Analysis: Proposed Rulemaking on Ensuring Access to Medicaid Services

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) has issued a notice of proposed rulemaking, *Ensuring Access to Medicaid Services*, which seeks to improve access to care and better address health equity issues in the Medicaid program.

Several provisions of the proposed rulemaking present promising opportunities to improve quality, transparency and consistency. Among others, these include provisions that require states to publish fee-for-service payment rates, report when payment rates were last updated, report on key metrics related to waiting lists for home- and community-based services, adopt the HCBS Quality Measure Set in 1915(c) programs, and establish a critical incident tracking and reporting system.

At the same time, one proposed provision in particular risks constraining access to home- and community-based services, rather than improving it. Noting the ongoing recruitment and retention crisis in the direct care workforce, CMS has proposed a requirement that 80% of Medicaid payments be spent on compensating direct care workers. **Unfortunately, this particular provision—which is neither tested nor driven by data—risks exacerbating barriers to access by failing to address severely inadequate provider payment rates.**

The remainder of this document provides additional background on CMS's proposed rulemaking, as well as detailed analysis of the promising and concerning provisions of the proposed rule.

Notice of Proposed Rulemaking

On May 3, 2023, CMS issued a notice of proposed rulemaking, *Ensuring Access to Medicaid Services*, which seeks to improve access to care, quality, and health outcomes, and better address health equity issues in the Medicaid program across fee-for-service, managed care, and home- and community-based service delivery systems. The proposed Access Rule is intended to create benchmarks and enforcement of the statutory equal access provision to "assure payments are consistent with efficiency, economy, and quality of care" while also ensuring payments are sufficient to enlist enough providers in each geographic region.

Addressing the Direct Support Workforce Crisis

The Medicaid Home and Community Based Services (HCBS) program assists people with intellectual and developmental disabilities (I/DD) to live in their communities through a broad range of long-term services. These include support with skill development and community integration, from assistance with grocery shopping to advanced job training and employment support.

Currently, a direct support workforce crisis is impacting the ability of providers to sustain the level of services necessary to ensure access. Characterized by high turnover rates and growing vacancy rates, this workforce crisis stems from decades of underinvestment in the HCBS program. Stagnant reimbursement rates and increasing costs of care delivery have left providers unable to offer wages that are competitive with those of hourly-wage industries, such as fast food, retail, and convenience

stores. The COVID-19 pandemic exacerbated this crisis to levels that threaten the very existence of community-based services.

Requiring Minimum Performance Standards to Ensure HCBS Payment Adequacy

CMS acknowledges that the direct support workforce crisis limits access to and impacts the quality of HCBS. Simply put, "without access to a sufficient pool of direct care providers, individuals are forced to forgo having their needs met or addressed by workers without sufficient training, expertise, or experience to meet their unique needs, both of which could lead to worsening health and quality of life outcomes, loss of independence, and institutionalization*."*

In response, CMS has proposed the following new rule to ensure HCBS payment rates are adequate to attract a sufficient workforce.

- The proposed rule seeks to require states to assure that at least 80% of all Medicaid payments for homemaker services, home health aide services, and personal care services are spent on compensation to direct care workers.

Unfortunately, the proposed rule does not get at the heart of the problem: stagnant and insufficient Medicaid payment rates that do not include adequate funding for competitive wages.

- Creating a percentage threshold using existing payment rates will not raise wages for direct care workers and could have the unintended consequences of decreasing access to services and undermining quality of services.

In order to raise wages for direct care workers, payment rates must be sufficient to include competitive wages. Without necessary increases, HCBS providers will be forced to cut funding from other areas which also ensure access, such as training or supervision. This provision may also trigger an effect counter to CMS's intention by curtailing providers' investment in programming in areas such as technology and/or regulatory compliance. In worst case scenarios, smaller providers unable to shoulder the additional expense will be forced to close—a result that would certainly undermine the proposed rule's intent to ensure greater access to services.

