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Medicaid Access Rule Impact on DD Providers & ICF Payment Transparency Rule

Will begin at 10:00 am

AGENDA

- Payment Adequacy Provision
- Payment Adequacy Reporting
- HCBS Quality Measures
- Incident Management
- Person-Centered Planning
- State Reporting and Transparency
- Waiting List/Access Reporting
- Other Provisions
- ICF Payment Transparency
- What's Next

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Payment Adequacy Provisions – Minimum Performance Level (80/20)

- Minimum performance level – 80% of Medicaid Reimbursement for specific services must be spent on compensation for direct care workers
- Services include:
  - Home Health Aide
  - Personal Care
  - Homemaker
- Habilitation is excluded from the minimum performance level provision
  - CMS will issue guidance to states with additional detail
- State can set small provider requirements and a hardship exemption

  "We note that we expect that most providers would be subject to a hardship exemption on a temporary basis, and that States would still need to collect and report data as required in § 441.302(k)(2) and § 441.311(e) for providers with hardship exemptions."
- Effective 6 years from date published in federal register (expected May 10)

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Payment Adequacy Provisions – Minimum Performance Level (80/20)

Regarding the decision to exclude habilitation services from the minimum performance level, CMS states,"…because of differences in these services, we do not believe we can set an appropriate minimum performance level for these services at this time."

"Although we are not requiring that habilitation or other facility-based services (in which services are delivered in a provider-operated physical location and for which facility-related costs are included in the Medicaid payment rate) be included in the minimum performance requirement, States are able to set wage pass-through requirements of their own for such services to promote the stability of the workforce; we also believe that States may naturally adjust rates or wages in other services in response to the implementation of the minimum performance requirement for homemaker, home health aide, and personal care services."

Payment Adequacy Provisions - Reporting Component

- Habilitation services included – in addition to Home Health Aide, Personal Care and Homemaker services
- Annually, states must report percentage of reimbursement spent on compensation for direct care wages.
- States required to report aggregated data, not at the provider level
- The state must report separately for each service and, within each service, must separately report services that are self-directed* and services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.
- Effective 4 years from date published in Federal Register

*self-directed services where beneficiary hires direct care worker are excluded, but self-directed services where beneficiary works with agency are included

Direct Care Worker Definition

- Nurses
- Certified Nursing Assistant
- Direct Support Professional
- Personal care attendant
- Home Health Aide
- Other individuals who are paid to provide services to address activities of daily living, including *nurses and other staff providing clinical supervision.*

Compensation Definition

- Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations;
- Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and
- The employer share of payroll taxes for direct care workers delivering services authorized under section 1915(c) of the Act.

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Excluded Costs

- 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

- In calculating the percentage of Medicaid reimbursement spent on compensation for direct care workers, the state will take the total reimbursement, subtract out the excluded costs and then compare to the direct care compensation amount to determine the percentage.

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HCBS Quality Measures

- July 1, 2022 CMS released a State Medicaid Director's letter (SMD#22-003) establishing the first official HCBS Quality Measure Set.
- Establishes the HCBS Quality Measure Set in regulation and requires States to report every other year according to the format and schedule prescribed by CMS. The set itself must be reviewed and updated no more frequently than every other year.
- States must report data for specific populations:
  - Fee-for-service, managed care, etc.
  - Dually eligible for Medicare and Medicaid
  - Older Adults
  - Physical Disabilities
  - Intellectual and Developmental Disabilities
  - Serious Mental Illness
  - Other Health Conditions
- States would be required to stratify data for certain measures by race, ethnicity, Tribal status, sex, age, rural/urban status, disability, language, and other factors. This stratification has a phased in approach starting with 25% of measures in 4 years and allowing up to 8 years for 100% of measures to be stratified

HCBS Quality Measures

- April 2024 HCBS QMs : https://www.medicaid.gov/media/175211
  - 10 measures from NCI-IDD in-person survey
  - 18 measures from NCI-AD in-person survey
  - 8 measures from HCBS Consumer Assessment of Healthcare Providers and Systems
  - 8 from case management data
  - 4 LTC admission, length of stay, transition & readmission measures
  - 7 personal outcome measures

- MFP early reporting requirements – States begin reporting in 2026 for 2025 data.
  - Sub-set of measures
  - States select 2 measures to create Quality Improvement Programs
  - DODD still reviewing to determine if additional data collection from providers will be needed to meet the reporting requirements.

