Joint Association Call:
CMS Access Regulation

May 8, 2024

NASDDDS
National Association of State Directors of Developmental Disabilities Services

ADVANCING STATES

NAMD
National Association of Medicaid Directors

NASHIA

NASMHPD
Supporting Excellence in Behavioral Health

Welcome & Opening Remarks

Webinar Logistics

Agenda

Welcome & Opening Remarks

Logistics

Overview of Access Regulation Requirements:

- Payment Adequacy & Transparency
- Critical Incidents
- Timeliness of Access
- Quality Measure Set
- FFS Grievance Process
- MAC & BAC

Q&A / Discussion

Payment Adequacy & Transparency

Payment Adequacy: Minimum Performance Standard

The state must ensure 80% of Medicaid payments go to compensation for direct care workers.

Affected services:

- Personal care services
- Home health aide services
- Homemaker services

Compliance timeframe: 6 years

Payment Adequacy: Reporting Requirements

The state must report to CMS annually on the percentage of total payments for furnishing personal care, homemaker services, home health aide services, **and habilitation services** that goes to compensation for DCWs

NEW!

The report must:

- Separately report by service
- Within each service, separately report self-directed services
- Within each service, separately report services with facility-related costs

Compliance timeframe: 4 years

Payment Adequacy *(cont.)*

Definition of *direct care worker*:

- Includes nurses (RN, LPN, NP), licensed/certified nursing assistant, direct support professional, personal care attendant, home health aide, or
- Other individuals paid to provide services to address ADL or IADL, behavioral support, employment supports, or other services to promote community integration to Medicaid beneficiary receiving HCBS
- **Includes clinical supervisors**

NEW!

Definition of *compensation*:

- Salary, wages, and other renumeration as defined by the Fair Labor Standards Act (FLSA)
- Benefits, such as health and dental benefits, paid leave, and tuition reimbursement
- Employer share of payroll taxes

Applies to both reporting requirement and minimum performance standard

Payment Adequacy *(cont.)*

NEW!

Exclusions:

- *Excluded costs:* Costs that are not included in the calculation of the percentage of Medicaid payments to providers spent on DCW compensation:
  - Costs of required trainings for DCWs
  - Travel costs
  - Costs of personal protective equipment
- Self-directed services delivered through models in which the beneficiary sets the payment rate for the worker are not included in either requirement

Applies to both reporting requirement and minimum performance standard

Payment Adequacy *(cont.)*

NEW!

Small provider minimum performance level:

- State may set a % requirement for compensation to DCW for small providers
- State must develop criteria to identify small providers (through a transparent process with public comment period)
- **Annual reporting to CMS:** On criteria, provider minimum performance level, % of providers that qualify, and plan for small providers to meet the 80% minimum performance standard within a reasonable timeframe

Hardship exemption:

- State may develop criteria to exempt a reasonable number of providers who face extraordinary circumstances that prevent compliance (through a transparent process with public notice/comment period)
- **Annual reporting to CMS:** On criteria, % of providers that qualify and a plan for reducing the number of providers receiving hardship exemption

Applies to only to minimum performance standard

Rate Analysis & Disclosure

Comparative Rate Analysis:

- A state must develop and publish a comparative rate analysis between Medicaid FFS rates and Medicare rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health.

Rate Disclosure:

NEW!

- A state must publish rate disclosure for FFS personal care, home health aide, homemaker **and habilitation** services. The disclosure must be updated every 2 years. The disclosure must include:
  - Avg. hourly payment rates, separated by agency and self-directed options, and stratified by population, provider type, and location
  - Number of Medicaid-paid claims
  - Number of beneficiaries who received a service within a calendar year

Interested Parties Advisory Group

A state must establish an Interested Parties Advisory Group to advise and consult on FFS payment rates for direct care workers. This group operates separately from MAC and BAC groups.

Meeting membership & frequency:

- Membership must include direct care workers, beneficiaries and their authorized reps, and other interested parties.
- The group must meet every two years, at minimum.

Rate review & recommendations:

- The group will make recommendations on the sufficiency of State plan, 1915(c), and 1115 demonstration direct care worker payment rates.

Critical Incidents

New Assurance

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

Effective Date — 3 years (July 9, 2027).

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.

Effective Date — 3 years (July 9, 2027).

