# Policy Update

## CMS Releases Final Rule: Medicaid Program; Ensuring Access to Medicaid Services


### Summary

On April 22, 2024 the Centers for Medicare & Medicaid Services (CMS) published the Medicaid Program; Ensuring Access to Medicaid Services final rule. The rule has a particular focus on home- and community-based services (HCBS), including direct care worker compensation requirements, HCBS waitlists, grievance process development, critical incident reporting definitions and HCBS quality reporting. The final rule also seeks to increase transparency in payment rates.

The rule is effective 60 days after publication, but many provisions have an effective date that widely differs from the overarching effective date. CMS released a fact sheet on the regulation and a timeline for the various effective dates.


### Key Takeaways

The Medicaid Program; Ensuring Access to Medicaid Services final rule includes the following key provisions:

- CMS requires that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead). CMS made many modifications in the proposed rule that altered the applicability of the provision.
- States will be required to establish a grievance process for fee-for-service (FFS) HCBS beneficiaries to submit complaints.
- CMS establishes a minimum definition of “critical incident”; establishes minimum state performance and reporting requirements for investigation and action related to critical incidents; and requires states to operate and maintain an electronic incident management system.
- The final rule requires states to ensure that the person-centered service plan is reviewed and revised at least every 12 months for at least 90% of individuals continuously enrolled in a state’s HCBS programs.
- CMS requires states to report on waiting lists in section 1915(c) waiver programs and on service delivery timeliness for personal care, homemaker, home health aide and habilitation services.
- CMS requires states to report every other year on the HCBS Quality Measure Set and establishes a process for updating the measure set.
- The final rule requires states to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website. It also requires states to compare their FFS payment rates for primary care, obstetrical and gynecological care, and outpatient mental health and substance use disorder services to Medicare rates and publish the analysis every two years. States must publish the average hourly rate paid for personal care, home health aide, homemaker and habilitation services, and must publish the disclosure every two years.
- States will be required to establish and operate the newly named Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Council (BAC) one year after the rule’s effective date.

## Home- and Community-Based Services

### *Compensation to HCBS Direct Care Workers*

**Key Takeaway: CMS requires that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead). CMS also made many modifications from what was in the proposed rule which altered the applicability of this provision.**

One of the most controversial provisions in the final rule is the requirement that at least 80% of Medicaid payments for homemaker, home health aide and personal care services be spent on compensation for direct care workers. CMS finalized its proposal that this policy apply to both Medicaid FFS and managed care delivery systems. In particular, it applies to homemaker, home health aide and personal care services provided through section 1915(c), (j), (k) and (i) authorities, and is applicable to managed care delivery systems authorized by section 1915(a), 1915(b), 1932(a) or 1115(a).

Although the services and authorities did not change from the proposed rule to the final rule, CMS made several definitional changes that impact this provision.

CMS changed the definition of compensation in the final rule. Compensation is defined to include salary, wages and other remuneration defined by the Fair Labor Standards Act, benefits and the employer share of payroll taxes. In the final rule, CMS updated the definition of "benefits" within compensation, noting that benefits are inclusive of health and dental benefits, life and disability insurance, paid leave, retirement and tuition reimbursement. The final rule changed "sick leave" to "paid leave," added "life and disability insurance," and added "retirement" as a blanket term for retirement plans and contributions. In the final rule, CMS also created a new definition of "excluded costs," which are costs not included in the state's calculation of the percentage of Medicaid payment that is spent on compensation. Excluded costs are "training costs (such as costs for training materials or payment to qualified trainers); travel costs for direct care workers (such as mileage reimbursement or public transportation subsidies); and costs of personal protective equipment for direct care workers."

CMS modified and expanded the definition of direct care workers to include clinical supervisors. Under the final rule, direct care workers include individuals who may be employed or contracted by a Medicaid provider, state agency or third party, or who deliver services under a self-directed services delivery model:

- A registered nurse, licensed practical nurse, nurse practitioner or clinical nurse specialist who provides nursing services to Medicaid beneficiaries receiving HCBS available under this subpart;
- A licensed or certified nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner or clinical nurse specialist;
- A direct support professional;
- A personal care attendant;
- A home health aide; or
- Other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports or other services to promote community integration directly to Medicaid beneficiaries receiving HCBS available under this subpart, including nurses and other staff providing clinical supervision.

