Home and Community-Based Services (HCBS) Payment Adequacy Provisions in the *Ensuring Access to Medicaid Services* Final Rule

July 2024

Background

- The *Ensuring Access to Medicaid Services* final rule (Access final rule) and the *Managed Care Access, Finance, and Quality* (Managed Care final rule) were issued in April 2024
- The final rules establish historic national standards for access to care regardless of whether that care is provided through managed care plans or directly by states through fee-for-service (FFS), including by:
  - Establishing national maximum standards for certain appointment wait times for Medicaid and CHIP managed care enrollees
  - Requiring states to conduct secret shopper surveys of Medicaid and CHIP managed care plans
  - Requiring states to conduct enrollee experience surveys annually for each managed care plan
  - Establishing a framework for states to implement a Medicaid and CHIP quality rating system, a "one-stop-shop" for enrollees to compare Medicaid and CHIP managed care plans
  - Creating new rate transparency requirements for FFS and managed care
  - Strengthening how states use state Medicaid Advisory Committees
  - Strengthening HCBS oversight, monitoring, quality assurance, quality improvement, and payment adequacy

Overview of HCBS Provisions

- Strengthens oversight of person-centered service planning in HCBS
- Requires states to meet nationwide incident management system standards for monitoring HCBS programs
- Requires states to establish a grievance system in FFS HCBS
- Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers
- Requires that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers, subject to certain flexibilities and exemptions
- Requires states to report on waiting lists in waiver programs and on service delivery timeliness for certain HCBS
- Requires states to report on a standardized set of HCBS quality measures and sets requirements for CMS to develop and update the measure set
- Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures

HCBS Provisions: Focused on Improving Access and Quality, Promoting Health Equity, and Strengthening the HCBS Workforce

- **Person-Centered Service Planning and Reporting Requirements** (§§ 441.301(c), 441.450(c), 441.540(c), 441.725(c), 441.311(b)(3), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Incident Management Systems and Critical Incident Reporting Requirements** (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **FFS Grievance Systems** (§§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii))
- **HCBS Payment Adequacy Reporting Requirements** (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Payment Adequacy Minimum Performance Level** (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))
- **Waiting List and Access Reporting Requirements** (§§ 441.311(d), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Quality Measure Set and Reporting Requirements** (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Website Transparency** (§§ 441.313, 441.486, 441.595, and 441.750)

HCBS Access Provisions: Applicability Dates

2026

- FFS grievance systems

2027

- Incident management system
- Critical incident reporting and minimum performance level
- Person-centered planning reporting and minimum performance level
- Waiver waiting list reporting
- ~~Access reporting~~
- HCBS payment adequacy reporting readiness
- ~~Website transparency~~

2028

- ~~HCBS Quality Measure Set reporting~~
- HCBS payment adequacy reporting

2029

- Electronic incident management system

2030

- HCBS payment adequacy minimum performance level

2031

2032

HCBS Payment Adequacy Reporting Requirements (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires states to report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers	Added as a new requirement	Beginning July 9, 2027

HCBS Payment Adequacy Reporting Requirements (cont.) (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	• Requires states to report annually on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers, subject to certain exceptions • Requires states to report separately on self-directed services and on facility-based services	• Added habilitation as a service subject to the reporting requirement • Exempted the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 • Clarified that clinical supervisors are included in the definition of direct care workers • Excluded costs associated with travel, training, and personal protective equipment (PPE) for direct care workers from the calculation • Required states to exclude data on self-directed services in which the beneficiary sets the direct care worker's payment rate • Required states to report separately on facility-based services	Beginning July 9, 2028

HCBS Payment Adequacy Minimum Performance Level (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))

Requires that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires that states generally ensure that a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions	• Changed applicability date from 4 years to 6 years • Exempted the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 • Clarified that clinical supervisors are included in the definition of direct care workers • Excluded costs associated with travel, training, and PPE for direct care workers from the calculation • Excluded self-directed services in which the beneficiary sets the direct care worker's payment rate	Beginning July 9, 2030

HCBS Payment Adequacy Minimum Performance Level (cont.) (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))

Allows flexibilities and exemptions to the requirement that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Gives states the option, subject to certain reporting requirements, to establish a hardship exemption based on a transparent state process and objective criteria for providers facing extraordinary circumstances. States must submit 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	Added as a new flexibility for states	Beginning July 9, 2030
No prior regulatory requirement	Gives states the option, subject to certain reporting requirements, to establish a separate minimum performance level for small providers meeting state-defined criteria based on a transparent state process and objective criteria. States must submit a plan, subject to CMS review and approval, for small providers to meet the 80% minimum performance requirement within a reasonable period of time	Added as a new flexibility for states	Beginning July 9, 2030
No prior regulatory requirement	CMS may waive the plan reporting requirements if the state demonstrates it has applied the small provider minimum performance level or the hardship exemption to less than 10 percent of the state's providers	Added as a new flexibility for states	Beginning July 9, 2030

Website Transparency (§§ 441.313, 441.486, 441.595, and 441.750)

Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures

Prior Requirements	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulatory requirement	Requires the state to operate a website (either directly or by linking to managed care plan websites) that provides the results of the HCBS reporting requirements and meets availability and accessibility requirements	Minor changes only	Beginning July 9, 2027
No prior regulatory requirement	Requires CMS to report on its website the results of the HCBS reporting requirements that states report to CMS	None	Beginning July 9, 2027

Questions for Discussion

- What additional information or clarification do you need from CMS to be able to report on the percent of Medicaid payments spent on compensation?
- What additional information or clarification do you need from CMS to be able to meet the minimum performance level?
- How much time do you need after the end of each calendar year to be able to report on the percent of Medicaid payments spent on compensation?
- Do you plan to report the data directly to states or would your organization use a third party to calculate and report the information to states?

Questions for Discussion (cont.)

- What recommendations do you have for how states collect the data from providers? Are there existing information systems you would want states to use to collect the data?
- States have flexibility to provide hardship exemptions from the minimum performance requirement for providers facing extraordinary circumstances. What types of factors or considerations do you think states should take into account in establishing their criteria for hardship exemptions?
- States also have flexibility to establish a separate small provider minimum performance level. What types of factors or considerations do you think states should take into account in establishing their criteria for which providers qualify for the small provider minimum performance level? What types of factors or considerations do you think states should take into account in establishing the minimum performance level that small providers need to meet?

Questions for Discussion (cont.)

- Do you have recommendations for how bundled payments (those in which multiple services are included in a single payment rates) or alternative payment models should be handled related to the HCBS payment adequacy reporting requirement or the requirement for states to meet a minimum performance level related to the percentage of payments for certain HCBS that is spent on compensation to direct care workers?

Questions?

Email HCBSAccessRule@cms.hhs.gov