New Information System

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

Effective Date — 5 years (July 9, 2029).

New Reporting Requirements

- 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.

New Identification Requirements *(1 of 3)*

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.

New Identification Requirements *(2 of 3)*

- 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 *(3 of 3)*

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").

Effective Date — 3 years (July 9, 2027)

Timeliness of Access

Timeliness Reporting Requirements

- Final rule adds habilitation to homemaker, home health aide, and personal care services as a service type for which states must report on two timeliness factors:
  - Average amount of time from when homemaker services, home health aide services, personal care services, and habilitation services are initially approved to when services began, for individuals newly receiving services within the past 12 months.
  - Percent of authorized hours for homemaker services, home health aide services, personal care services, and habilitation services that are provided within the past 12 months.
- States may report these metrics using statistically valid random sampling of beneficiaries.
- Final rule specifies that the reporting is for individuals newly receiving services within the past 12 months, rather than for individuals newly approved to begin receiving services.

Effective Date — 3 years (July 9, 2027)

Waiting List Reporting Requirements

- States must report:
  - A description of how the State maintains the list of individuals who are waiting to enroll in the waiver program, if the State has caps and maintains a list. This description must include:
    - Whether the State screens individuals on the list for eligibility for the waiver program; re-screens individuals; and the frequency of re-screening, if applicable.
    - Number of people on the list of individuals who are waiting to enroll in the waiver program.
    - Average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list

  Effective Date — 3 years (July 9, 2027)

Quality Measure Set

HCBS Quality Measure Set: Background

September 2020

- RFI seeking feedback on a draft set of recommended HCBS measures

July 21, 2022 - SMDL 22-003 released

May 3, 2023 – July 2, 2023

- Access NRPM

January 25, 2024 - CMS outlines requirement for MFP Grantees

April 11, 2024 - Informational Bulletins

- 2024 Home and Community-Based Services (HCBS) Quality Measure Set (QMS)
- Home and Community-Based Services (HCBS) Quality Measure Set (QMS) Reporting Requirements for Money Follows the Person (MFP) Demonstration Grant Recipients

April 11, 2024 - LTSS Quality Measures Technical Specifications and Resources Manual

April 2024 - Final Access Rule

Access Rule Quality Section Overview

- Requires adoption of HCBS Quality Measure Set
  - Originally shared as guidance in SMD Letter #22-003
  - Applies to all HCBS authorities (except state plan personal care) and all delivery systems, as well as self-directed programs
  - Requires stratification and sampling phase-in
  - Updated every other year by HHS Secretary
- Process includes soliciting public comment including the Federal Registrar

Access Rule Quality Section Overview

- States must establish performance targets, reviewed and approved by CMS, of each mandatory measure.
- The state must establish performance targets, approved by CMS, for each measure in the HCBS Quality Measure Set that are identified as mandatory, and describe the state's quality improvement (QI) strategies they will pursue to achieve performance of those measures.
    - The state may establish performance targets and QI strategies for measures that are not yet required but will be, and on populations for whom reporting is not yet required but will be.

Access Rule Quality Section Overview

- Requires the Secretary to make technical updates and corrections to measure set annually as appropriate, otherwise biennial updates
- Requires the Secretary to ensure all measures:
  - Reflect an evidence-based process including testing, validation, and consensus among interested parties; and
  - Are meaningful for states and are feasible for State-level, program-level, or provider-level reporting as appropriate.
- HHS Secretary to begin identifying quality measures no later than December 31, 2026.

Access Rule
Reporting on the HCBS Quality Measure Set

- Replace the minimum 86% performance level for states performance measures described in 2014 guidance
- States report every other year on all measures in the HCBS Quality Measure Set that are identified by the Secretary (following phased in approach)
- CMS will report on a subset of the measures

Stratified Data

- Stratification would allow CMS and states to identify health and quality of life outcomes, and differences in outcomes
  - Identifies subset of measures to be stratified by race, ethnicity, sex (biological), age, rural/urban status, disability, language, or other factors.
- CMS "recognizes challenges to stratification;" phased-in approach:
  - Provide stratified data for 25% of measures by 4 years after effective date
  - 50% of measures by 6 years
  - 100% of measures by 8 years

MFP Grantee States and Territories – HCBS Quality Measure Set Implementation

- MFP grant recipients are required to report in Fall 2026 on the HCBS Quality Measure Set every other year for their section 1915(c), (i), (j), and (k) programs and section 1115 demonstrations that include HCBS.
    - For the initial implementation of the measure set, MFP grant recipients can opt to, but are not required to, stratify data for MFP participants and by demographic or other characteristics of their HCBS participants.

