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CMS Finalizes Major Regulatory Changes to Medicaid Access Standards and HCBS

Overview

On April 22, 2024, CMS issued a Final Rule aimed at enhancing access to and transparency of Medicaid services, including HCBS. This rule pairs with two other final rules published in April 2024 that focus on improving Medicaid eligibility and access to Medicaid services. Although this rule is focused on a fee-for-service (FFS) system, many of these requirements could impact additional states, such as changes to underlying FFS rates in base data and rate setting for managed long-term services and supports (MLTSS).

CMS finalized most of its rules, as proposed. The most notable changes between the proposed and final rules are:

- CMS added habilitative services to reporting payment transparency/disclosure and payment adequacy requirements.
- CMS exempted self-directed services from the payment adequacy and reporting requirements.
- CMS modified the application of the 80% rule to give states six years to implement and refine the elements of the calculation, added new readiness reporting requirements, and provided a limited set of provider exemptions.
- CMS revised the FFS grievance provision including removing the requirement for an expedited grievance resolution process.
- CMS extended the compliance dates for certain provisions (e.g., implementation of an electronic incident management system).

A list of implementation dates can be found at the end of this Flash.

Mercer Government previously prepared an overview on the Financial Requirements and the Access and Quality Requirements that are found in the Medicaid managed care final rule.

FFS State Plan Procedures and Access Reviews

States are no longer required to submit the Access Monitoring Review Plans every three years. Instead, states are now required to meet the following standards for Medicaid State Plan Amendments (SPAs) in cases when provider reimbursement rates are reduced or restructured.

- **Two-tiered analysis of rate reduction impact.** States must complete a two-tier access analysis. First, states must complete an analysis to determine whether certain conditions are not met (e.g., aggregate payments rates are above 80% of Medicare, the rate reduction is less than 4%, and public comments do not identify concerns). If any of those conditions are not met, then states must complete a more extensive analysis demonstrating that approval of the SPA will not impact access to care.

- **Care access monitoring.** After SPA approval, states must have monitoring systems to address access issues. If issues are identified, states must submit a corrective action plan.

FFS Payment Rate Transparency and Comparative Rate Analyses

The rule adopts several reimbursement transparency requirements, including the following standards that states will need to comply with:

- **Publicly accessible fee schedules.** States must post all FFS Medicaid fee schedules on a publicly accessible website, including when rates differ by various demographic factors. In cases where Medicaid programs use bundled payment rates, states are required to identify each individual service included in the bundled rate and how much of the payment is allocated to each respective service.

- **Comparative rate analysis.** States must complete comparative FFS reimbursement rate analyses for primary care, OB/GYN, and outpatient behavioral health services relative to Medicare rates in the same manner as managed care organizations must complete an analysis in the Managed Care Rule.

- **Payment Rate Disclosure.** States must post rates for personal care, home health aides, homemaker services, and habilitation services converted into hourly rates (HCBS hourly rate reporting is discussed in greater detail below in HCBS section).

HCBS and MLTSS

The Rule replaces 2014 CMS guidance on monitoring and reporting for HCBS programs, which includes MLTSS programs authorized through any authority, including 1115 waivers, other than a 1905(a) State Plan. These changes are intended to refocus HCBS programs on person-centered planning, health and welfare, access, participant protections, and quality improvement.

- **Payment transparency and reporting.** States are required to report on hourly reimbursement rates for personal care, home health, homemaker services, and habilitative services. The addition of habilitative services is new in the Final Rule. Rate information must be reported by categories of service and separated for individual direct care workers and those employed by an agency. Additional reporting is required on the number of paid claims and number of participants using HCBS.

