 months for states with incident management systems that are determined by CMS to meet the requirements.
2. The state must report to CMS annually the number and percent of critical incidents for which an investigation was initiated, for which the state determines the resolution, and for which the required corrective action has been completed within state-specified timeframes.

**Proposed Effective Date — 3 years after the effective date of the final rule.**

# HCBS Quality Measure Set

States:

- Must establish state performance targets and describe the quality improvement strategies that the state will pursue.
- Must report every other year on all measures in the Home and Community-Based Services Quality Measure Set that are identified by the Secretary.

**Proposed Effective Date — 3 years after the effective date of the proposed rule.**

# Website Transparency

# Website Transparency

The state must operate a website that

1. provides the results of the reporting requirements in the rule.
    A. Rates, including last time updated
    B. Incident management system assessment/number and percent of critical incidents
    C. Person-centered planning percentages
    D. Quality measure set
    E. Timeliness
    F. Waiting lists
2. Includes all content on one web page, either directly or by linking.

**Proposed Effective Date — 3 years after the effective date of the final rule.**

# HCBS Rate Provisions

# HCBS Rate Provisions (1 of 8)

- **REQUIRES** that state Medicaid agencies demonstrate that payment rates for certain HCBS authorized under section 1915(c) of the Act are sufficient to ensure a sufficient direct care workforce (defined and explained later in this section of the proposed rule) to meet the needs of beneficiaries and provide access to services in accordance with the amount, duration, and scope specified in the person-centered service plan, as required under § 441.301(c)(2).

# HCBS Rate Provisions (2 of 8)

- **REQUIRES** that at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to the following services be spent on compensation to direct care workers: homemaker services, home health aide services, and personal care services. Defines compensation to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act and benefits (such as health and dental benefits, sick leave, and tuition reimbursement). In addition, we propose to define compensation to include the employer share of payroll taxes for direct care workers delivering services under section 1915(c) waivers.

# HCBS Rate Provisions (3 of 8)

**DEFINES** 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.

Propose to define direct care workers to include nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists) who provide nursing services to Medicaid-eligible individuals receiving HCBS, licensed or certified nursing assistants, direct support professionals, personal care attendants, home health aides, and other individuals who are paid to directly provide services to Medicaid beneficiaries receiving HCBS to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration.

Direct care workers to include individuals 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.

# HCBS Rate Provisions (4 of 8)

**PROPOSES** that states report annually on the percent of payments for homemaker, home health aide, and personal care services, as listed at § 440.180(b)(2) through (4), that are spent on compensation for direct care workers. States would separately report for each service subject to the reporting requirement and, within each service, separately report on payments for services that are self-directed.

# HCBS Rate Provisions (5 of 8)

**PUBLISHING** Medicaid fee schedule payment rates (defined as payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through a FFS delivery system) on a state Medicaid agency website. In the interest of enabling members of the public to readily determine rates, CMS is further proposing to require states, in constructing their websites, to:

- Clearly organize and enumerate rates;
- Include the dates on which rates were last updated;
- Disclose the constituent components of bundled rates as well as how much of the bundled fee schedule payment rate or rate determined by a similar payment methodology is allocated to each constituent service;
- Stratify rates by population (pediatric and adult), provider type, and geographical location, if rates vary; and
- Updates to rate schedules (e.g. automatic updates that reflect changes to Medicare fee schedules) within one month of the date of CMS approval.

CMS includes detailed illustrative examples on the granularity of required detail for these elements.

# HCBS Rate Provisions (6 of 8)

**WITH RESPECT** to the disclosure of HCBS payment rates, CMS is proposing to require it to include:

- Average hourly payment rates for personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency, and stratified by population (pediatric and adult), provider type, and geographical location, as applicable.
- Medicaid-paid claims volume, and number of Medicaid enrolled beneficiaries who received personal care, home health aide, and homemaker services.

CMS is proposing to require states to distinguish the average hourly payment rates for personal care, home health aide, and homemaker services provided by individual providers with rates paid to providers employed by an agency.

# HCBS Rate (7 of 8)

CMS proposes to require states to establish an interested parties' advisory group that must meet at least every two years to advise and consult on FFS rates paid to direct care workers (defined in the HCBS section) providing self-directed and agency-directed HCBS, at a minimum for personal care, home health aide, and homemaker services that are provided under authorities including 1905(a), 1915(i), 1915(j), and 1915(k) state plan authorities; section 1915(c) and 1115 waivers; and at the states' option, other HCBS.

CMS is proposing to require that this group advise and consult with the Medicaid agency on current and proposed payment rates, HCBS payment adequacy data, and access to care metrics. CMS is also proposing to require states to consider recommendations of and publish via the same website that fulfills transparency requirements recommendations made by the group, within one month of when those recommendations are made.

