

# CMS Proposed Rules Part 3: Home and Community-Based Services (HCBS) Program Changes

June 12, 2023

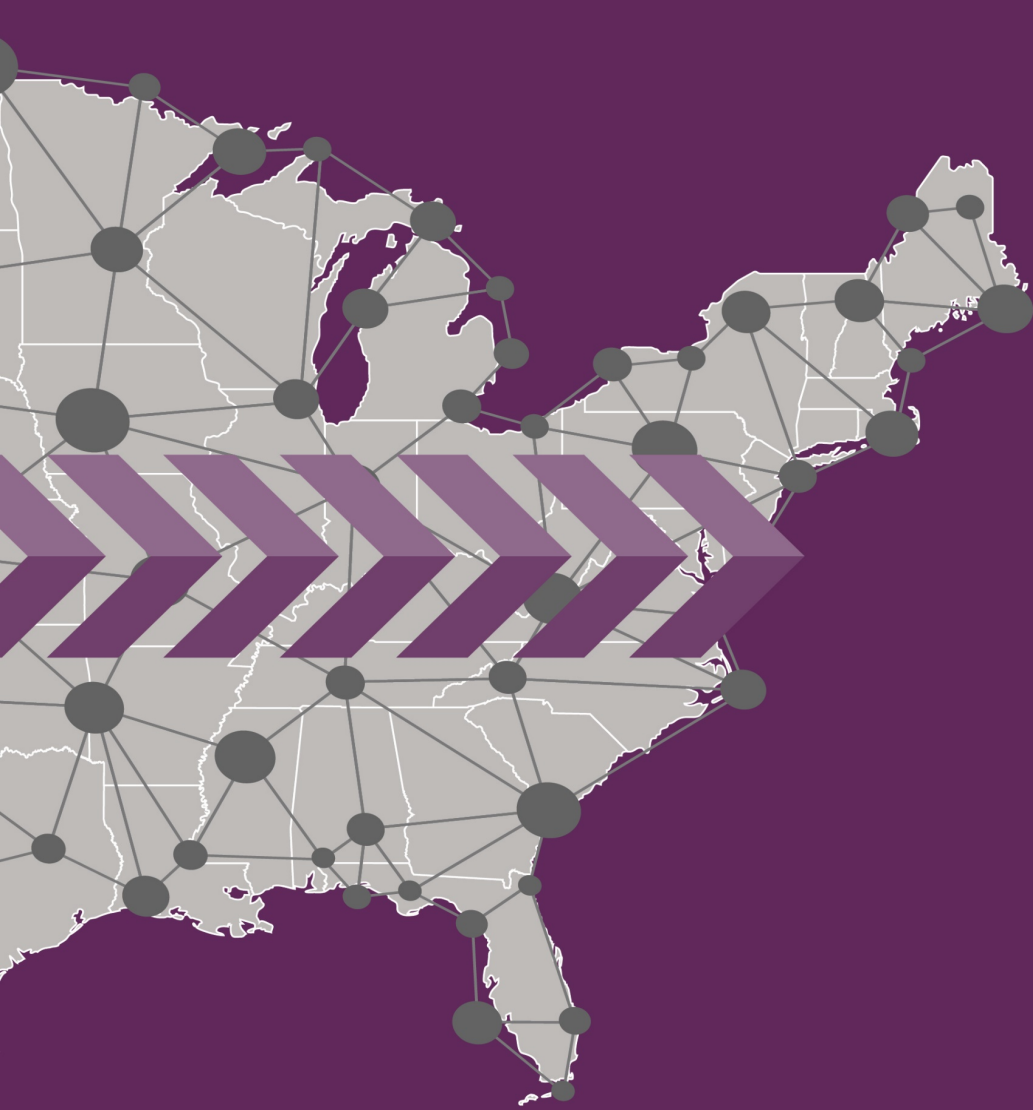
12:00 to 1:00 p.m. ET

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



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Manatt Health

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**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# About Manatt Health

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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](http://www.manatt.com/ManattHealth.aspx)

# Housekeeping Details

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- 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.** The meeting facilitators will address questions and comments verbally in a manner that maintains the anonymity of the state.
- All participant lines are muted. Use the 'raise hand' feature in Zoom if you would like to speak during the discussion portion. The meeting facilitators will then unmute you.
- After the webinar, the slide deck and a recording will be available at [www.shvs.org](http://www.shvs.org).