An effective way to ensure sufficient payment for direct support workers is to require regular review and adjustment of state Medicaid payment rates. While people with I/DD primarily rely on habilitation services, addressing stagnant and insufficient payment rates supports the direct care workforce across the entire HCBS program. Regular review of payment rates which adjust for inflation and include a competitive wage within the underlying payment rate model can ensure the rule achieves its intended outcome of addressing the direct care workforce crisis and increasing access to services.

Increasing Transparency & Consistency

The proposed rule would require states to report to CMS on key metrics to ensure transparency and consistency in service utilization, authorization, and delivery.

Payment Rates

The proposed rule would require states to publish their fee-for-service Medicaid payment rates in a clearly accessible, public location on states' websites and must include the date the payment rates were last updated. The proposed rule would also require that for any state plan amendment that

reduces or restructures provider payment rates, states must demonstrate that (1) the proposed reduction or restructuring would likely result in no more than a four-percent reduction in expenditures for each benefit category, and (2) a mandatory public comment period yielded no significant access concerns from beneficiaries, providers, or other interested parties. The proposed rule would separately establish an advisory group for interested parties to advise and consult on provider rates where payments are made to direct care workers for personal care, homemaker, and home health services.

While these proposed requirements are a positive step forward in ensuring transparency, the rule should go farther by requiring regular reviews of and adjustments to payment rates. HCBS beneficiaries and providers will benefit from the increased transparency of their state's rate-setting processes and the requirement that states publish all Medicaid fee-for-service payment rates, especially the requirement that states note when payment rates were last updated. However, the proposed rule does not compel regular review of rates or inclusion of a competitive wage within the underlying payment rate model. Without these provisions, providers will be no better equipped to compete against other hourly wage industries for labor.

Waiting Lists

The proposed rule would require states to report annually to CMS on metrics regarding the state's waiting list, including (1) how the state maintains its list of individuals who are waiting to enroll in a section 1915(c) waiver program, (2) the number of people on the waiting list, and (3) the average amount of time that individuals newly enrolled in the waiver program were on the waiting list. HCBS beneficiaries and providers will benefit from the increased transparency in how states maintain their waiting lists, while states will be better positioned to quantify the accessibility of services and the scope of unmet need.

HCBS Quality Measure Set

The proposed rule would require states to use a Home and Community Based Services Quality Measure Set in 1915(c) waiver programs to promote public transparency related to the administration of Medicaid-covered HCBS and would require states to report every other year on the HCBS Quality Measure Set. Providers and beneficiaries of HCBS will benefit from the proposed rule's inclusion as part of the advisory group that informs the composition of the Home and Community Based Services Quality Measure Set. While ensuring quality is critical to access, it is crucial that the process provides adequate opportunity for public input to prevent unnecessary administrative barriers.

Critical Incident Systems

The proposed rule would define critical incidents and require states to operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. The proposed rule would also require providers to report critical incidents and use data from Medicaid fraud control units and other state agencies to cross reference and verify. Finally, the proposed rule would require providers to report every 24 months on the result of critical incident management system assessments with performance benchmarks for response.

Although we applaud these provisions for the ways they seek to ensure beneficiaries and providers benefit from greater transparency and standardization across states, it should be noted that implementation will require adequate time and funding to adapt systems accordingly.

Additional Protections for Beneficiaries

Beneficiaries of HCBS and their families will benefit from requirements that states (1) establish clearer processes that allow for the filing of grievances, (2) reassess person-centered plans annually, and (3) enhance transparency regarding critical incidents and quality measure set reporting. Beneficiaries will also benefit from increased oversight through the creation of a Medicaid Advisory Committee (MAC) with a dedicated Beneficiary Advisory Group (BAG). These protections strengthen the infrastructure of HCBS by creating more transparency and more opportunities for stakeholder engagement and response.

Contact

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