Access Rule and Quality Measure Set Goals

- The set of nationally standardized quality measures for Medicaid-funded HCBS is intended to:
- Promote more common and consistent use within and across states of nationally standardized quality measures in HCBS programs;
- Create opportunities for states and CMS to have comparative quality data on HCBS programs;
- Drive improvement in quality of care and outcomes for people receiving HCBS; and
- Support states' efforts to promote equity in their HCBS programs.

Background: Access Rule and Quality Measure Set

Source

Vast majority of measures are drawn from surveys of people with lived experience

Flexibility

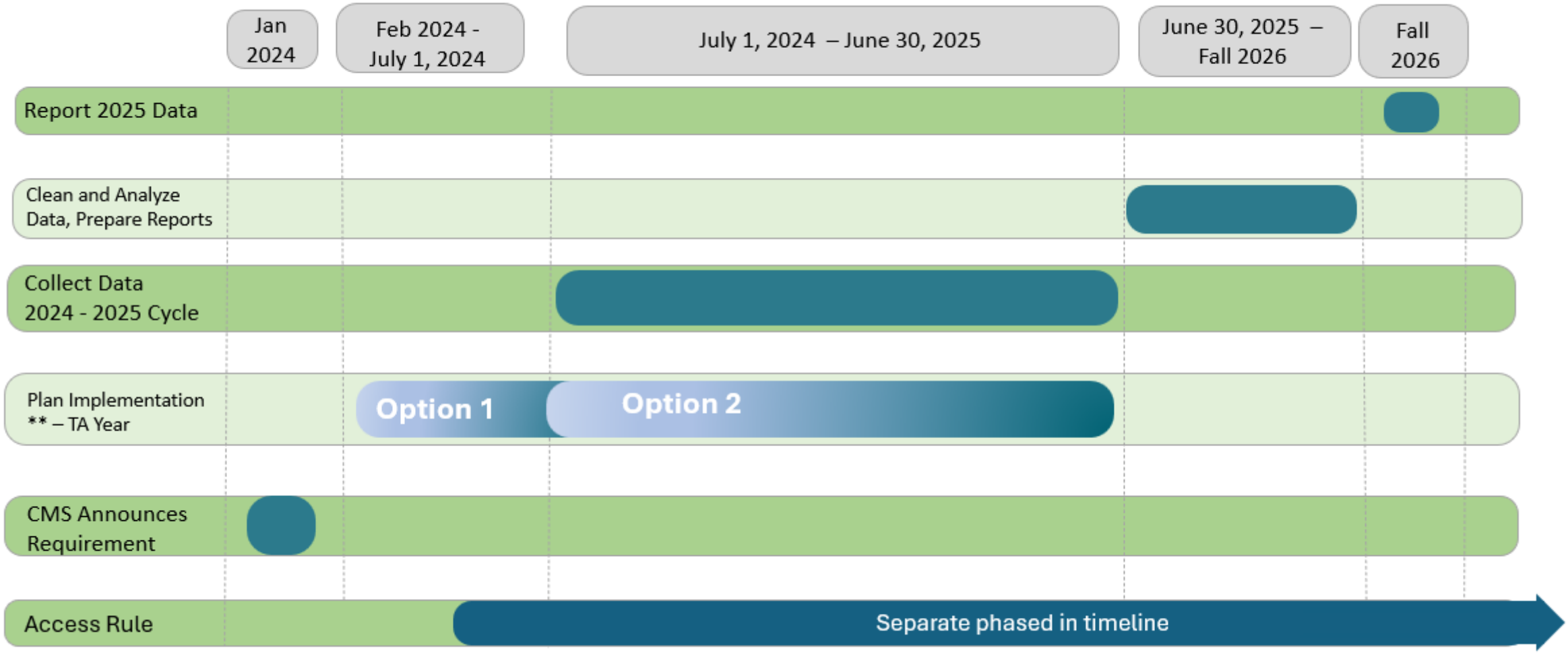
CMS permits states flexibility to determine which survey tool they implement (from the following):