# HCBS Rate Provisions (8 of 8)

**Proposed Effective Date — 4 years to implement these requirements in FFS delivery systems following effective date of the final rule.**

- For states with managed care delivery systems under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and that include HCBS in the MCO's, PIHP's, or PAHP's contract, provide States until the first managed care plan contract rating period that begins on or after 4 years after the effective date of the final rule to implement these requirements.

# HCBS Payment Transparency

# Timeliness Reporting

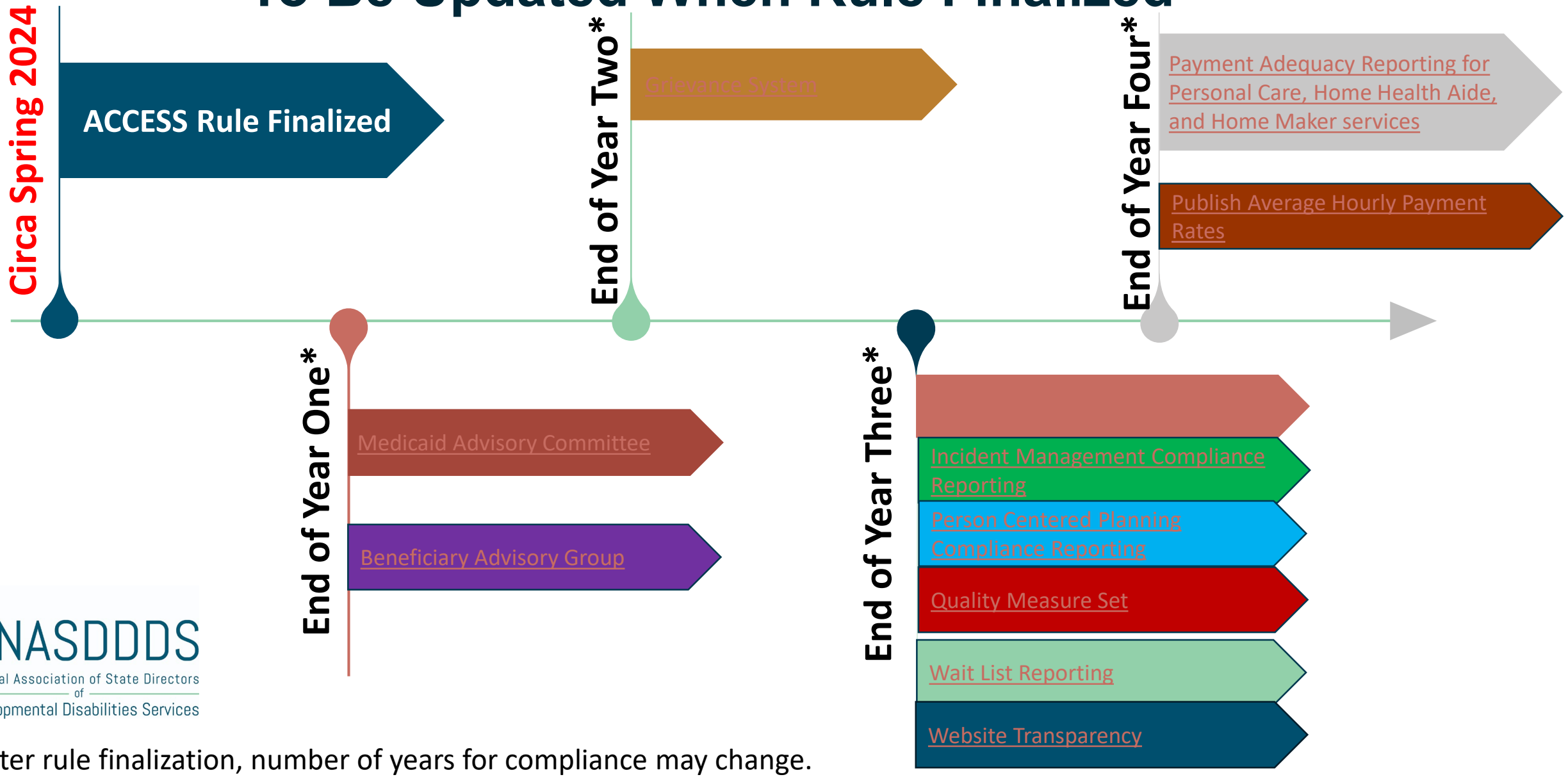
The state must:

1. Report annually the percent of payments for personal care, home health aide, and homemaker services that are 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.
2. Publish average hourly Medicaid payment rates for personal care, home health aide, and homemaker services, separately identifying the payment rates by population (pediatric and adult), provider type, and geographical location, if those vary.
   A. 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 average hourly payment rates are published.

**Proposed Effective Date — 4 years after the effective date of the final rule.**

# Timeline for ACCESS Rule as Proposed

## To Be Updated When Rule Finalized

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*After rule finalization, number of years for compliance may change.

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