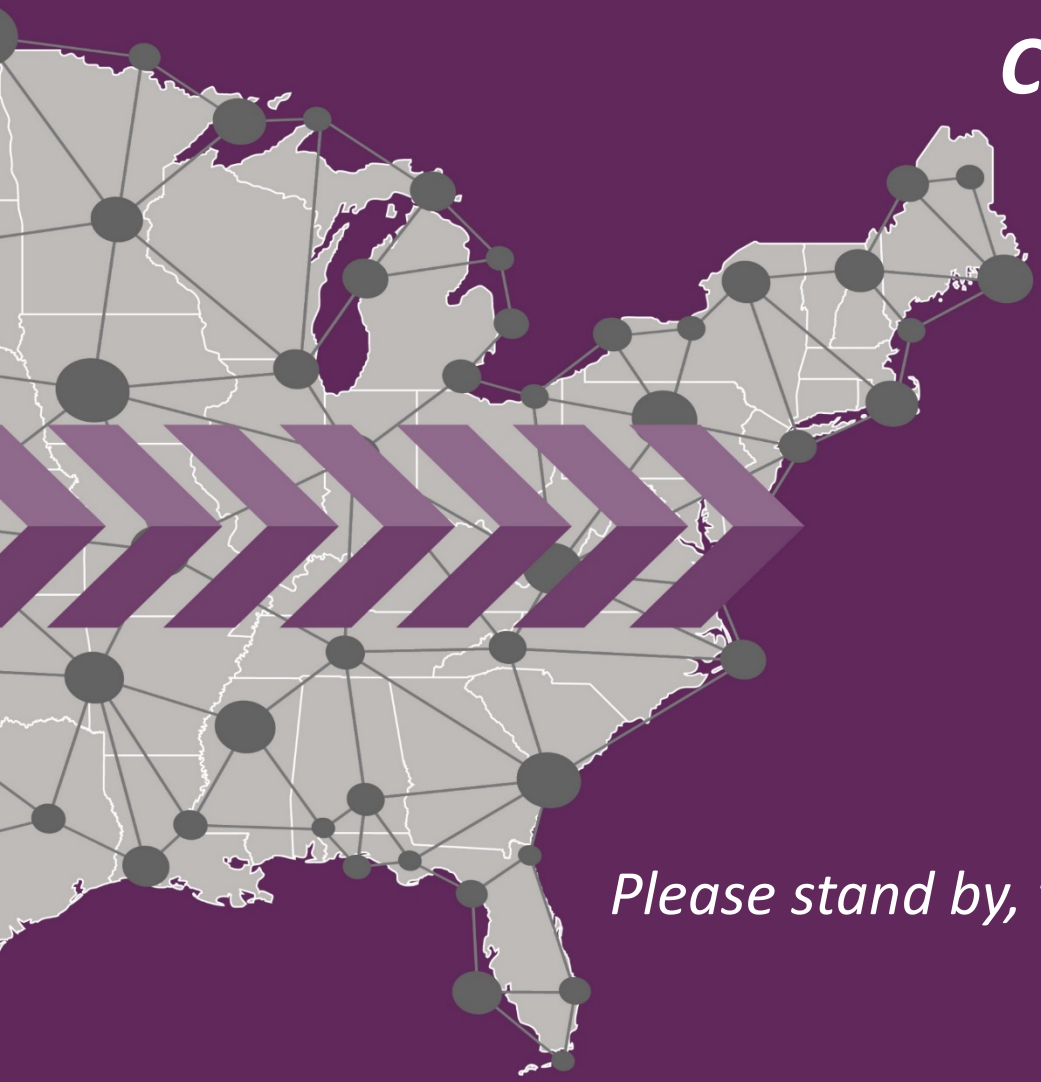

CMS Final Rules Part 3: Home and Community-Based Services

June 6, 2024

2:30 – 3:30 p.m. ET

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES

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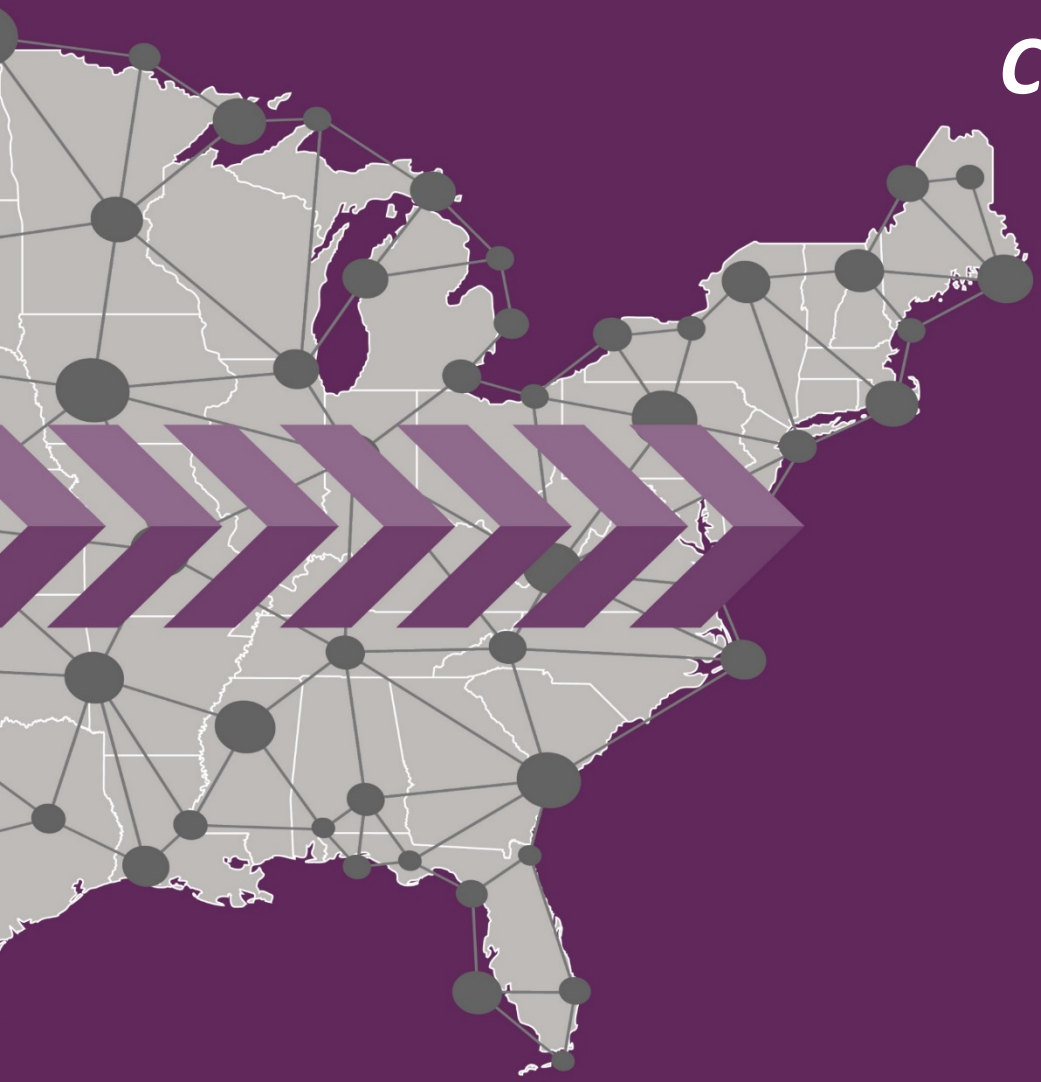

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation.
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About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Webinar Series on Centers for Medicare & Medicaid Services (CMS) Final Rules

This is the final webinar in our three-part series on the Medicaid Access and Managed Care final rules. You can view our May 9 and May 20 webinars at the links below.

CMS Final Rules Part 1:

Access, Enrollee Engagement, and Provider Payment Transparency

Thursday, May 9, 2024, 3:00 to 4:00 p.m. ET

See this link

CMS Final Rules Part 2:

Managed Care Payments, Quality, and Oversight

Monday, May 20, 2024, 3:00 to 4:00 p.m. ET

See this link

CMS Final Rules Part 3:

Home and Community-Based Services (HCBS)

Thursday, June 6, 2024, 2:30 to 3:30 p.m. ET ***(Today)***

Agenda

- **Level-Setting**
  - Medicaid HCBS
  - CMS Managed Care and Access Final Rules

- **HCBS Provisions in the Access Final Rule**
  - Payment for Home Care and Habilitation Services
  - Oversight of HCBS Access, Quality, and Safety

- **Discussion**

Level-Setting

Background on Medicaid HCBS (1/2)

HCBS address the needs of people with functional limitations through person-centered care delivered in the home and the community; HCBS are often designed to enable people to stay in their homes.

Examples of HCBS:

In the Home	On the Job and in the Community	Other Supportive Services
✓ Assistance with activities of daily living (e.g., toileting, transferring). ✓ Help with chores and other in-home activities. ✓ Home health services (including nursing and home health aide services).*	✓ Job coaching. ✓ Community volunteering. ✓ Day programs.	✓ Case management. ✓ Psychosocial rehabilitation. ✓ Assistive equipment and technology.