- NCI®-IDD
- NCI-AD™
- HCBS CAHPS®
- POM®

Background: Access Rule and Quality Measure Set

- Multiple measures for each 'topic' means that states can use the consumer survey(s) of their choice to collect and report data on those topics, so that:
  - a state that fields the NCI-AD™ survey would only use the applicable NCI-AD™ measures in the measure set to report to CMS on outcomes for older adult and persons with physical disabilities
  - a state that fields the NCI-IDD™ survey would only use the applicable NCI-IDD™ measures in the measure set to report to CMS on outcomes for adults with intellectual or developmental disabilities

NCI ®Data Reporting Timeline



** includes any state procurement and contracting requirements for survey vendor

FFS Grievance Process

FFS Grievance Process: Overview

CMS finalizes creation of FFS grievance process in 1915(c) waivers and 1915(i), (j), and (k) State Plan authorities. Grievances are defined as "expressions of dissatisfaction or complaints." This system does not impact existing member fair hearing rights.

CHANGE FROM NPRM: CMS clarifies that grievances may be filed related to state or provider **performance (as opposed to compliance)** with person-centered planning and HCBS settings requirements.

Compliance Date: Two years following effective date of the rule **(July 9, 2026)**

FFS Grievances: Notable Details

- Beneficiaries, authorized representatives, **or other disinterested individuals or entities with permission from the beneficiary/authorized representative** may file a grievance and/or support a beneficiary through the grievance process – with **no punitive or retaliatory action taken because of grievance filings**
- Grievances must be resolved within **90 calendar days** and as expeditiously as a beneficiary's health condition requires**,** with option to extend an additional 14 days. **CMS does not finalize a separate, expedited grievance pathway.**
- Information on the process must be provided in plain language to new and current beneficiaries, with reasonable assistance in navigating the process (including for LEP individuals and people with disabilities)

MAC & BAC

Changing MCACs to MACs and BACs

CMS finalizes policies to restructure current Medical Care Advisory Committees into two distinct bodies: a **Medicaid Advisory Committee (MAC)** and a **Beneficiary Advisory Council (BAC)**.

These are separate and distinct entities from the HCBS Interested Parties Advisory Group discussed earlier in this webinar (though to the extent the MAC makes payment recommendations, these can count as rate activities by the Interested Parties Advisory Group).

Compliance Date: One year following effective date of the rule **(July 9, 2025)**

MAC and BAC: Composition *(1 of 2)*

MAC and BAC membership selected by Medicaid agency leadership, with mandatory rotating terms to promote diversity of viewpoints.

MAC must include, but is not limited to:

- State and/or local consumer advocacy groups representing interests of Medicaid recipients
- Clinical providers or administrators (with suggestions of categories to consider, including providers of services to people with disabilities and people over age 65)
- If applicable, Medicaid managed care organizations or their state associations
- Other state agencies serving Medicaid members, serving as non-voting ex officio members

BAC must be composed of people with lived Medicaid experience, including current or former recipients of Medicaid services and their caregivers (including family members and unpaid caregivers).

MAC and BAC: Composition *(2 of 2)*

A portion of the MAC must be composed of BAC members, on the following lines:

- **10% of BAC on MAC** for period of effective date through 1 year after effective date **(July 9, 2024 through July 9, 2025)**
- **20% of BAC on MAC** for period of 1 year and one day after effective date through 2 years after effective date (July 10, 2025 – July 9, 2026)
- **25% of BAC on MAC** after 2 years and one day post-effective date (July 10, 2026 and beyond)

Unclear at this point how the 10% BAC on MAC provision intersects with these bodies being developed by July 9, 2025. We are seeking clarification from CMS on what looks like misaligned dates.

MAC and BAC: Scope of Activities

MAC and BAC advise the Medicaid agency and are to consider an array of topics, including but not limited to:

- Service additions, changes, and quality
- Coordination of care
- Eligibility, enrollment, and renewal processes
- Beneficiary and provider communications
- Cultural competency, language access, health equity and disparities, and biases in the Medicaid program

MAC recommendations are to be made to the Medicaid agency in a formal report which the agency finalizes and publishes. The first report is to be finalized **within two years of the rule's effective date** and annually thereafter.