# Agenda

- **Level-Setting: Centers for Medicare & Medicaid Services (CMS) Managed Care and Access Proposed Rules**

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- **Payment for Home Care and Home Care Workers Provisions**

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- **Oversight of HCBS Access, Quality, and Safety Provisions**

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- **Discussion**



# Level-Setting

# Overview of the Managed Care and Access Proposed Rules

On April 27, 2023, CMS released two highly anticipated proposed rules that would reshape the federal regulatory landscape for Medicaid and the Children’s Health Insurance Program (CHIP).

## “Managed Care Access, Finance, and Quality” (or the “Managed Care Proposed Rule”)

Managed Care Delivery System Focus

## “Ensuring Access to Medicaid Services” (or the “Access Proposed Rule”)

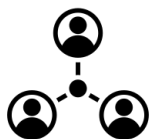
Fee-for-Service (FFS)  
Delivery System Focus

HCBS Focus Across Delivery  
Systems

*Together, the rules would transform...*



**Standards for  
Ensuring Access to  
Care**



**Engagement of  
People Enrolled in  
Medicaid**



**Transparency/  
Oversight of  
Payment Rates**



**Quality  
Measurement**



**Program  
Accountability**



These rules build upon CMS’ September 2022 proposed rule on Medicaid and CHIP eligibility, enrollment, and renewal, and make up CMS’ comprehensive strategy to improve access to coverage and care.

**Citation:** CMS Managed Care Access, Finance, and Quality, Ensuring Access to Medicaid Services, and Streamlining Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.



# Summary of Provisions in the Proposed Rules

While the proposed rules have differences that extend beyond the delivery system of focus, provisions are complementary, overlap in some cases, and together create CMS' integrated access framework.

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

*The proposed rule would, among other things...*

- Strengthen access to care and monitoring through appointment wait time standards and secret shopper/enrollee surveys.
- Create new reimbursement transparency requirements.
- Codify and revise the federal regulations governing state directed payments (SDPs).
- Codify and build on recent CMS policy changes related to in lieu of services (ILOS).
- Modify medical loss ratio (MLR) methodologies and processes.
- Establish new quality requirements, including a framework and enhanced requirements for managed care quality rating systems.

## **"Ensuring Access to Medicaid Services" (or the "Access Proposed Rule")**

*The proposed rule would, among other things...*

- Create new transparency and consultation requirements for FFS provider payment rates.
- Modify the procedures for requesting federal approval to reduce or restructure FFS rates.
- Strengthen program advisory groups.
- Update HCBS program standards and processes regarding care access, quality, and payment.

★ **Comments Due  
July 3, 2023**

**CMS seeks public input on all aspects of both proposed rules and invites comment on potential alternative or additional provisions (more on this in subsequent slides).**

**Citation:** CMS [Managed Care Access, Finance, and Quality](#) and [Ensuring Access to Medicaid Services](#).

# HCBS Context: Services and Authorities

HCBS address the needs of people with functional limitations through person-centered care delivered in the home and the community and are often designed to enable people to stay in their homes, rather than moving into a nursing home or other residential facility.

## Examples of HCBS



### In the Home

- Home health services (including nursing and home health aide services).
- Assistance with self-care.
- Help with chores.
- Budgeting.
- Socializing.



### On the Job and in the Community

- Job coaching.
- Community volunteering.
- Day programs.



### Other Supportive Services

- Case management.
- Psychosocial rehabilitation.
- Assistive equipment and technology.

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

## HCBS Authorities

- States can cover HCBS under the Medicaid state plan.
- States can also develop targeted HCBS programs under section 1915 of the Social Security Act:

✓ 1915(c) waivers for targeted populations who would otherwise need institutional care.

✓ 1915(i) option for targeted populations below an institutional level of care.

✓ 1915(j) option for self-directed personal assistant services.

✓ 1915(k) Community First Choice option to provide personal assistant services for individuals meeting an institutional level of care.

- Some states also cover HCBS under section 1115 demonstration projects.