**All states are required to provide home health services. All other HCBS are provided at state option.*

Medicaid Authorities for HCBS:

States may cover certain HCBS under the Medicaid state plan pursuant to section 1905(a) of the Social Security Act (SSA).	**States can develop targeted HCBS programs under section 1915 of the SSA:** ✓ **1915(c)** waivers for targeted populations who would otherwise need institutional care. ✓ **1915(i)** state plan option for targeted populations below an institutional level of care. ✓ **1915(j)** state plan option for self-directed personal assistant services. ✓ **1915(k)** Community First Choice state plan option to provide HCBS personal attendant services/supports for individuals meeting an institutional level of care	**States can cover HCBS under section 1115 demonstration waivers.**

Background on Medicaid HCBS (2/2)

Populations Eligible for HCBS

All states provide HCBS to:

- People with intellectual and developmental disabilities.
- Older adults.
- Nonelderly people with physical disabilities.

Some states also target HCBS services to populations such as:

- Individuals with traumatic brain or spinal cord injuries.
- Medically fragile children.
- People with serious behavioral health needs.

To qualify for HCBS, individuals may be required to meet additional eligibility criteria based on functional status, income, and assets.

Delivery of HCBS

Covered Provider Types:

- Professional direct care workers (DCWs).
  - All states cover the services of HCBS agencies, meaning corporate entities that employ individual DCWs.
  - Most states cover independent providers (IPs) for at least some services, referring to DCWs that are employed by the consumer, or jointly by the consumer and state.
- Paid family caregivers. As of 2022, 48 states allow legally responsible relatives to be paid providers of HCBS waiver services.
- Unpaid caregivers. For many people with functional limitations, informal caregivers—such as family or friends—provide HCBS-like services without receiving any payment.

Self-Direction Opportunities:

- "Self-direction" allows enrollees to select and dismiss their direct care workers, determine worker schedules, set worker payment rates, and/or allocate their service budgets.

Source: KFF, State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic; KFF, Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey.

= Today's Focus
★ = Significantly Modified from Proposed Rule

Summary of Provisions in the Final Rules

As in the proposed rules, the final rules describe complementary policies that often align across managed care and fee-for-service (FFS) delivery systems.

Managed Care Final Rule

- Strengthens access to care and monitoring through appointment wait time standards and secret shopper/enrollee surveys; and includes guidance on how telehealth can play a role.
- Creates new reimbursement transparency requirements.
- ★ Codifies and revises the federal regulations governing state-directed payments, including by prohibiting the use of separate payment terms.
- Codifies and builds on recent CMS policy changes related to in lieu of services.
- Modifies medical loss ratio methodologies and processes.
- Establishes new quality requirements, including a framework and enhanced requirements for managed care quality rating systems.

Access Final Rule

- Creates new transparency and consultation requirements for FFS provider payment rates.
- Modifies the procedures for requesting federal approval to reduce or restructure FFS rates.
- Strengthens program advisory groups.
- ★ Establishes new payment standards for certain HCBS.
- Updates HCBS program standards and processes regarding care access and quality.

Implementation Timeframe
July 9, 2024 – 2030

Although the final rules formally take effect on July 9, 2024, CMS has defined implementation deadlines over the next six years, in addition to defining new exceptions and areas of state flexibility.

Source: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Key HCBS Provisions in the Access Rule

The Access Rule includes several provisions to enhance access to HCBS and standardize quality measures and reporting requirements:

Payment for HCBS and DCWs

1. Payment Adequacy
2. Payment Transparency
3. Interested Parties' Advisory Group

Oversight of HCBS Access, Quality, and Safety

1. Person-Centered Service Plan
2. Grievance Systems
3. Incident Management System
4. Access Reporting
5. HCBS Quality Measure Set
6. HCBS Reporting Requirements and Transparency

Framing CMS' HCBS Program Changes

- Except as otherwise noted or explicitly waived, these provisions:
  - **Apply across Medicaid FFS and managed care.**
  - **Apply across 1915 HCBS authorities** (1915(c), (i), (j), and (k)) **and section 1115 demonstrations,** but *not* to HCBS under the Medicaid state plan as defined at section 1905(a) of the SSA.
- **Certain provisions—including the payment provisions—focus on a subset of HCBS:** Home care (i.e., personal care, home health aide, and homemaker services), and—new in the final rule—habilitation.*
- Many of the non-payment provisions are **intended to supersede the performance and reporting requirements** set forth in CMS' 2014 guidance on HCBS quality assurance systems.

*States use varying terms to refer to these services. Although certain HCBS provisions were proposed as applying only to home care services, **the final rule added habilitation services (including residential, day, or home-based habilitation services)** in response to public comments emphasizing the important role of habilitation services for enrollees with intellectual and developmental disabilities.

