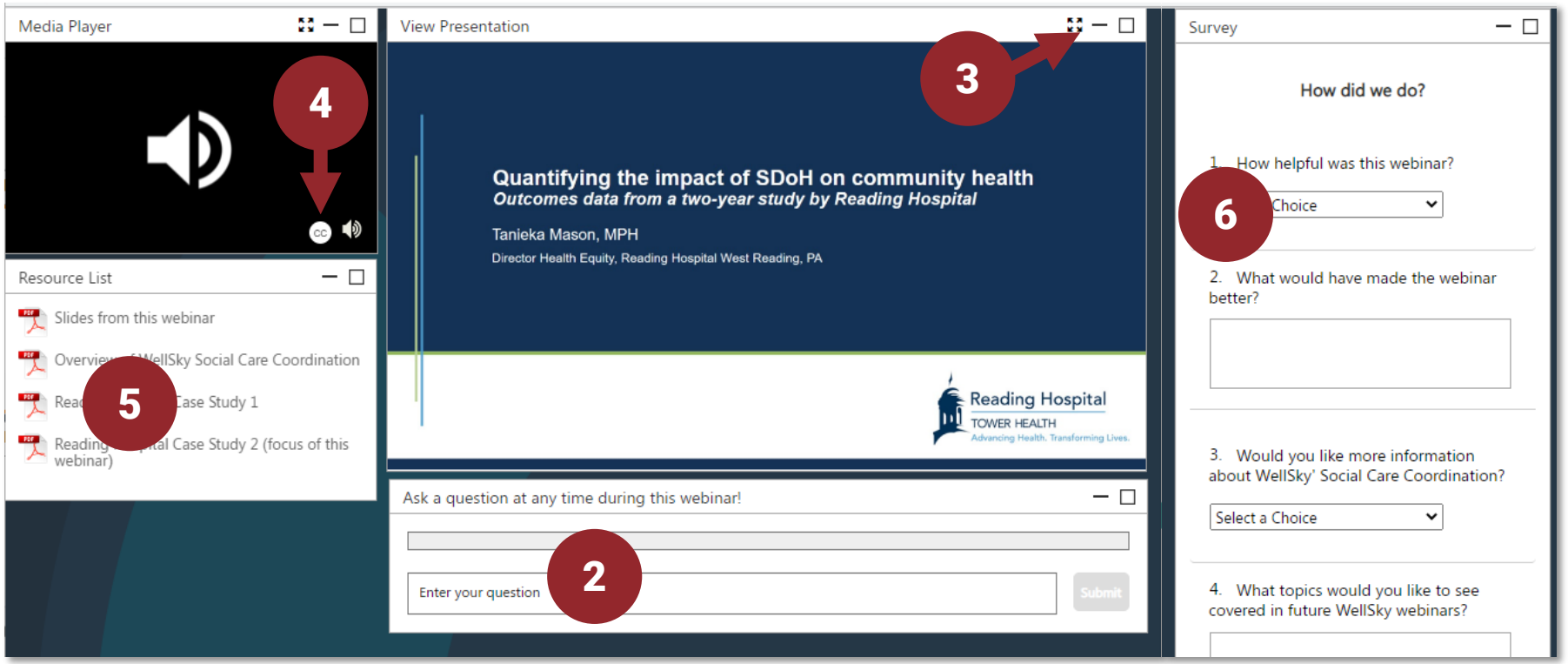
Understanding the Proposed HCBS Access Rule

Rachel Neely, Director of LTSS Policy

Abby Holm, Senior Policy Associate

Annie Kimbrel, Policy Associate

Wednesday | 6/28/2023 | 1:00 pm ET



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- Housing & Homelessness
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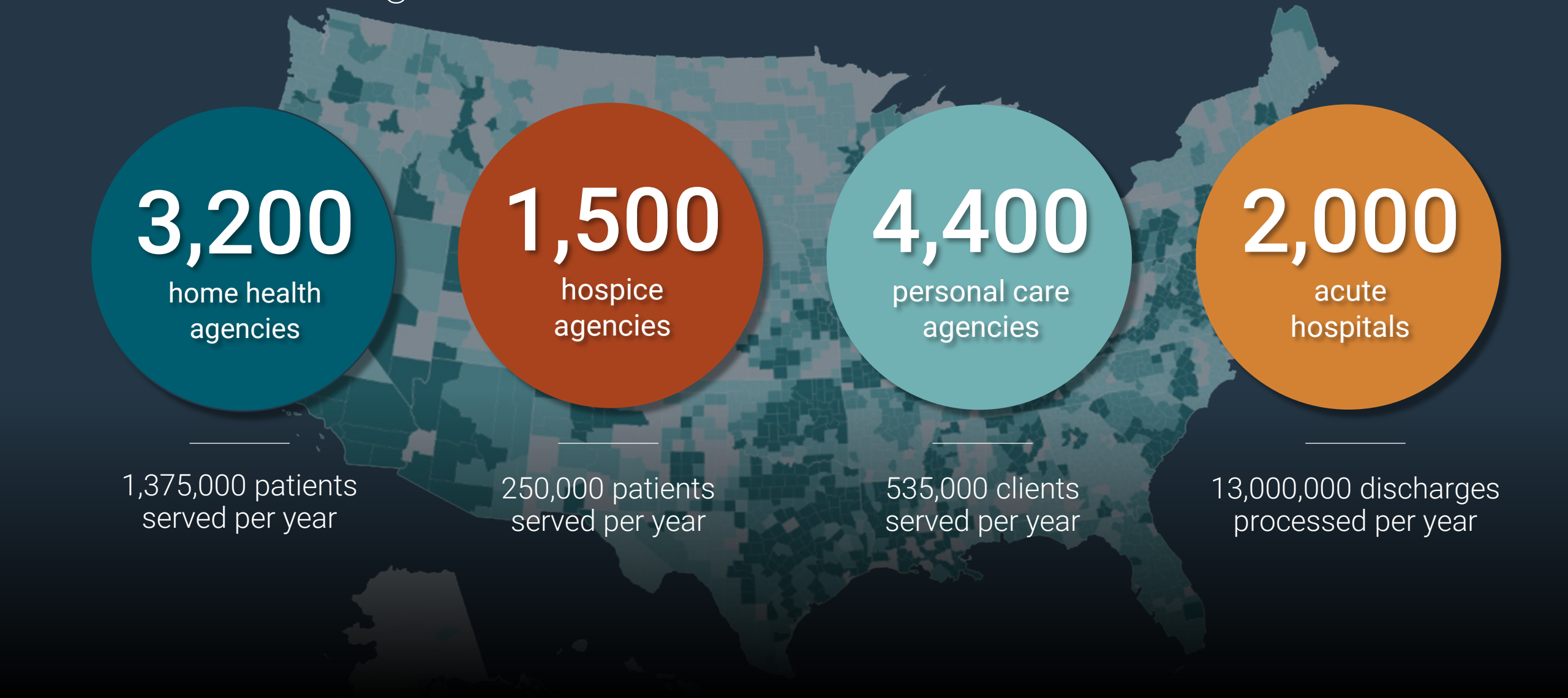
A DISTINCTIVE ADVANTAGE