- **Minimum of 80% of Medicaid payment for personal care, homemaker, and home health aide services must be spent on direct care worker compensation.** The Rule defines "compensation" as salaries and wages, worker benefits (e.g., health and dental benefits, sick leave, and tuition reimbursement), and employer share of payroll taxes. States are also required to report on their readiness to report payment rate adequacy of direct care workers prior to when the actual reporting requirements take effect.
- **Nationally standardized HCBS quality measures.** States are required to report on nationally standardized HCBS quality measures and progress towards meeting state-developed performance targets. Reporting will be required every other year, with a phased-in approach to compliance, and states must develop quality improvement strategies.
- **Oversight and monitoring.** The Rule requires HCBS and MLTSS oversight with the following standards:
  - **Reassessment of need.** To demonstrate appropriate person-centered planning, reassessment of need must be completed at least annually, and states must ensure service plans are reviewed and revised annually based on that reassessment.
  - **Member grievances.** State Medicaid FFS programs must establish a new grievance process for HCBS enrollees. Managed care programs continue to follow Medicaid managed care regulations.
  - **Electronic incident management.** States must develop an electronic incident management system (using a common minimum definition for what is considered a critical incident) and investigate, address, and report on the outcomes of the incidents within specified timeframes.
  - **HCBS waiver waitlist reporting.** States must report information on HCBS waiver waitlists, including the length of the waitlists, how the list is maintained, screening requirements, and length of time newly enrolled individuals have been on the list.
  - **Service access reporting.** States must report whether participants can access services across HCBS authorities once the services are approved.

Medicaid Advisory Committee and Benefit Advisory Council

The Rule replaces the current requirement for states to maintain a Medical Care Advisory Committee (MCAC) with a "Medicaid Advisory Committee" (MAC). The Rule also requires states to develop and maintain a "Beneficiary Advisory Council" (BAC). The purpose of the MAC and BAC is to advise the state on issues related to health and medical services (as the MCAC did), but also on Medicaid policy. There are several administrative requirements for states on MAC and BAC operations.

Effective Dates

The Rule's effective date is July 9, 2024, which is 60 days post-publication, but several provisions have delayed enforcement dates. The table below is meant to be a shorthand for teams to reference when considering the impacts of the rule.

Policy	Compliance Date
MAC and BAC	July 9, 2025
Phase-in crossover membership	Immediately, but fully phased-in over three years
Annual Reporting	July 9, 2026
FFS State Plan Access Reviews	
Rate reduction and restructuring SPA procedures and access review	July 9, 2024
FFS Payment Rate Transparency and Comparative Rate Analyses	
Post and maintain publicly accessible Medicaid fee schedules	July 1, 2026, then updated within 30 days of a payment rate change
Comparative rate analysis for primary care, OB/GYN, and outpatient behavioral health services	July 1, 2026, then every two years
Publish the average hourly rate paid for personal care, home health aide, homemaker, and habilitation services, and publish the disclosure every two years	July 1, 2026, then every two years
Establish an advisory group on payment rates for direct care workers for personal care, home health aide, homemaker, and habilitation services	First meeting must occur by July 9, 2026 and then at least every two years
HCBS and MLTSS	
Strengthened person-centered planning	July 9, 2027; for MLTSS, the first rating period following this date
Nationwide electronic incident management system standards	July 9, 2029; for MLTSS, the first rating period following this date
HCBS FFS Grievance System	July 9, 2026
State readiness and reporting on compensation for personal care, home health care, homemaker services, and habilitation services	July 9, 2027; for MLTSS, the first rating period following this date
Payment rate adequacy reporting requirements for compensation for personal care, home health care, homemaker services, and habilitation services	July 9, 2028; for MLTSS, the first rating period following this date
80% rule for direct care worker compensation (not including habilitation services)	July 9, 2030; for MLTSS, the first rating period following this date
HCBS Access to Services, including waiver waiting list reporting	July 9, 2027; for MLTSS, the first rating period following this date
Requirement for states to report on nationally standardized HCBS quality measures and progress towards meeting goals	July 9, 2027; for MLTSS, the first rating period following this date

Caveats and limitations

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