The final rule specifies that for self-directed services, when the beneficiary who is directing the services sets the direct care worker's payment rate, then the state does not include such payment data in its calculation of the state's compliance with the 80% requirement.

However, the final rule makes modifications to allow states to exclude certain providers and provide some flexibilities from the requirement. First, CMS allows states to set a separate minimum performance level for

small providers and allows states the option to develop "reasonable, objective criteria to identify small providers" to meet this small provider minimum performance level. Second, the final rule allows states to develop a "hardship exemption" for providers determined by the state "to be facing extraordinary circumstances" that prevent them from meeting the 80% pass-through requirement. And finally, CMS exempts Indian Health Service and Tribal health programs from the 80% pass-through requirement.

In three years, states will be required to report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care and habilitation services spent on compensation to the direct care workers furnishing these services. In four years, states must report to CMS annually on the percentage of total payments (not including excluded costs) for furnishing homemaker, home health aide, personal care and habilitation services that is spent on compensation for direct care workers. States must report separately for each service and within each service must separately report services that are self-directed and services that are delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.

CMS notes that it intends this policy to apply to the provider level and that states must ensure that each provider spends 80% of Medicaid payments they receive for certain HCBS on direct care worker compensation.

These payment and transparency requirements will be effective six years after the effective date of the final rule for FFS, and will apply to the first managed care plan contract rating period that begins on or after the date six years following the final rule's effective date. This represents a delay in effective date compared to the proposed rule, which included a four-year effective timeframe.

Regarding enforcement of this provision, CMS notes it will "continue to use our standard enforcement tools and discretion, as appropriate." However, no specific enforcement actions are outlined in the final rule.

### *HCBS Grievance Procedures*

**Key Takeaway: States will be required to establish a grievance process for FFS HCBS beneficiaries to submit complaints.**

Beginning two years after the effective date of the final rule, states will be required to establish grievance procedures for Medicaid beneficiaries who receive FFS HCBS through section 1915(c) and in the final rule made the requirements applicable to section 1915(j), (k) and (i) Medicaid authorities. The grievance process gives beneficiaries (or an authorized representative) an opportunity to file an expression of dissatisfaction or complaint related to the state's or a provider's performance of the person-centered service plan and HCBS settings requirements. The rule outlines requirements for the grievance procedures, including recordkeeping, timelines for acknowledgments and procedures, notices to beneficiaries and protocols for handling grievance submissions. The final rule specifies that states must provide beneficiaries with reasonable assistance in ensuring that grievances are appropriately filed with the grievance system.

### *Definition of Critical Incident*

**Key Takeaway: CMS establishes a minimum definition of "critical incident" and minimum state performance and reporting requirements for investigation and action related to critical incidents. CMS requires states to operate and maintain an electronic incident management system.**

CMS finalized as proposed a new standard definition of a critical incident to include, at a minimum, "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." No such standardized federal definition previously existed.

In the final rule, CMS requires that states operate and maintain an electronic incident management system that identifies, reports, triages, investigates, resolves, tracks and trends critical incidents. States must report to CMS every 24 months on the results of an incident management system assessment.

States must identify critical incidents through required provider reporting and other data sources (*e.g.*, claims, Medicaid Fraud Control Units, Adult Protective Services, Child Protective Services, law enforcement) and have information sharing agreements with those entities for investigations.

These requirements will be effective three years after the effective date of the final rule for FFS, but CMS allows five years for states to implement the electronic incident management system.

### *HCBS Person-Centered Planning*

**Key Takeaway: The final rule requires states to ensure that the person-centered service plan is reviewed and revised at least every 12 months for at least 90% of individuals continuously enrolled in a state's HCBS programs.**

Under the final rule, states are required to demonstrate that an assessment of functional need is conducted annually for at least 90% of individuals continuously enrolled in a state's HCBS programs. States are required to demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of this required reassessment of functional need every 12 months, for at least 90% of individuals continuously enrolled in the state's HCBS programs. These requirements will be applied across section 1915(c), (i), (j) and (k) waiver authorities. They will not apply to section 1905(a) "medical assistance" state plan personal care, home health and case management services.

The rule also requires states to report on the percentage of beneficiaries continuously enrolled in the state's HCBS programs for 365 days or longer who had a service plan updated as a result of a reassessment of functional need within the past 12 months.