WellSky represents the widest range of providers & patients across the largest connected **home-based care network**



3,200
home health agencies

1,375,000 patients served per year

1,500
hospice agencies

250,000 patients served per year

4,400
personal care agencies

535,000 clients served per year

2,000
acute hospitals

13,000,000 discharges processed per year

New Possibilities

Improve incident management with hospital discharge data on beneficiaries

Raise quality measures with analytics on home health

Enhance person-centered care with options for employment, housing and well-being

Presenter

Rachel Neely, LMSW (She/Her)

Director of LTSS Policy, ADvancing States

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Leadership, innovation, collaboration
for state Aging and Disability agencies

Understanding the Proposed HCBS Access Rule

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Our Vision:

Older adults, individuals with disabilities, and their caregivers will have access to the resources they need to live well & thrive in every community.

Our Mission:

To design, improve, and sustain state systems delivering long-term services and supports for people who are older or have a disability, and their caregivers.

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ADvancing States contributes to shared success:

For state agencies:

We provide a state-to-state exchange of information that informs and enhances policy and program development, reaching beyond departments focused on aging and disabilities.

For federal partners:

We deliver accurate, timely, national and state specific information vital to the interests of older adults and persons with disabilities and their caregivers.

For the networks:

We contribute to meaningful collaboration among partners, including other national associations, to achieve desired results.

For individuals:

We enhance the ability to live healthily, safely and engaged in all communities with appropriate services, supports and opportunities.

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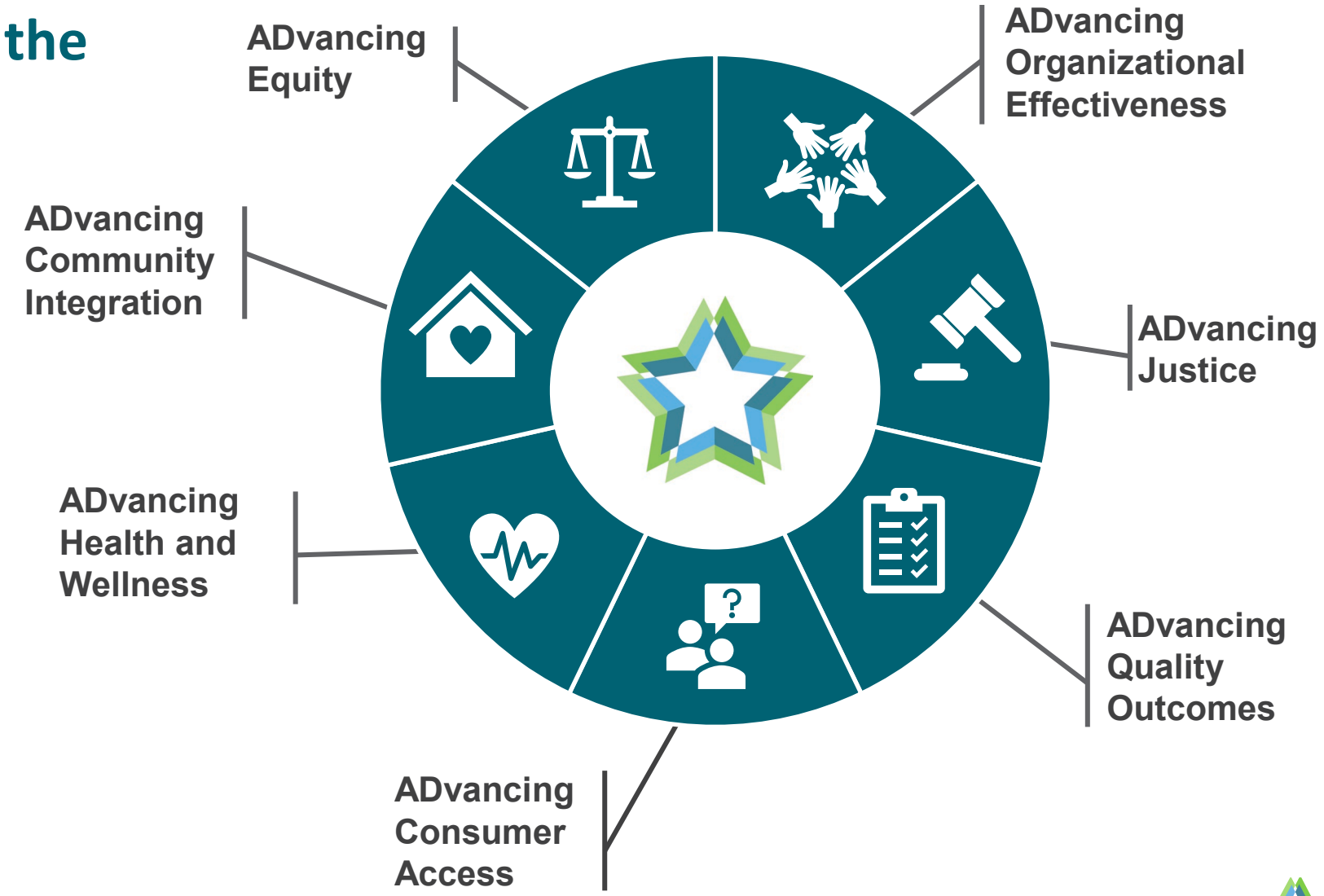
Provide Leadership, Technical Assistance, and Policy Support to State LTSS Systems in the Following Areas