HCBS Provisions Implementation Timeline (1/2)

HCBS Payment Provisions *(Access Rule)*	Effective Date*	Material Changes from the Proposed Rule
Payment Adequacy	**July 10, 2028** (for managed care, first rating period beginning on/after): Annual reporting on DCW compensation percentage for home care and habilitation services.	▪ Reporting (but not the 80% compensation standard) now applies to habilitation services as well as home care services. ▪ Longer implementation timeline. ▪ New exclusions and flexibility for state-defined exemptions.
	July 9, 2030 (for managed care, first rating period beginning on/after): Compliance with the 80% compensation standard for home care (but not habilitation).	
Payment Rate Transparency	**July 1, 2026** (using Medicaid payment rates in effect as of July 1, 2025).	Now applies to habilitation services as well as home care services.
Interested Parties' Advisory Group	**July 9, 2026.**	Now applies to habilitation services as well as home care services.

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.

HCBS Provisions Implementation Timeline (2/2)

HCBS Non-Payment Provisions *(Access Rule)*	Effective Date*	Material Changes from the Proposed Rule
Person-Centered Service Plan	**July 9, 2027** (for managed care, first rating period beginning on/after).	Finalized as proposed.
Grievance Systems	**July 9, 2026.**	CMS did not finalize proposed provisions on expedited grievances.
Incident Management System	**July 9, 2027:** All requirements except as noted below (for managed care, first rating period beginning on/after).	Longer implementation period.
	July 9, 2029: Electronic critical incident data collection, tracking, and trending (for managed care, first rating period beginning on/after).	
Access Reporting	**July 9, 2027** (for managed care, first rating period beginning on/after). Thereafter, states must report annually.	Now applies to habilitation services as well as home care services.
HCBS Quality Measure Set	**July 10, 2028** (for managed care, first rating period beginning on/after). Thereafter, states must report every other year.	▪ Longer implementation period. ▪ Modified cadence for measure updates.
Website Availability and Accessibility	**July 9, 2027** (for managed care, first rating period beginning on/after).	Finalized as proposed.

*This chart lists the initial implementation deadline for each provision. In some cases, additional requirements will phase in over a longer timeline.

HCBS Provisions: Payment for Home Care and Habilitation Services

Context: Direct Care Workforce Challenges

CMS acknowledges and seeks to address the direct care workforce crisis: "Direct care workers typically earn low wages and receive limited benefits, contributing to a shortage of direct care workers and high rates of turnover in this workforce, which can limit access to and impact the quality of HCBS."

Workforce Shortages Create Access Issues

- **Millions of older adults and people with disabilities depend on HCBS** to continue living safely at home and in the community versus moving into an institution.
- **Workforce shortages are becoming more acute over time** due to the aging population and the "rebalancing" trend away from institutions and toward community living.
- From 2013 to 2019, **the number of home care workers per 100 HCBS participants declined by almost 12%.**[1]
- **Four out of five Medicaid HCBS consumers report unmet needs** for self-care and other services.[2]

This Is an Equity Issue

- The home care workforce is disproportionately composed of low-income women of color.[3]
- Medicaid HCBS consumers, by definition, have low incomes and physical or intellectual impairments. The Medicaid program disproportionately serves people of color.

Fast Facts

	The Home Care Workforce[3]	Living Wage for a Family of Four[4]
Median hourly wage	**$14.50**	**$25.02**
Median annual income	**$20,599**	**$104,077**
% of home care workers who rely on public benefits	**55%**	

Source: Health Affairs, The Home Care Workforce Has Not Kept Pace With Growth In Home And Community-Based Services; Brandeis Heller School for Social Policy and Management, Care Can't Wait: How Do Inadequate Home- and Community-Based Services Affect Community Living and Health Outcomes?; PHI, Direct Care Workers in the United States: Key Facts (2023); MIT, 2023 Living Wage Calculator.

Payment Adequacy for Home Care and Habilitation DCWs (1/2)

CMS finalized a requirement that 80% of Medicaid payments for home care services must go to "compensation" for home care workers, plus related reporting for habilitation.

Calculating the Compensation %

- **Eligible DCWs** include licensed and unlicensed workers performing eligible services, including nursing staff who provide nursing services to HCBS recipients or (new in final rule) clinical supervision for workers.
- **Eligible "compensation"** includes salary/wages, benefits, and the employer share of payroll taxes.

Reporting Requirements

- **By July 2028, states must report annually on the DCW compensation %** for home care and habilitation services. Separate compensation reporting is required for:
  - Each type of service; and
  - Within each service type, services that are: (1) Self-directed and/or (2) delivered at a provider site with facility costs built into the payment rate (most relevant for habilitation services).

