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Medicaid Access Rule Impact on AL Providers

Will begin at 11:30 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
- 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
- Applied to following parts of Medicaid:
  - 1915(c)
  - 1915(i)
  - 1915(j)
  - 1915(k)
  - 1115
  - NOT applied to 1905(a) [State plan]
- Services include:
  - Home Health Aide
  - Personal Care
  - Homemaker
- Effective 6 years from date published in federal register (expected May 10)

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

- Services (b)(2) through (4) of 42 CFR 440.180
  - (b) ***Included services.*** Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
    - (1) Case management services.
    - (2) Homemaker services.
    - (3) Home health aide services.
    - (4) Personal care services.
    - (5) Adult day health services.
    - (6) Habilitation services.
    - (7) Respite care services.
    - (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
    - (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

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

- Components of Rule only apply to RCF providers under Assisted Living Waiver
- Ohio Assisted Living Waiver
  - 1915 (c) Waiver
  - "Other- Residential" Services
  - Does included personal care under bundled payment, but not categorized as such on the CMS Waiver application
- 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."

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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

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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.

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.
- Measures must be updated by December 31, 2026
- 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.
- April 2024 HCBS QMs : https://www.medicaid.gov/media/175211

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HCBS Quality Measures

- 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

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;

Incident Management

- 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

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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

- By July 1, 2026, 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.)
  - Must show variations in rates based on population
  - Show geographic payment differences (if applicable)
  - For personal care, homemaker, home health aide and homemaker, must clearly identify the average hourly payment rates
  - Delineate components of a bundled rate
  - Show variations in self-direction, pediatric/adult, inclusion of facility costs
  - Show number of Medicaid paid claims within a calendar year for each service

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State Reporting – Rate Transparency

- 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 above 80% of the Medicare equivalent
  - The proposed reduction or restructuring would result in no more than 4% reduction in aggregate for each category
  - Services without corresponding Medicare services (such as Assisted Living) would always be subject to higher reporting requirements
  - 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 effective 2 years from effective date of final rule (May 2026)
  - 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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What's Next?

- 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.

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QUESTIONS?

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