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Introductions

Rachel Neely, Director of LTSS Policy

Abby Holm, Senior Policy Associate

Annie Kimbrel, Policy Associate

Agenda

Overview of Medicaid HCBS

Rulemaking Process

The HCBS Access Rule

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Poll #1

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Poll Question:

- What type of organization are you affiliated with?
  - State Medicaid Agency
  - State Unit on Aging
  - Case Management/Service Coordination
  - HCBS/Aging Network Provider
  - Area Agency on Aging/Aging and Disability Resource Center
  - Member/beneficiary of Medicaid HCBS
  - Advocacy organization
  - Other

CMS and HCBS Authorities

Federal Partners

Medicaid/CHIP

Medicare-Medicaid Coordination

Medicaid Benefits & Health Programs Group

The Medicaid Benefits & Health Programs Group (MBHPG) leads the Center's work on Medicaid coverage and delivery systems for all Medicaid populations, including long-term services and support (LTSS) reform that promotes community integration and the integration of primary care, acute care, pharmacy, behavioral health and LTSS.

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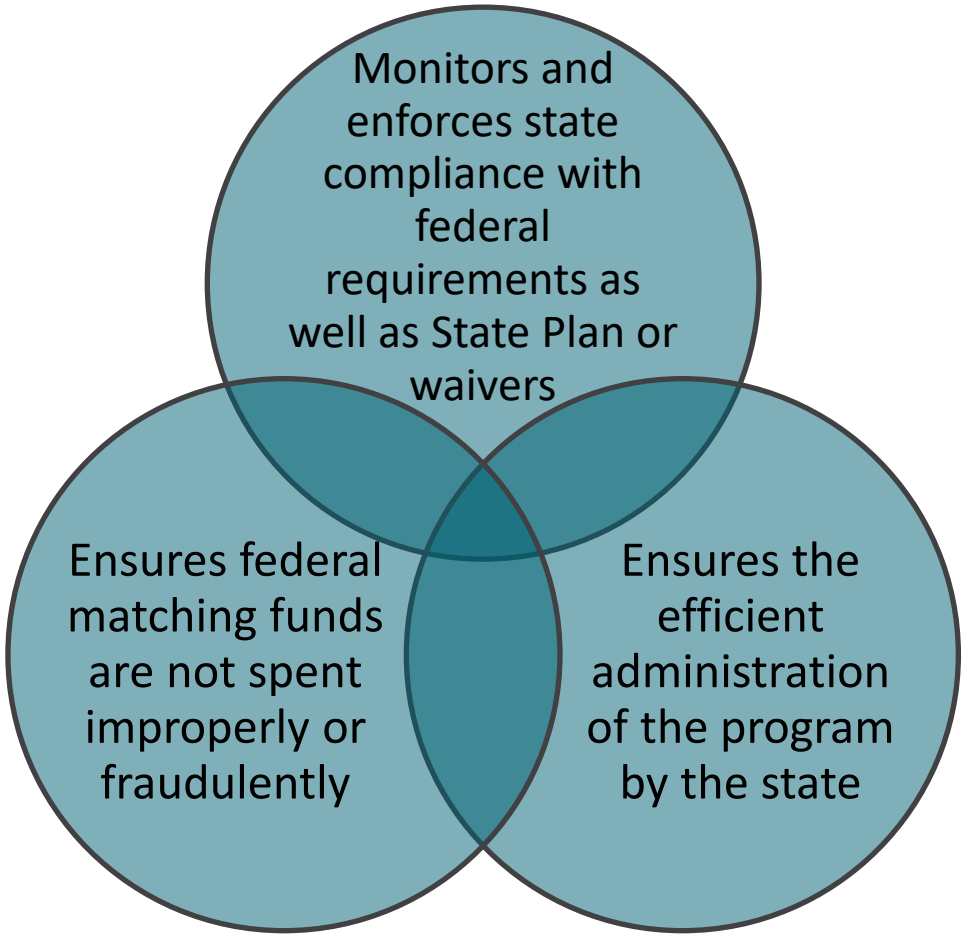
Primary Role of CMS