  (By July 2027, states must report to CMS on their readiness to begin these annual reports.)
- **By July 2030,** states and providers must comply with the 80% compensation standard for home care (but not habilitation).

Payment Adequacy for Home Care and Habilitation DCWs (2/2)

In the final rule, CMS created new exclusions and flexibilities for states and providers in response to stakeholder concerns.

Automatic Exclusions From DCW Compensation Calculation

- **Excluded costs.** Before calculating the DCW compensation percentage, exclude the following costs from total payments:
  (1) Required trainings;
  (2) Worker travel; and
  (3) Personal protective equipment.

- **Excluded providers** not subject to the 80% standard:
  (1) Workers under a self-directed model with enrollee-determined rates (i.e., with "budget authority"); and
  (2) Indian Health Service and Tribal health programs.

Optional State-Defined Exemptions From the 80% Standard

- For **small providers**, the state may establish a compensation threshold below 80%.
- States may temporarily exempt providers that face "**extraordinary circumstances**" from the 80% standard.

States have flexibility to define "small providers" and "extraordinary circumstances," but must use:

- Reasonable, objective criteria; and
- A transparent process with **public notice and comment.**

***Note**: Additional reporting requirements apply if more than 10% of providers receive an exemption.*

HCBS Payment Rate Transparency

The final rule requires standardized reporting on provider rates for home care and habilitation services.

Requirements	Reporting
FFS	
▪ States must publish their payment rates in the form of **an hourly payment rate** (regardless of whether the state pays for such services on an hourly, daily, or other basis). ▪ Within each service category, **separate reporting** is required if rates vary based on: – Whether the payment is made to an agency vs. directly to an IP. – Provider type, adult vs. pediatric patient, or geographical location. – Whether the payment rate includes facility-related costs (re: habilitation services). ▪ States must also disclose, for each service, **the number of Medicaid-paid claims and the number of enrollees who received a service** within a calendar year (separate reporting for agencies vs. IPs).	**Beginning July 2026,** states must publish a new analysis **every other year** along with recommendations from the HCBS Interested Parties' Advisory Group.
Managed Care	
▪ States must publish an analysis of (1) **total spending on each service type** and (2) **a comparison of those total managed care payments against FFS**, for adult and pediatric consumers (i.e., how much would the FFS program have paid for the same services?). ▪ States must report for **each plan** and a **weighted statewide average** for each service type.	**Beginning July 2026,** states must publish an analysis **every year**.

Interested Parties' Advisory Group

States must establish an advisory group to "advise and consult" on payment rates and access metrics for home care and habilitation services.

New Requirements

Advisory group membership must include, at a minimum:

- DCWs.
- Medicaid enrollees.
- Authorized representatives of Medicaid enrollees.
- "Other interested parties impacted by the services rates in question, as determined by the State" (e.g., unions, family members, HCBS provider agencies, advocacy organizations).

Reporting Requirements

- **Beginning July 2026, the advisory group must meet at least every other year** to issue "recommendations to the Medicaid agency on the sufficiency of … direct care worker payment rates" under all HCBS authorities (including section 1905(a) state plan services).
- The state must **provide the advisory group with relevant data** on HCBS payment rates and enrollees' access to services.
- Although the state is not required to adopt the advisory group's recommendations, **the state must publish these recommendations** along with the biennial report on FFS home care rate transparency.

Reminder: *States may receive a* ***50% federal match*** *for expenses related to advisory groups.*

CMS also finalized requirements for a **Medicaid Advisory Committee (MAC)** and a **Beneficiary Advisory Council (BAC)** to advise on a range of Medicaid issues pertaining to eligibility, coverage, payment, etc. States are permitted, but not required, to have the MAC perform the functions of the Interested Parties' Advisory Group, so long as the MAC satisfies all relevant requirements.

HCBS Provisions: Oversight of HCBS Access, Quality, and Safety

Person-Centered Service Plan

The final rule revises and strengthens state reporting requirements related to the completion of person-centered service plans.

- Medicaid-covered HCBS must be provided under a **person-centered service plan** that reflects the individual's personal goals and maximizes their independence.
- Currently, states are required to reassess an individual's functional needs and make appropriate revisions to the person-centered service plan:
  1. At least once every 12 months;
  2. If the individual's needs change "significantly"; or
  3. If the individual requests a change to their plan.