A person-centered plan includes six elements: level of care, service plan, qualified providers, health and welfare, financial accountability and administrative authority. States are required to conduct systemic remediation and implement a quality improvement project when they score below 90% on any of these performance measures, as proposed.

### *Wait List Reporting*

**Key Takeaway: CMS requires states to report on waiting lists in section 1915(c) waiver programs and on service delivery timeliness for personal care, homemaker, home health aide and habilitation services.**

States have the option to cap the number of people enrolled in HCBS waivers. As a result, there are often waiting lists for individuals to receive HCBS. Under this final rule, CMS requires states to report on waiting lists in section 1915(c) waiver programs and on service delivery timeliness for personal care, homemaker, home health aide and habilitation services. Compared to the proposed rule, the final rule expands the list of services subject to the reporting requirement to include habilitation services.

Specific reporting requirements for the state include:

- A description of how the state maintains the list of individuals who are waiting to enroll in the waiver program, if the state has a limit on the size of the waiver program.
- Average amount of time from when homemaker, home health aide, personal care and habilitation services are initially approved to when services began, for individuals newly receiving services within the past 12 months.
- Percentage of authorized hours for homemaker, home health aide, personal care and habilitation services that are provided within the past 12 months.

### *HCBS Quality Measure Set*

**Key Takeaway: CMS requires states to report every other year on the HCBS Quality Measure Set and establishes a process for updating the measure set.**

The HCBS Quality Measure Set is a set of nationally standardized quality measures for Medicaid-covered HCBS. The final rule requires that states report every other year on the elements identified in the HCBS Quality Measure Set as mandatory measures. The rule also creates a process to regularly update and maintain the required measure set.

Beginning December 31, 2026, CMS will solicit comments on the HCBS Quality Measure Set no more frequently than every other year in order to do the following:

- Establish priorities for the development and advancement of the HCBS Quality Measure Set;
- Identify newly developed or other measures that should be added, including to address gaps in the HCBS Quality Measure Set;
- Identify measures that should be removed because they no longer strengthen the HCBS quality measures; and
- Ensure that all measures included in the HCBS Quality Measure Set are evidence-based, meaningful for states, and feasible for state-level and program-level reporting as appropriate.

The final rule also establishes a process for updating the HCBS Quality Measure Set that includes the following steps:

- Identify all measures in the HCBS Quality Measure Set, including newly added measures, measures that have been removed, mandatory measures, measures that the Secretary will report on states' behalf, measures that states can elect to have the Secretary report on their behalf and measures for which the Secretary will provide states additional time to report;
- Inform states how to collect and calculate data on the measures;
- Provide a standardized format and schedule for reporting the measures;
- Provide procedures that states must follow in reporting the measure data;
- Identify specific populations for which states must report the measures;
- Identify the subset of measures that must be stratified by race, ethnicity, sex, age, rural/urban status, disability, language or other factors as may be specified by the Secretary; and
- Describe how to establish state performance targets for each of the measures.

The requirements will be effective four years after the final rule's effective date (rather than three as proposed).

## Payment Rate Transparency

**Key Takeaway: The final rule requires states to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website. It also requires states to compare their FFS payment rates for primary care, obstetrical and gynecological care, and outpatient mental health and substance use disorder services to Medicare rates and publish the analysis every two years. States must publish the average hourly rate paid for personal care, home health aide, homemaker and habilitation services, and must publish the disclosure every two years.**

State Medicaid programs are required to ensure that payments to providers are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to beneficiaries at least to the same extent as to the general population in the same geographic area.

However, there are currently no specific requirements for how much a state Medicaid program pays providers. Moreover, in *Armstrong v. Exceptional Child Center*, the Supreme Court of the United States ruled that Medicaid providers and beneficiaries do not have a private right of action to challenge Medicaid payment rates in federal courts. As a result, there is significant variation across states in payment rates for services rendered. Medicaid payment rates are historically lower than Medicare payment rates across provider types.

Prior to the implementation of this rule, there are no requirements for states to publicly post payment rate information. If information is made available, it often is not easily accessible or understandable. States are required to conduct access monitoring review plans (AMRPs) to analyze data and supporting information to reach conclusions on sufficient access for covered services provided under FFS. When states submit a state plan amendment to reduce or restructure provider payment rates, they must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the final reduction or restructuring of Medicaid FFS payment rates on beneficiary access to care.