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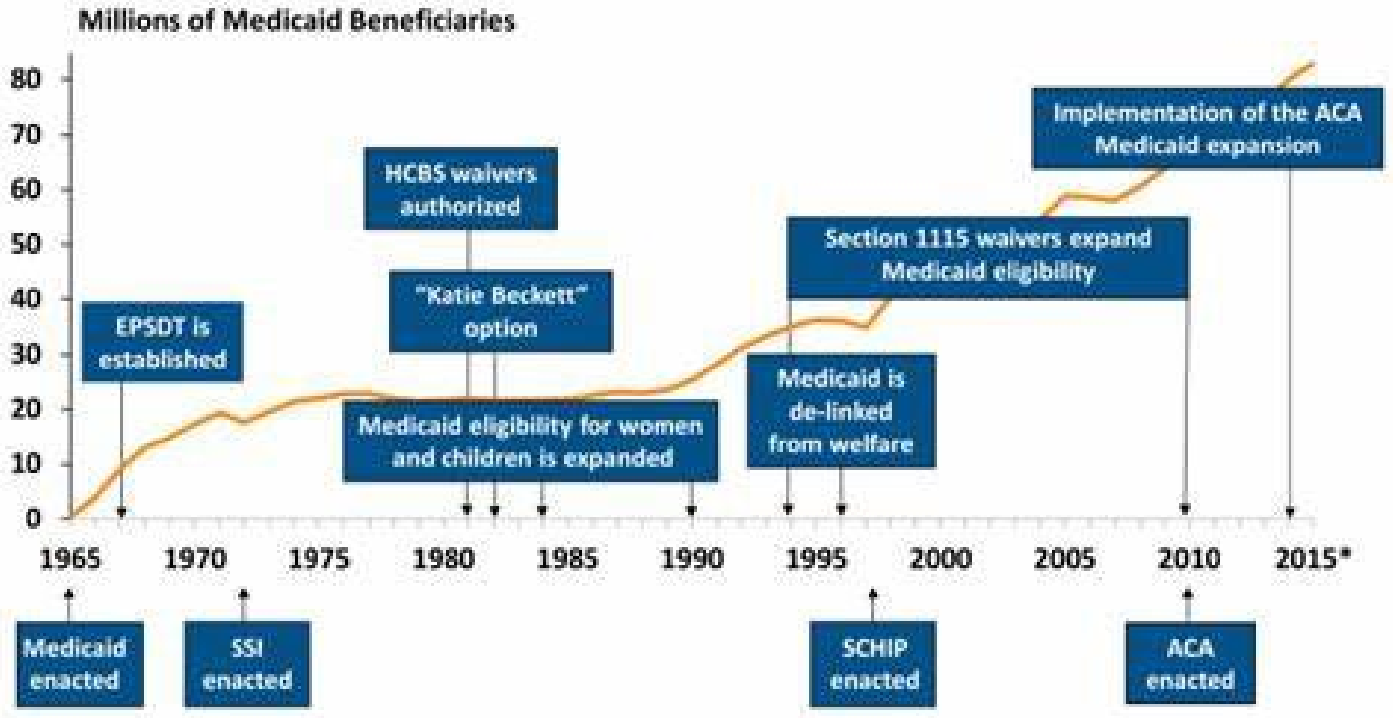
Medicaid History: Big Picture

Figure 2

Medicaid has evolved over time to meet changing needs.



NOTE: *Projection based on CBO March 2015 baseline.
SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.

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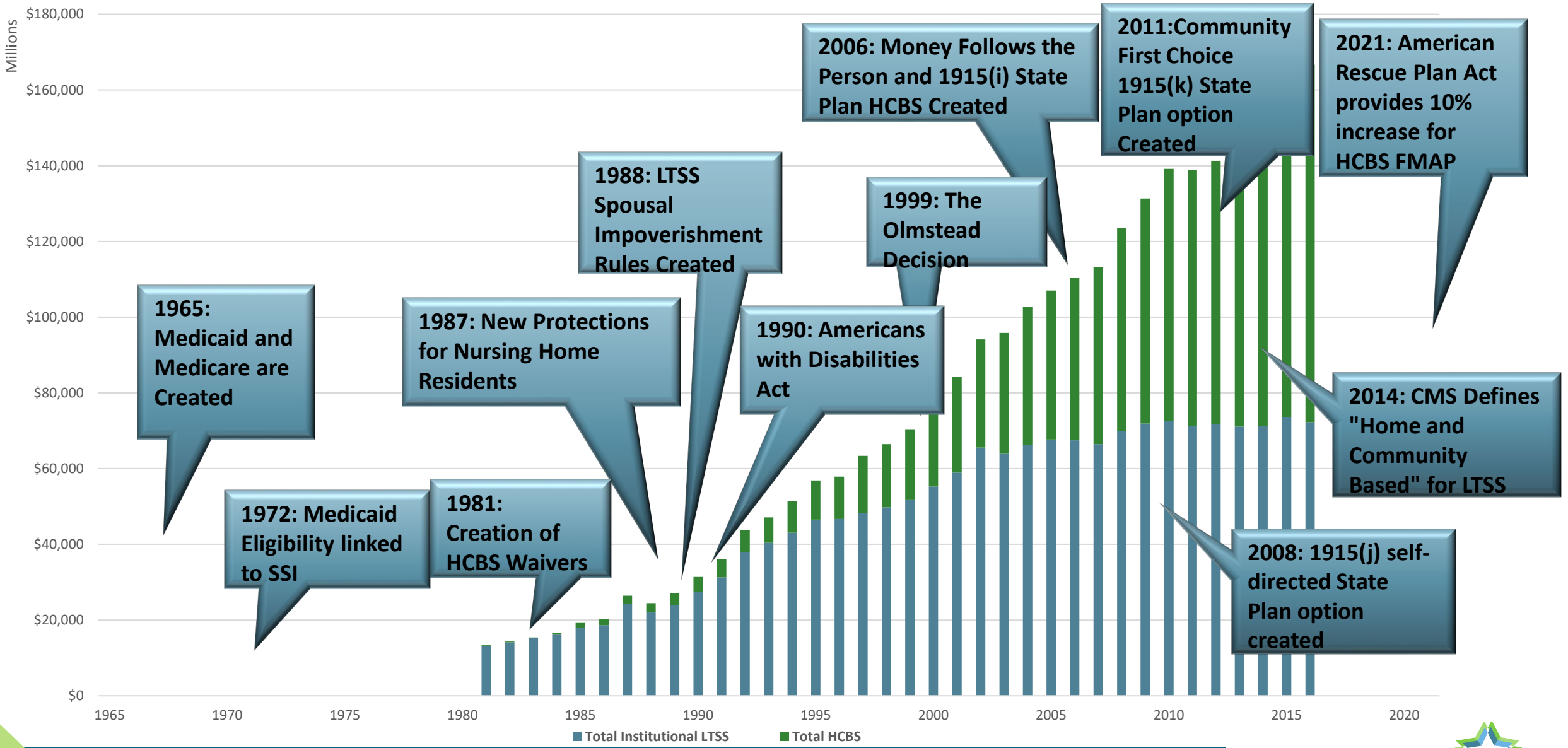
Medicaid History: HCBS Milestones and Distribution of LTSS Expenditures