- **Finalized Changes to the Compliance Threshold**. States will be required to demonstrate that these steps were completed for at least 90% of individuals enrolled in the waiver for at least 365 days—up from the current compliance threshold of 86%.
- **Reporting Requirements**. The final rule requires states to report annually on the percentage of individuals continuously enrolled for at least 365 days:
  1. For whom a reassessment of functional need was completed within the past 12 months; and
  2. Who had a service plan updated as a result of reassessment within the past 12 months.

Note: For both new reporting metrics, states may report on a statistically valid random sample, rather than for all individuals.

Grievance Systems for HCBS Recipients

CMS requires states to establish an HCBS grievance system for FFS enrollees to file complaints about state/ provider performance with person-centered planning, service plans, and HCBS settings requirements.

- Current federal law requires a complaint or "grievance" system to be established for all enrollees of Medicaid managed care plans, but no such requirement exists for FFS delivery systems (although they can appeal adverse actions affecting eligibility or benefits).
- The new HCBS FFS grievance system is modeled on existing requirements for managed care plans.

State Requirements. Among other requirements, the HCBS FFS grievance system* must:

- ✓ Accept grievances either orally or in writing and provide individuals with reasonable assistance in completing the necessary procedural steps (including ensuring accessibility for individuals with disabilities or limited English proficiency);
- ✓ Allow another individual or entity to file a grievance on one's behalf with written consent (subject to "conflict of interest" guidelines);
- ✓ Ensure decisions on grievances are not made by individuals involved with the issue being addressed;
- ✓ Provide individuals with a reasonable opportunity to present evidence related to their grievance, with their case files or other related information, and with translation and interpreter services; and
- ✓ Resolve grievances within 90 days of receipt.**

*CMS proposed, but did not finalize, a requirement for states to have a 14-day expedited resolution process for situations involving substantial risk to the individual's health, safety, or welfare. In the final rule, CMS encourages states to establish a process for identifying, triaging, and expediting resolution of grievances based on prioritization criteria.

**May be extended up to 14 additional days if an individual requests an extension or if the state documents a need for additional information and how the delay is in the individual's best interest.

Incident Management System

The final rule requires states to implement an electronic incident management system, collect a range of data to identify critical incidents, and meet new reporting requirements.

Electronic Incident Management Systems

- States must maintain an **electronic incident management system** that "identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents."
- CMS establishes a comprehensive common **minimum definition of "critical incident,"** which states may build upon.

Data Sources and Data-Sharing Agreements

- States must use a **variety of data sources** to identify critical incidents.
- States are required to **establish data-sharing agreements** with any other entities not identified in the final rule that investigate critical instances.

Reporting Requirements

- States are required to **report annually on how they initiate and complete investigations** into critical incidents and complete corrective actions (as needed) within state-specified timeframes.
  - CMS raises the performance standard for initiating and completing investigations and corrective actions to 90%—up from the current 86%.
- **States must report every 24 months on the results of an "incident management system assessment"** to demonstrate compliance with system requirements (may be reduced to once every 60 months if deemed in compliance).

The state's definition of a "critical incident" must include, at a minimum:

- Verbal, physical, sexual, psychological, or emotional abuse, as well as neglect;
- Exploitation, including financial exploitation;
- Misuse or unauthorized use of restrictive interventions or seclusion;
- 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
- An unexplained or unanticipated death, including a death caused by abuse or neglect.

Reminder: States may receive enhanced federal funding for information technology investments that meet the requirements for a Medicaid Enterprise System.

HCBS Access Reporting

The final rule creates several new annual reporting requirements for states related to HCBS waiver waiting lists, timely access to HCBS, and HCBS utilization.

Waiting Lists. States must report how they maintain waiting lists, whether the state screens/rescreens people on the waiting list for waiver program eligibility, the number of people on the waiting list (if applicable), and the average amount of time individuals newly enrolled in the past 12 months spent on the waiting list.

Timely Access. States must report on the average amount of time between HCBS being approved and when services begin for individuals newly approved to begin receiving services within the past 12 months.

Service Utilization. States must report on the percent of authorized HCBS hours that were actually provided in the past 12 months.

Both requirements apply to personal care, home health aide, homemaker, and habilitation services. States are permitted to report on a statistically valid random sample.

The final rule requires states to share FFS HCBS access reporting data with the **Interested Parties' Advisory Group**.

HCBS Quality Measure Set

States must establish performance targets and begin reporting on the HCBS Quality Measure Set (which has been voluntary to date).

- **Reporting Requirements.**
  - States must report every other year on a subset of mandatory measures, in addition to any measures that CMS will report on behalf of the states.
  - CMS will also require states to establish performance targets, subject to CMS approval, for each of these measures, and to describe the quality improvement strategies they will pursue to achieve performance targets.
- **Phasing-In Reporting.** The final rule authorizes CMS to phase in reporting of certain mandatory measures, reporting for certain populations, and measure stratification requirements.
- **Updates to the HCBS Quality Measure Set.** CMS will update the HCBS Quality Measure Set over time (at most, every other year*). This must be done in consultation with states and other interested parties and allow for public comment.