# HCBS Context: Eligible Populations and Delivery of Services

States can target HCBS coverage for specific populations; there is also state variation in the delivery of HCBS (though most states deliver at least some HCBS through the managed care delivery system).

Eligible Populations	HCBS Delivery
<p><b>All states provide HCBS to:</b></p> <ul style="list-style-type: none"><li>▪ People with intellectual and developmental disabilities.</li><li>▪ Older adults.</li><li>▪ Nonelderly people with physical disabilities.</li></ul> <p><b>Some states also target HCBS services to populations such as:</b></p> <ul style="list-style-type: none"><li>▪ Individuals with traumatic brain or spinal cord injuries.</li><li>▪ Medically fragile children.</li><li>▪ People with serious behavioral health needs.</li></ul>	<p><b>Covered Provider Types:</b></p> <ul style="list-style-type: none"><li>▪ <i>Professional direct care workers.</i> All states cover the services of HCBS agencies, meaning corporate entities that employ individual direct care workers. Most states cover independent providers for at least some services, referring to direct care workers that are not employed by a home care agency.</li><li>▪ <i>Family caregivers.</i> Almost two thirds of states allow legally responsible relatives to be paid providers of HCBS waiver services.</li></ul> <p><b>Self-Direction Opportunities:</b></p> <ul style="list-style-type: none"><li>▪ “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.</li><li>▪ Nearly 437,000 individuals self-direct at least some of their Medicaid HCBS waiver services, typically with the assistance of a financial management services (FMS) provider.</li></ul>

Source: KFF, [State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic](#).

# Overview and Timeline of Key HCBS Provisions

Regulatory Proposal	Effective Date
<b>Payment for Home Care and Home Care Services Provisions</b>	
▪ Payment Adequacy for Home Care Workers	4 years after the final rule's effective date.
▪ Payment Transparency in FFS	First biennial report would be due in January 2026.
▪ Payment Transparency in Managed Care	Annual reporting would begin 2 years after CMS issues a final rule.
▪ Interested Parties' Advisory Group	States would begin publishing Advisory Group recommendations in January 2026.
<b>Oversight of HCBS Access, Quality, and Safety Provisions</b>	
<ul style="list-style-type: none"> <li>▪ HCBS Access Reporting</li> <li>▪ Person-Centered Service Plans</li> <li>▪ Incident Management Systems</li> <li>▪ HCBS Quality Measure Set</li> <li>▪ HCBS Reporting Requirements and Transparency</li> </ul>	3 years after the final rule's effective date, except as otherwise specified.
▪ Grievance Systems for HCBS Recipients	2 years after the final rule's effective date.

- Except as otherwise noted, these proposals:
  - **Apply across FFS and managed care.**
  - **Apply across 1915 HCBS authorities** (1915(c), (i), (j), and (k)), but *not* to HCBS under the Medicaid state plan as defined at section 1905(a) of the Social Security Act.
- **Certain proposals focus on a subset of home care services:** personal care, home health, and homemaker services (*some states may use different terms to refer to these services*).
- **Many of the oversight proposals are intended to supersede CMS' 2014 guidance on HCBS quality assurance systems,** including performance measures and expectations referenced in the guidance.



# Payment for Home Care and Home Care Workers Provisions

**Reminder:** “Home care” encompasses personal care, home health aide and homemaker services.

# Payment Adequacy for Home Care Workers

To ensure that home care workers are adequately paid, CMS has proposed that 80% of Medicaid payments for home care services must go to “compensation” for home care workers.

## Additional Details



Worker “compensation” would include salary/wages, benefits, and the employer share of payroll taxes. Training costs would not count as “compensation.”

The 80% standard would apply across FFS and managed care delivery systems.

## Annual Reporting



Each year, states would be required to publish a report listing the percentage of home care payments that went to compensation for direct care workers. States would report:

- A separate percentage for each type of home care service that is covered.
- Within each type of home care service, a separate percentage for self-directed services.

**CMS’ Rationale:** Unlike facility-based services, CMS expects that the “vast majority of payment” for home care services “should be comprised of compensation for direct care workers.” By “enhancing salary competitiveness” for home care services, CMS believes this proposal would “result in better qualified employees, lower turnover, and a higher quality of care.”