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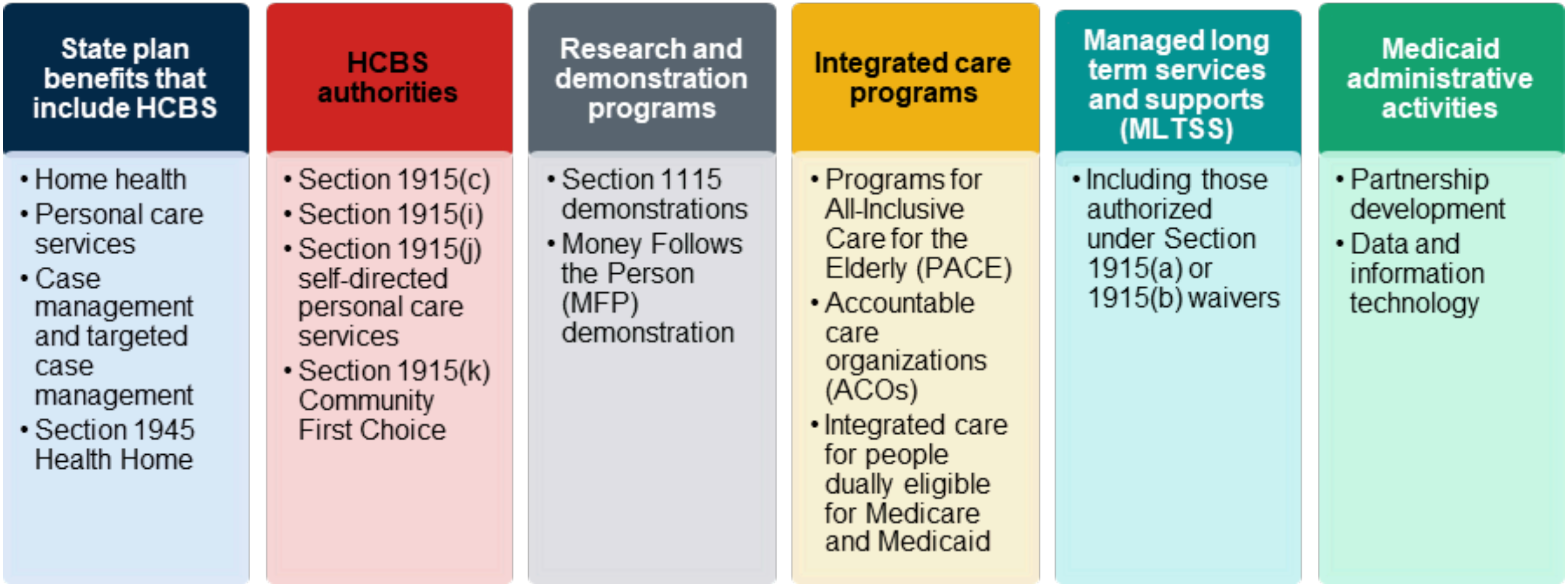
Key Milestones in Medicaid HCBS

- 1999: Olmstead Decision
  - Protect the right of people to receive services in the most integrated setting
- 2014: HCBS Settings Rule
  - Define home and community-based settings and requirement for person-centered planning process
  - Most recent major regulation for Medicaid HCBS
- 2016: Cures Act
  - Requires electronic visit verification (EVV) of personal assistance and home health aide services including type of service performed; the individual receiving the service; the date of the service; the location of service delivery; the individual providing the service; and the time the service begins and ends
- 2022: Quality Measure Set
  - CMS issued SMDL #22-003, releasing first official version of the HCBS Quality Measure Set

Medicaid Benefits and Programs that Support Community-based Services



CMS LTSS Toolkit: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

Rulemaking & the NPRM

CMS Rulemaking

- A "proposed rule" or notice of proposed rulemaking (NPRM) announces CMS' intent to issue a new regulation or modify an existing regulation.
- It proposed changes to the Code of Federal Regulations (CFR).
- Members of the public are invited to submit comments.
- After considering public comments, CMS will develop and publish a final rule amending the CFR.
- **Public comments for the Access NPRM are due to CMS by July 3, 2023.**

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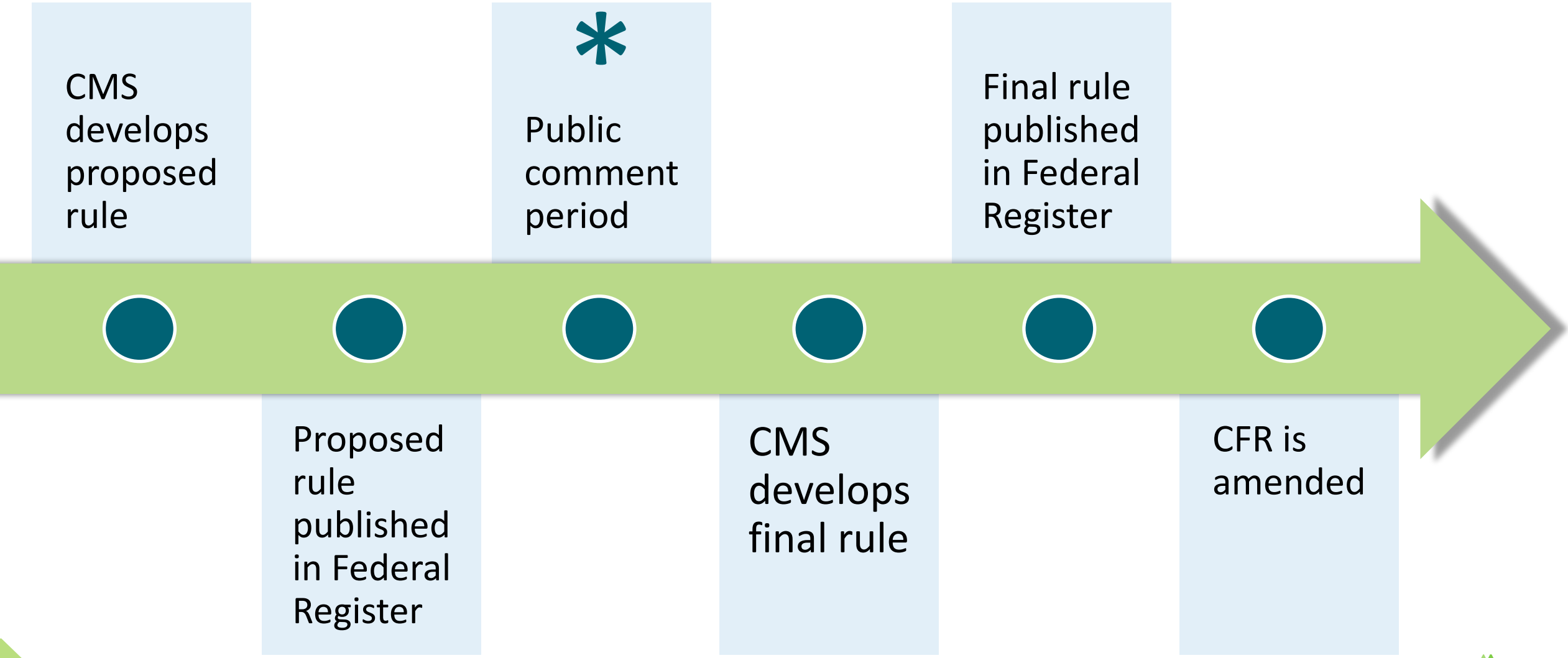
Rulemaking Process