CMS will ensure that measures are evidence-based and feasible for state- and program-level reporting, as appropriate, and will further identify:

- ✓ How to collect and calculate measurement data.
- ✓ Standardized reporting formats.
- ✓ Identifying populations for which states are required to report measures.
- ✓ Subset of measures for which data must be stratified by race, ethnicity, sex, age, rural/urban status, disability, language, etc.
- ✓ How to establish state performance targets.

*Down from "at least every other year" under the proposed rule, responding to commenter concerns about implementation costs.

Website Availability and Accessibility

States must maintain an accessible website to house the various HCBS reports described in CMS' Access Final Rule.

In the preamble, CMS acknowledged stakeholder concerns that, currently, it can be "difficult to find information on HCBS access, quality, and outcomes in many States."

Reports That Must Be Posted on the Website

- Person-centered planning
- Incident management and critical incidents
- HCBS Quality Measure Set
- Access reporting data
- HCBS payment adequacy (i.e., the direct care worker compensation percentage)

Note: *States may consider posting additional HCBS information on this website, such as their biennial HCBS payment disclosure and the report from their Interested Parties' Advisory Group.*

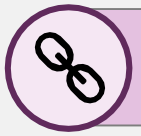
All content must be included in a single website, either posted directly or by linking to managed care plan websites.

At least quarterly, states will be required to confirm the accurate function of the website and the timeliness of the information and links.

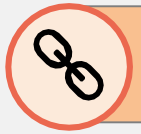
CMS will publish data submitted by the states on its own website to provide HCBS comparative data, and for potential use in the CMS Medicaid and CHIP Scorecard.

Discussion

The slides and a recording of the webinar are available at www.shvs.org.



The Managed Care Final Rule is available here.



The Access Final Rule is available here.

Thank You

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Appendix

Medicaid's Federal Regulatory Landscape

On April 22, 2024, CMS finalized two rules that flow from a years-long process to develop a "comprehensive access strategy" in Medicaid and the Children's Health Insurance Program (CHIP).

2022

CMS Request for Information on issues related to access, payment, and eligibility and enrollment (E&E)*

7,000+ stakeholder comments

2023

Managed Care Access, Finance, and Quality Proposed Rule (the "Managed Care Proposed Rule")

Ensuring Access to Medicaid Services Proposed Rule (the "Access Proposed Rule")

>2,500 stakeholder comments (415 on Managed Care & >2100 on Access)

2024

Managed Care Final Rule

Access Final Rule

These rules will modernize how Medicaid and CHIP define, measure, and enforce the standards for access to care—the most significant change since CMS' 2016 managed care regulations.

***New E&E Rules.** In addition to rulemaking on access and managed care, CMS recently finalized two rules to streamline E&E for Medicaid and CHIP. These are the most significant E&E regulations since 2012 and 2013. See the SHVS webinar for more information, as well as this expert perspective specifically addressing Medicare Savings Programs.

Source: CMS, Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment (September 2023); CMS, Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (April 2024); and CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Overview: Managed Care and Access Final Rules

The Managed Care and Access Final Rules generally align with the May 2023 proposed rules and share common goals and themes.

Managed Care Final Rule	Access Final Rule	
Managed Care Delivery System Focus*	FFS Delivery System Focus	HCBS Focus Across Delivery Systems

Once implemented, these rules will transform:

Standards and Monitoring for Access to Care

Engagement of People Enrolled in Medicaid

Transparency and Oversight of Payment Rates

Quality Measurement

Program Accountability

**Most of the Managed Care Rule's requirements apply across Medicaid and CHIP managed care, and apply equally across managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (PAHPs), but not to PAHPs that exclusively provide non-emergency medical transportation (NEMT) or to primary care case management (PCCM) entities.*

Source: CMS, Managed Care Access, Finance, and Quality and Ensuring Access to Medicaid Services (April 2024).

Home Care Registries and Enhanced Funding

In December 2023, CMS released guidance advising states about best practices for home care "registries."

States have substantial flexibility to design home care worker registries. In addition to helping consumers match with qualified workers, a registry can perform a variety of other functions to:

- Help consumers and their families navigate the HCBS system.
- Support workforce recruitment and retention.
- Facilitate data collection and program oversight by state officials.

Registries can help states implement the new HCBS requirements in the Access Rule by collecting data on the home care workforce, payment, and access.