# Payment Transparency in FFS

Under existing regulations, home care payment rate data are presented in different ways in different states for different services. The proposed rule would make changes to FFS rate transparency:



**Every other year, states would be required to publish their home care payments in form of an “average hourly payment rate,”** regardless of whether the state reimburses on an hourly, daily, or some other basis.



**States must report separately if the hourly rate varies** based on client age, geographical location, or provider type/qualifications (including whether the home care worker is independent or employed by an agency).



**States must also report the total number of Medicaid home care claims and home care clients** in the last year.

In addition to this home care requirement, CMS has proposed a **requirement for states to publish their current FFS rates for *all* services** (HCBS and otherwise) in a centralized location, and to update those rates within one month of any changes.

# Payment Transparency in Managed Care

Under current regulations, payment data are generally not publicly available for managed care delivery systems. CMS proposes the following for managed care rate transparency:



**Every year, states must publish an analysis of:**

- **Total spending** on each type of home care service.
- **A comparison of those total managed care payments against FFS**—i.e., how much the state would have paid for those same services under the FFS system.



**The state must report:**

- Separate payment data for each managed care plan.
- A weighted average across all plans in the state.



# Interested Parties' Advisory Group

Under the proposed rule, each state must establish an Advisory Group to “advise and consult” on home care payment rates and access metrics.

**Advisory Group membership** must include, at a minimum:



- Direct care workers.
- Medicaid enrollees.
- The authorized representatives of Medicaid enrollees.
- “Other interested parties impacted by the services rates in question, as determined by the State.”

*States are permitted, but not required, to have the Medicaid Advisory Committee (MAC) perform the functions of the home care Advisory Group, as long as the MAC satisfies all relevant requirements.*

- 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 applicable HCBS authorities.
- The state must provide the Advisory Group with relevant data on home care payment rates and Medicaid enrollees’ access to care.
- 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.

# Request for Comment and Implications



## CMS Seeks Comment on...

- Whether these proposed requirements for home care services should apply to additional types of HCBS beyond home care.
- Regarding the payment adequacy requirement, whether 80% is the appropriate threshold, and whether to expand the definition of eligible “compensation” (e.g., training costs).
- The appropriate frequency of reporting with respect to payment adequacy and rate transparency.
- States’ support for the home care and home care workers provisions.



## Considerations for States:

- States may need to consider how to operationalize the 80% payment adequacy standard, both in terms of gathering necessary data and ensuring compliance with the 80% standard.
- States may want to consider commenting on CMS' proposed balance between rate transparency and administrative burden.
- States have an opportunity to meaningfully engage Medicaid enrollees and direct care workers through the proposed Advisory Group; they could also consider having the MAC perform these functions.



# Oversight of HCBS Access, Quality, and Safety Provisions

**Reminder:** Many of the oversight proposals are intended to supersede CMS' 2014 guidance on HCBS quality assurance systems.

# HCBS Access Reporting

The proposed rule would create several new annual reporting requirements for states related to HCBS waiting lists, timely access to home care, and home care utilization.



**Waiting Lists.** States would be required to 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, and the average amount of time individuals newly enrolled in the past 12 months spent on the waiting list.



**Timely Access.** States would be required to report on the average amount of time between home care services being approved and when services begin for individuals newly approved to begin receiving services within the past 12 months.



**Service Utilization.** States would be required to report on the percent of authorized home care services hours that were actually provided in the past 12 months.

States would be permitted to report on a statistically valid random sample.

# Person-Centered Service Plans

The proposed rule would revise state reporting requirements related to their completion of person-centered service plans.

## Current State

- 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:
  - At least once every 12 months;
  - If the individual's needs change significantly; or
  - If the individual requests a change to their plan.



## Proposed Rule

- **Changes to the Compliance Threshold.** States would 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 proposed rule would require states to **report annually** on the percentage of individuals continuously enrolled for at least 365 days:
  - ✓ For whom a reassessment of functional need was completed within the past 12 months; and
  - ✓ Who had a service plan updated as a result of reassessment within the past 12 months.

**Note:** For both new reporting metrics, states could report on a statistically valid random sample.

# Incident Management Systems

The proposed rule would require states to operate an electronic incident management system, collect a range of data to identify critical incidents, and meet new reporting requirements.