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Intent of the NPRM

- The proposed rule is intended to take a comprehensive approach to:
  - Improve access to care, quality & health outcomes
  - Better address health equity issues in the Medicaid program across FFS, managed care, and in HCBS programs
- The proposed improvements seek to:
  - Increase transparency & accountability
  - Standardize data & monitoring
  - Create opportunities for states to promote active beneficiary engagement in their Medicaid programs

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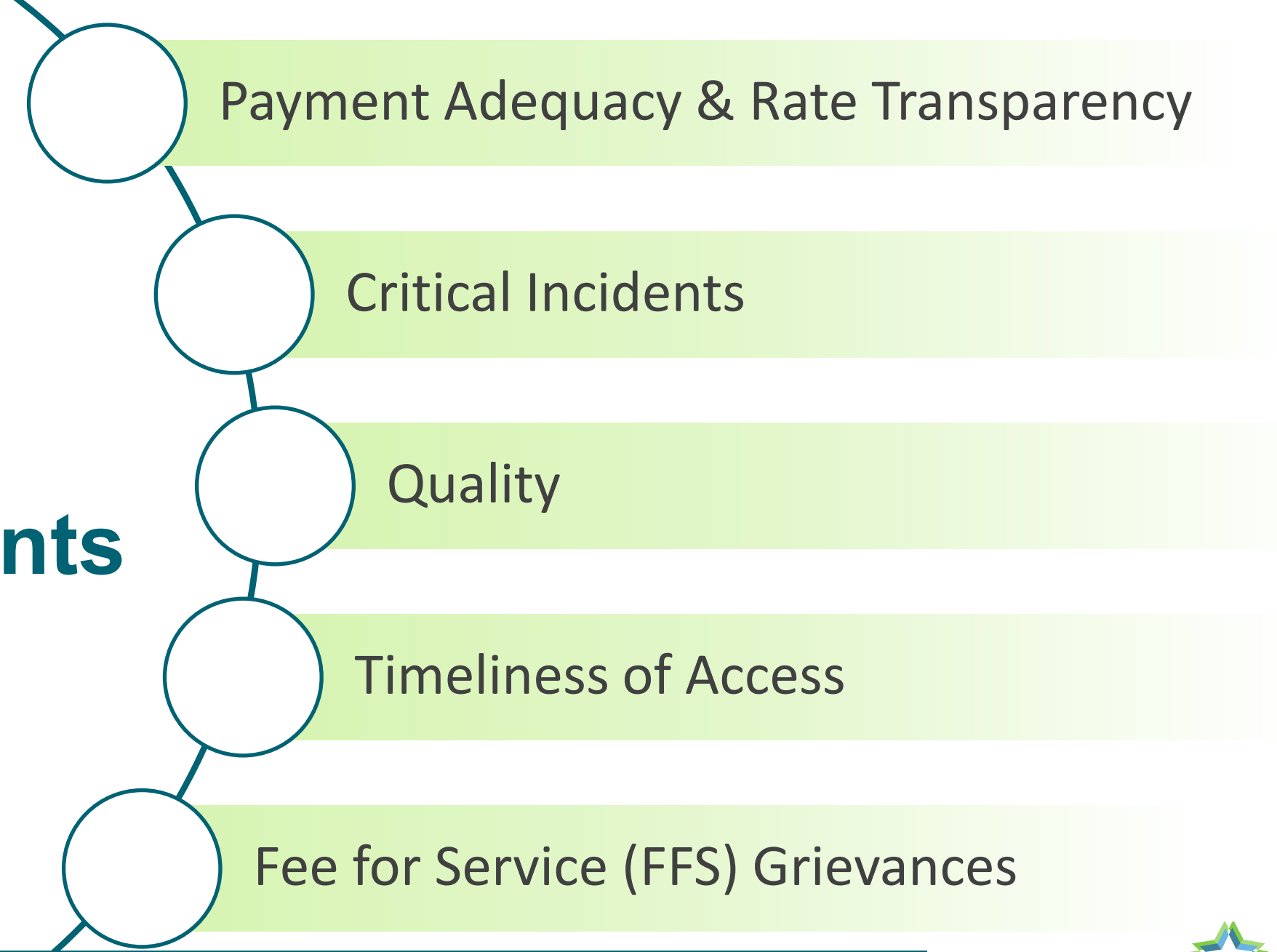
NPRM Requirements



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Compliance Timeframes

Rule Component	Implementation Timeframe
Rate Publication, Analysis, Disclosure	2 years
Payment to Direct Service Workers	4 years
Rates Interested Parties Advisory Group	2 years
Critical Incident Reporting and Incident Management System	3 years
Quality Measure Set	Stratified data reporting phased in over a 7-year period
Timeliness Reporting for Personal Care, Homemaker, and Home Health Aide Services	3 years
Waitlist Reporting	3 years
Person-Centered Service Plan Updates	3 years
FFS Grievance Process	2 years
MAC/BAG	1 year
Data Reporting on State Website	3 years

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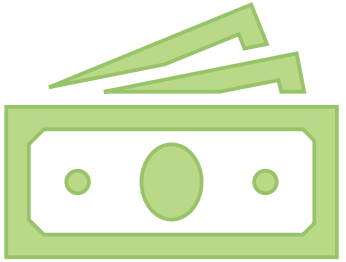
Payment Adequacy & Rate Transparency

Payment Adequacy



Payments to Direct Service Workers:

- The state must ensure 80% of Medicaid payments go to direct care workers for personal care services, homemaker services, and home health aide services
- Propose definition of compensation to include: salary, wages, and other remuneration as defined by the Fair Labor Standards Act; benefits; and employer share of payroll taxes.
- Propose definition of direct care worker to include: workers who provide nursing services, assist with activities of daily living or instrumental activities of daily living, and provide behavioral supports, employment supports, or other services to promote community integration.