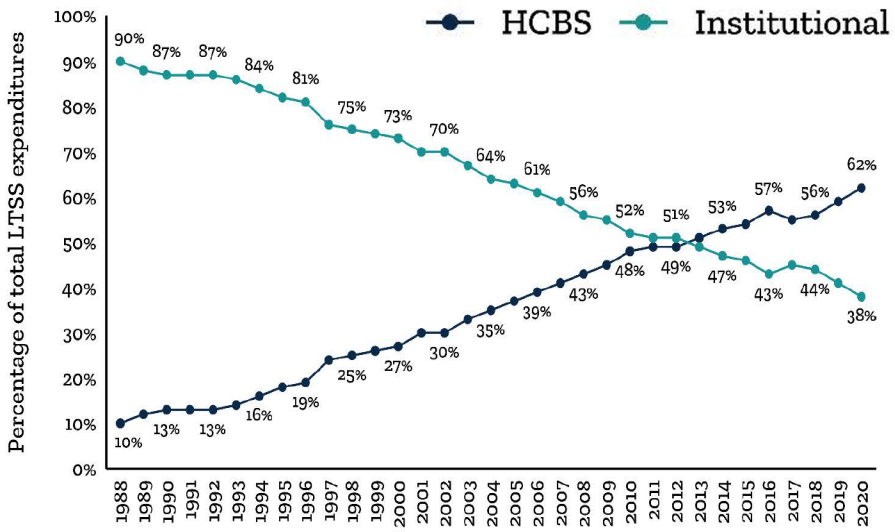
Federal funding is available to support certain Medicaid-related registry functions, potentially including:

- 75 – 90% federal match for certified IT costs under the Medicaid Enterprise System (MES).
- Temporary HCBS funding under section 9817 of the American Rescue Plan Act of 2021 (ARP) Spending deadline: March 31, 2025.
- 50% federal match for Medicaid administrative expenses.

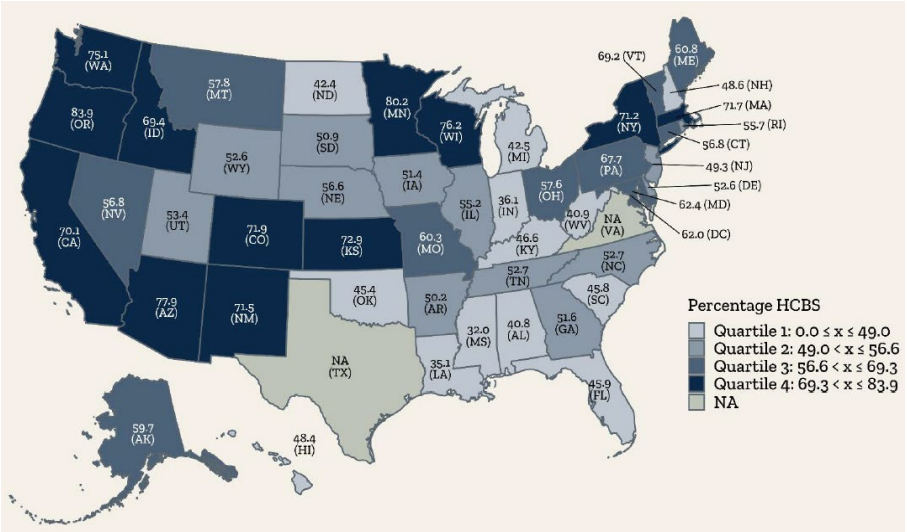
Trends in Medicaid Coverage of HCBS

Medicaid is the nation's dominant payer for HCBS. As part of a decades-long effort to "rebalance" LTSS, federal and state officials have supported access to HCBS as an alternative to institutional care (e.g., nursing homes).

HCBS vs. Institutional LTSS as a Percentage of Total National Medicaid LTSS Expenditures, FY 2020



HCBS as a Percentage of Total State Medicaid LTSS Expenditures, FY 2020



Source: CMS, Medicaid Long Term Services and Supports Annual Expenditures Report.

HCBS Provisions: Key Takeaways

As finalized, these new reforms aim to…

- Encourage state action to strengthen the direct care workforce providing HCBS to Medicaid enrollees.
- Require meaningful work by states and managed care plans to develop required processes, gather data, and publish analyses of HCBS payment rates.
- Require home care agencies to adjust their compensation for workers and/or administrative expenditures.
- Increase opportunities for input by Medicaid enrollees and caregivers, DCWs, and other stakeholders.
- Support oversight of HCBS access and quality by states, CMS, and private entities by increasing HCBS data transparency, especially with respect to home care services and the HCBS workforce; and standardizing HCBS data reporting and program operations across states.
- Strengthen compliance standards regarding HCBS quality and safety.