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Incident Management

- State must operates and maintains an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.
- Critical incident must 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;
- State sets process, technology system and timelines for reporting and investigating and they must meet minimum performance levels (typically 90%)
- State reporting requirements – compliance with requirements and specific critical incident data
- Effective 3 years from the date published in the federal register

Person Centered Planning

- Creates standards for a person-centered service plan that must be reassessed for functional need at least every twelve months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- State performance levels
  - Complete a reassessment of functional need at least every 12 months for no less than 90 percent of the individuals continuously enrolled in the waiver for at least 365 days.
  - Review, and revise as appropriate, the person-centered service plan, based upon the reassessment of functional need, at least every 12 months, for no less than 90 percent of the individuals continuously enrolled in the waiver for at least 365 days.

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State Reporting – Rate Transparency

- Requires that States publish all fee-for-service rates on a website accessible to the public, including notation of the dates the payment rates were last updated. (Within 30 days of a payment rate change.)
- Rates must be organized by category of service, disclosed as an average hourly payment, identify the number of Medicaid-paid claims and enrolled beneficiaries who received the service within a calendar year alongside a comparative payment rate analysis (including habilitation).
- Any State proposing to reduce payment rates or restructure provider payments when the change could impact access, the State must provide written assurance and support that:
  - Aggregate payment rates for each category would be at or above80% of the Medicare equivalent
  - The proposed reduction or restructuring would result in no more than 4% reduction in aggregate for each category
  - Public engagement processes does not yield concerns

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State Reporting - Waiting List/Access

- Requires states to annually describe how they maintain waiting lists for 1915(c) programs.
  - Description must include eligibility for the waiting list, number of people on the waiting list, and average amount of time that individuals remain on the waiting lists.

- For homemaker, home health aide, personal care, and habilitation services, the State must report:
  - Average amount of time from when services are initially approved to when services began for individuals newly receiving services(last12 months).
  - percent of authorized hours for services that are provided within the past 12 months.

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Other Provisions

- Medicaid Advisory Committee and Beneficiary Advisory Council
  - Increases the percentage of BAC members on the MAC
    - 10% 7/9/24 – 7/9/25
    - 20% 7/10/25 – 7/9/26
    - 25% after 7/9/26
- Grievance System
  - States must establish a system for beneficiaries to file grievance against state or provider
    - Can't limit time frame for reporting grievance
    - Minimum requirement to deal with issues related to state or provider's performance regarding person centered planning and HCBS settings requirements that establish criteria where HCBS may be provided

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ICF Payment Transparency

- Part of the minimum staffing rule for nursing facilities
- Aligns with Medicaid Access rule payment adequacy reporting provision
  - 2 differences – compensation is separated for direct care staff and support staff and states must report at the facility level instead of an aggregated level
  - Compensation definition
  - Direct care worker (expanded)
  - Support Staff
    - A housekeeper;
    - A janitor or environmental services worker;
    - A groundskeeper;
    - A food service or dietary worker;
    - A driver responsible for transporting residents;
    - A security guard; or
    - Any other individual who is not a direct care worker and who maintains the physical environment of the care facility or supports other services for Medicaid-eligible individuals receiving Medicaid services under this part.
  - Excluded Costs
  - Applicability Date (Effective) 4 years after June 21, 2024

What's Next?

MEDICAID ACCESS RULE:

- Legislation
  - HR 8114 : Prohibit implementation and enforcement of the 80% minimum performance level in the final rule or anything similar in the future
- Legal Action
- Political Landscape impact
- Severability – It's important to note that the rule includes language in multiple sections that each provision of the final rule that each provision is separate from the other provisions and if any provision is determined to be invalid or unenforceable, the remainder of the provisions are not impacted.

MEDICAID PAYMENT TRANSPARENCY RULE:

- Legislation
  - HR 7513: Prohibits implementation and enforcement of the entire rule or anything similar in the future
- Legal Action
- Political Landscape impact

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QUESTIONS?

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