Rate Publication

Rate Publication:

- All Medicaid FFS rates must be published on the state's website
- If rates vary, the state must separately identify rates by population, provider type, and geographical location
- Updates to the published rates must be made no later than one month following date of rate amount or methodology change

Rate Analysis & Disclosure

Comparative Rate Analysis:

- A state must develop and publish a comparative rate analysis between Medicaid FFS rates and Medicare rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health.

Rate Disclosure:

- A state must publish rate disclosure for FFS personal care, home health aide, and homemaker services. The disclosure must be updated every 2 years. The disclosure must include:
  - Avg. hourly payment rates, separated by agency and self-directed options, and stratified by population, provider type, and location
  - Number of Medicaid-paid claims
  - Number of beneficiaries who received a service within a calendar year

Critical Incidents & Incident Management System

Poll #2

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Poll Question

- Do you currently perform a role in a critical incident management system?
  - Yes
  - No
  - I'm not sure

Critical Incident Definition

- Establishes a minimum definition of critical incident that includes:
  - Verbal, physical, sexual, psychological, or emotional abuse;
  - 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 but not limited to a death caused by abuse or neglect.
- A provider must report a critical incident that occurs during service delivery or because of failure to deliver services as authorized.

Incident Management System

- The state must operate and maintain an incident management system that identifies, investigates, resolves, tracks, and trends critical incidents.
- Use data from other sources to identify critical incidents that are unreported to providers (to the extent possible)
  - For example: provider claims, other state agencies such as Adult Protective Services, Medicaid fraud control unit, etc.
- Share information on reported incidents and their status and resolution with other state entities responsible for investigating critical incidents.

Incident Management System

- Separately investigate critical incidents if the agency fails to report within state-specified timeframes if the state refers investigation of critical investigation to other agencies-
- Meet uniform performance standards for no less than 90% of critical incidents within state-specified timeframes:
  - Initiate investigation;
  - Complete investigation and determine resolution; and
  - Complete corrective action for incidents that require corrective action.

Reporting Timelines

- Report every 2 years on the result of incident management system assessment to demonstrate that it meets system requirements
  - 5-year timeframe when CMS determines state meets system requirements
- Annually report on number and precent of incidents (90% threshold):
  - For which an investigation was initiated
  - For which the state determines a resolution
  - Requiring corrective action.

Quality Measures & Reporting

Quality Section Overview

- Requires adoption of HCBS Quality Measure Set
  - Originally shared as guidance in CMS State Medicaid Director Letter #22-003
- Applies to all HCBS authorities (except state plan personal care) and all delivery systems as well as self-directed programs
- Requires stratification and sampling phase-in
- Measure set to be updated every other year

Quality Section Overview

- States must establish performance targets, reviewed and approved by CMS, of mandatory measures
  - Performance targets must include quality improvement strategies states will pursue to achieve the performance targets
- Several operational changes required of states to meet compliance

Review of HCBS Quality Measure Set SMDL #22-003

HCBS Quality Measure Set Organization

- Measures are arranged by the areas CMS is interested in:

1915(c) waiver assurance: Service Plans	1915(c) waiver assurance: Health and Welfare
Access	Rebalancing
Community Integration	

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HCBS Quality Measure Set Organization

Source

Vast majority of measures are drawn from consumer surveys

Flexibility

CMS permits states flexibility to determine which survey tool they implement:

- NCI®-IDD
- NCI-AD™
- HCBS CAHPS® and
- POM®

HCBS Quality Measure Set Organization

- Multiple measures for each ‘topic’ means that states can use the consumer survey(s) of their choice to collect and report data on those topics, so that:
  - a state that fields the NCI-AD™ survey would only use the applicable NCI-AD™ measures in the measure set to report to CMS on outcomes for older adult and persons with physical disabilities
  - a state that fields the NCI-IDD™ survey would only use the applicable NCI-IDD™ measures in the measure set to report to CMS on outcomes for adults with intellectual or developmental disabilities

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Additional NPRM Detail

Reporting on the HCBS Quality Measure Set

- The proposed rule would supersede and fully replace reporting expectations and the minimum 86% performance level (372 reporting) for states performance measures described in 2014 guidance.
- States report every other year on all measures in the HCBS Quality Measure Set that are identified by the Secretary (following phased in approach)
- CMS will report on a subset of the measures

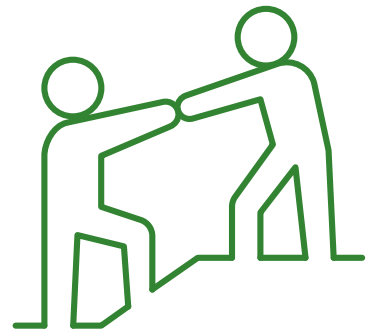
Stratified Data

- Stratification would allow CMS and states to identify health and quality of life outcomes, and differences in outcomes
- CMS recognizes potential need for enhancements to data and information systems and reminds states enhanced FFP is available
- CMS recognizes challenges to stratification, so is recommending a phased-in approach:
  - Provide stratified data for 25% of measures by 3 years after effective date
  - 50% of measures by 5 years
  - 100% of measures by 7 years

Timeliness of Access

Access Overview (from NPRM Preamble)