MAC and BAC: Administration

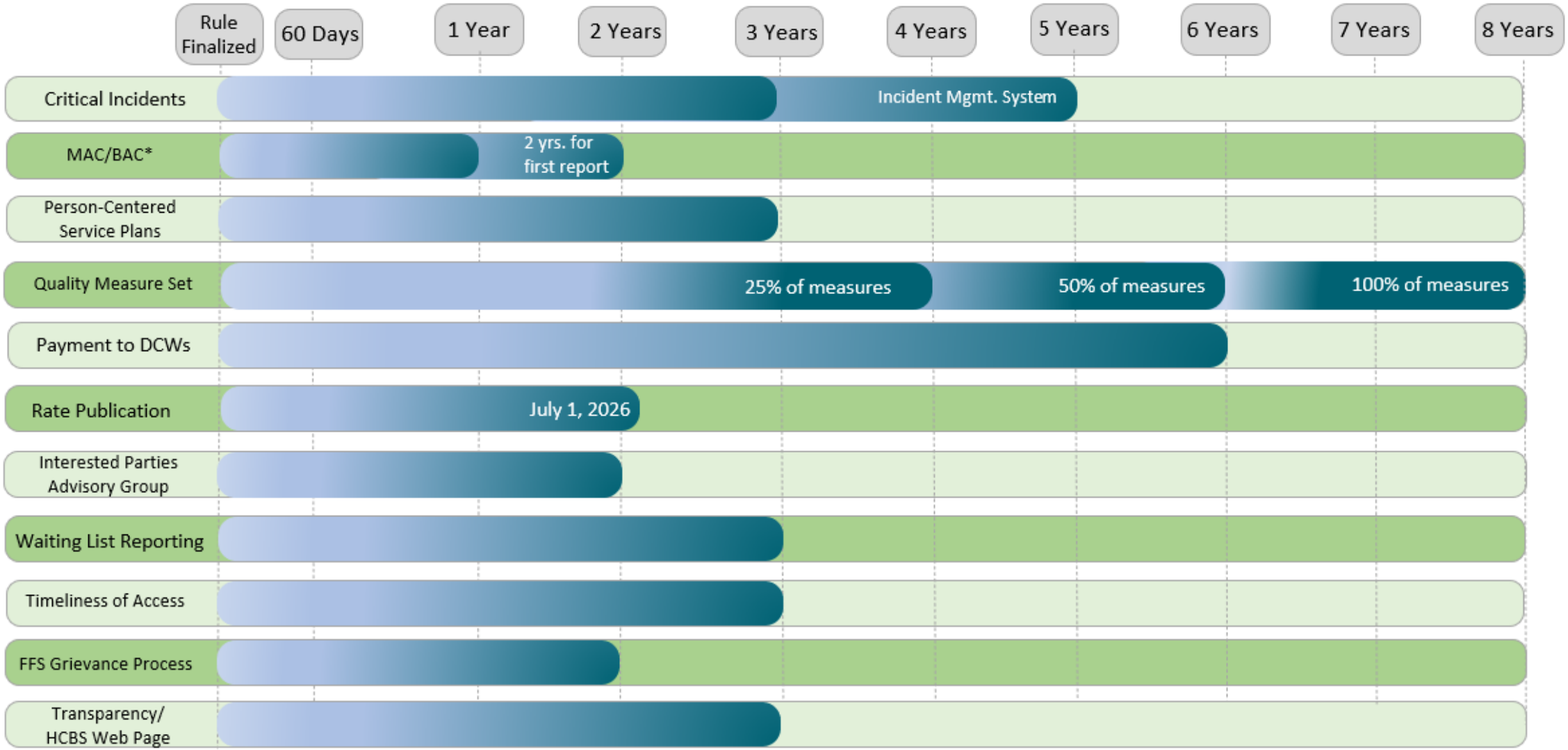
MAC and BAC must each meet on a quarterly basis, with BAC meetings preceding MAC meetings. At least two MAC meetings per year must be open to public comment.

Bylaws, governance structures, members, and minutes must be publicly posted. BAC members may choose to not have their names posted in these releases.

State agency staff must support meetings, including preparation of materials, financial supports to facilitate meaningful engagement, etc.

- 50% administrative match is available for these functions, as applicable under current MCAC rules.

Implementation Timeframes



*: Includes phased-in % of BAC members serving on the MAC over 3 years

Discussion