## Electronic Incident Management Systems

- ✓ States would be required to operate and maintain an electronic incident management system that “identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.”
- ✓ CMS would establish a comprehensive common minimum definition of “critical incident.”



## Data Sources and Data-Sharing Agreements

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



## Reporting Requirements

- ✓ States would be required to report on how they initiate and complete investigations into critical incidents and complete corrective actions (as needed) within state-specified timeframes.
- ✓ CMS would also raise the performance standard for initiating and completing investigations into critical incidents and completing corrective actions (as applicable) to 90%—up from the current standard of 86%.

# Grievance Systems for HCBS Recipients

The proposed rule would require states to establish a grievance system for individuals receiving HCBS through the FFS delivery system, modeled off of (though not identical to) existing requirements for establishing grievance systems in managed care.

## Among other requirements, states would be required to:

- ✓ Accept grievances either orally or in writing and provide individuals with reasonable assistance in completing the necessary procedural steps.
- ✓ Allow another individual or entity to file a grievance on an individual'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.
- ✓ Resolve grievances within 90 days of receipt, or within 14 days if an enrollee's grievance qualifies for expedited resolution due to a substantial risk to the individual's health, safety, or welfare.

**Grievances** are complaints about state/provider compliance with requirements for the person-centered planning process or HCBS settings requirements.

# HCBS Quality Measure Set

The proposed rule would require states to report on select measures in the HCBS Quality Measure Set established in 2022.

## ■ Reporting Requirements.

- The proposed rule would require states to report on a subset of mandatory measures, in addition to any measures that CMS will report on behalf of the states.
- It would also require states to establish performance targets, subject to CMS approval, for each of these measures, and to describe the quality improvement strategies they would pursue to achieve performance targets.

- **Phasing-In Reporting.** The proposed rule would authorize CMS to phase in reporting of certain mandatory measures, reporting for certain populations, and measure stratification requirements.

- **Updates to the HCBS Quality Measure Set.** The proposed rule would require CMS to identify and update, at least every other year, measures to be included in the HCBS Quality Measure Set. This would be done in consultation with states and other interested parties, and CMS would allow for public comment.

## CMS would provide guidance to states on:

- ✓ How to collect and calculate measurement data.
- ✓ Standardized reporting format and schedule.
- ✓ 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, etc.
- ✓ How to establish state performance targets.



# HCBS Reporting Requirements and Transparency

CMS acknowledges stakeholder feedback that, currently, “it is difficult to find information on HCBS access, quality, and outcomes in many States.”



**States would be required to develop an accessible website for the various HCBS reports** described in CMS’ proposed rules (including home care payment adequacy, access data, person-centered planning, incident management and critical incidents, and HCBS Quality Measure Set).



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



**CMS would publish data submitted by the states** to provide HCBS comparative data, and to potentially use the data in future iterations of the CMS Medicaid and CHIP Scorecard.

# Request for Comment and Implications



## CMS Seeks Comment on...

- For each of the access reporting requirements (e.g., waiting lists, timely access and service utilization), whether required frequency of reporting and if specific metrics or other reporting elements should be required.
- Whether the timely access and service utilization metrics should apply to other HCBS services.
- Whether there are other compliance measures related to person-centered planning that states should be required to report on, and whether states should be required to report less frequently and, if so, the rationale for the alternate timeframes.
- Whether states should be required to use external data sources to identify unreported critical instances and, if so, what data should be used.
- Establishing a compliance threshold that would exempt states from having to develop quality improvement strategies to achieve performance targets for mandatory quality measures.



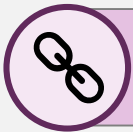
## Considerations for States:

- States would need to make significant program changes and investments, involving their quality and compliance teams, to implement the transparency, quality measure set and data reporting requirements.

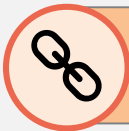
# Discussion

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**Reminder:** CMS seeks public input on all aspects of both proposed rules and invites comment on potential alternative or additional provisions **by July 3, 2023**.



The “Managed Care Access, Finance, and Quality” (or the “Managed Care Proposed Rule”) is available [here](#).



The “Ensuring Access to Medicaid Services” (or the “Access Proposed Rule”) is available [here](#).

# Thank You

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