- Continuum of health care access across three dimensions:
  1. **Enrollment in coverage:** Eligible people are able to enroll in Medicaid - beneficiary needs to know if they are or may be eligible
  2. **Maintenance of coverage**: Eligible individuals are able to stay enrolled in the program without interruption
  3. **Access to services and supports**



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Access Overview (from NPRM Preamble)

- This NPRM Focuses on addressing additional critical access elements:
  1. **Potential access:** individual's access to providers and services
  2. **Individual's utilization**: actual use of the providers and services that are available
  3. **Individual's perceptions and experiences** with the care they did or were not able to receive

HCBS Access: Timeliness Reporting

- States must report annually on timeliness of access to personal care, homemaker, and home health aide services.
- State would be required to report on:
  - The average amount of time from initial service authorization to the initiation of services months; and
  - The percent of authorized service hours there were actually provided in the past 12 months
- Reporting applies to individuals newly approved to receive services in 12 months
- States may report on statistically valid sample
- Reporting effective date is three years

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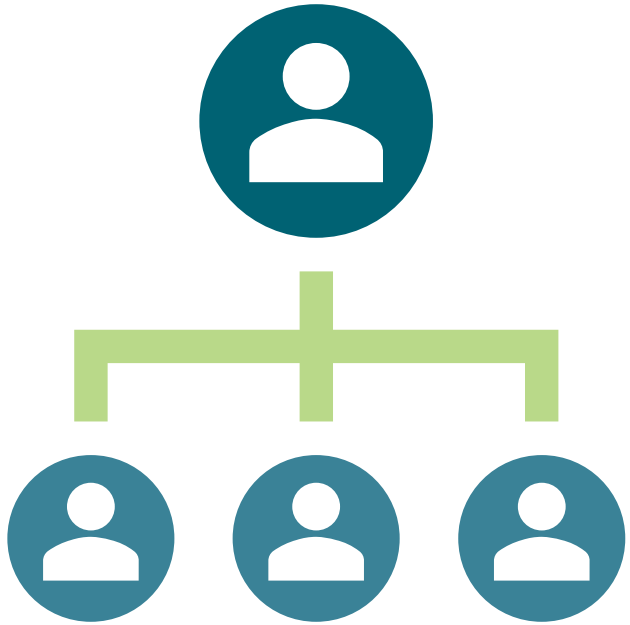
HCBS Access: Waiting List Reporting

- If a state limits enrollment in its 1915(c) waiver program and maintains a waiting list the state must report annually on:
  - How the state maintains the list of individuals waiting to enroll:
  - Whether the state screens individuals for eligibility for the program;
  - Whether the state periodically re-screens individuals on the list;
  - Frequency of re-screening;
  - Number of people on the waiting list;
  - Average amount of time individuals newly enrolled in the waiver program in the last 12 months spent on the waiting list.

Person-Centered Planning Reporting

- State must ensure the person-centered service plan is reviewed and revised, as appropriate, based upon the reassessment of functional need:
  - At least every 12 months,
  - When the circumstances or needs change significantly, or
  - At the request of the individual.



Person-Centered Planning Reporting

- For beneficiaries continuously enrolled for at least 365 days there will be minimum performance levels for person-centered planning requirements:
  - Annual reassessment of functional need for at least 90% of individuals continuously enrolled in an HCBS program.
  - Annual review and update of the person-centered service plan based on the reassessment for at least 90% of individuals continuously enrolled in an HCBS program.
  - States can report on a statistically valid sample

FFS Grievance Systems

Poll #3

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Poll Question

- Do you work primarily with Medicaid managed care or FFS programs/services?
  - Managed care
  - FFS
  - Both
  - Neither
  - I'm not sure

Establishing Grievance Systems in FFS

- States must establish a procedure under which a beneficiary can file a grievance related to compliance with **person-centered planning and service requirements** and **HCBS settings requirements**
- Implementation of proposed grievance system procedure does not apply to managed care delivery systems
  - Note: Grievance processes already exist in managed care delivery systems.

Definition of Grievance

- CMS proposes to define ‘grievance’ as an expression of dissatisfaction or compliant related to the state’s or a provider’s compliance with the person-centered planning and service plan requirements and the HCBS settings requirements, regardless of whether the beneficiary requests that remedial action be taken to address the area or dissatisfaction or complaint.

FFS Grievance Procedures

- States would be required to:
  - Have written policies and procedures for grievance processes
  - Provide beneficiaries with reasonable assistance in filing grievances
  - Ensure punitive action is not taken/threatened
  - Accept grievances, requests for expedited resolution, and requests for extensions
  - Provide beneficiaries with appropriate notice & information
  - Review grievance resolutions with which beneficiaries are dissatisfied
  - Provide information on the grievance system to providers and subcontractor

Responding to Grievances

- Grievance processes must:
  - Allow beneficiaries to file a grievance orally or in writing
  - Ensure decisions on grievances are not made by anyone previously involved in a review or decision making related to the problem
  - Provide beneficiaries reasonable opportunity to present evidence and testimony
  - Provide beneficiaries, free of charge and in advance, with their own case files and any evidence used related to the grievance
  - Provide beneficiaries, free of charge, with language services to support their participation in grievance process

Timelines

- CMS proposes:
  - Standard grievance resolution within 90 calendar days
  - Expedited grievance resolution within 14 calendar days
  - States can extend the timelines up to 14 calendar days under certain circumstances
- CMS invites comment on whether the expedited grievance resolution process should be applied in managed care.


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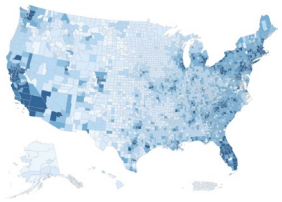
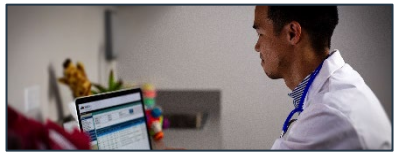
Solutions to meet Access Rule Requirements



Workforce Expansion

Wait List Management

Person-Centered Planning



Incident Management

Grievance Automation

Quality Measures

Ask your questions now!

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