This final rule rescinds the AMRP requirements and instead requires states to publish all Medicaid FFS payment rates in a clearly accessible location on a public website. The final rule requires Medicaid payment rates to be organized such that a member of the public could readily determine the amount that Medicaid would pay for a service and, in the case of a bundled or similar payment methodology, identify each constituent service included within the rate and how much of the bundled payment is allocated to each constituent service under the state's methodology. If the rates vary, the state is required to separately identify the Medicaid FFS payment rates by population (pediatric and adult), provider type (*e.g.*, physician, advanced practice nurse, physician assistant) and geographical location, as applicable. States must date when the payment rates were last updated on the state Medicaid agency's website. States are required to publish payment rates no later than July 1, 2026, including approved Medicaid FFS payment rates in effect as of July 1, 2026. The Medicaid managed care rule that was released in coordination with this final rule includes requirements for publishing Medicaid managed care payment rates.

CMS also finalized its proposal to require states to conduct a comparative payment rate analysis between their Medicaid payment rates and Medicare rates for primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services. If the rates vary, the state must separately identify the payment rates by population (pediatric and adult), provider type and geographical location, as applicable.

For HCBS services (personal care, home health aide, homemaker and habilitation services), states are required to develop and publish a disclosure of the average hourly Medicaid FFS fee schedule payment rates. The addition of habilitation services to this requirement is new and an expansion. For HCBS, if rates vary, states need separate identification of the average hourly Medicaid FFS fee schedule payment rates for payments made to individual providers and provider agencies by:

- Population (pediatric and adult),
- Provider type,
- Geographical location, and
- Whether the payment rate includes facility-related costs, as applicable (the requirement for states to include facility-related costs is new to the final rule).

The state agency must publish the initial comparative payment rate analysis and payment rate disclosure of its Medicaid FFS fee schedule payment rates in effect as of July 1, 2025, by no later than July 1, 2026. Thereafter, the state agency must update the comparative payment rate analysis and payment rate disclosure no less than every two years, by no later than July 1 of the second year following the most recent update.

In the final rule, CMS requires states to establish an interested parties advisory group to advise and consult with the state on payment rates for direct care workers for personal care, home health aide, homemaker and habilitation services. The addition of habilitation services to this group's purview is an expansion in the final

rule. This group would include, at a minimum, direct care workers, beneficiaries and their authorized representatives, and other interested parties. There appears to no explicit mention of providers in the group. The interested parties advisory group shall meet at least every two years and make recommendations to the Medicaid agency on the sufficiency of state plan, 1915(c) waiver and demonstration direct care worker payment rates.

Finally, states are required to conduct an "excess access review" if payment reduction or restructuring results in any of the following scenarios:

- Aggregate Medicaid payment rates are lower than 80% of the most recently published Medicare payment rates.
- Changes to Medicaid payment rates are a reduction of more than 4% in aggregate FFS Medicaid expenditures for each affected benefit category during the state fiscal year.
- The public processes raise significant access-to-care concerns from beneficiaries, providers or other interested parties.

## Medical Care Advisory Committees

**Key Takeaway: States will be required to establish and operate the newly named MAC and a BAC one year after the rule's effective date.**

Currently, states are required to have a Medical Care Advisory Committee (MCAC) in place to advise the state Medicaid agency about health and medical care services. However, current laws include very little specificity regarding how states should use MCACs to ensure proper and efficient administration of the Medicaid program and promote beneficiary perspectives. As a result, MCAC membership, transparency, meeting frequency and meeting structure vary significantly across states. The final rule seeks to increase transparency and uniformity while also improving committee effectiveness.

The final rule renames the MCAC to the Medicaid Advisory Committee (MAC) and create a separate Beneficiary Advisory Council (BAC). In the proposed rule, this was referred to as the Beneficiary Advisory Group. The MAC and BAC will serve as vehicles for bidirectional feedback between interested parties and the state on matters related to the effective administration of the Medicaid program. Federal matching funds for Medicaid administrative activities will remain available to states in the same manner as the former MCAC.

The MAC and its corresponding BAC will advise the state on issues related to health and medical services, matters related to policy development and the effective administration of the Medicaid program, consistent with the requirement that a state plan must meaningfully engage Medicaid beneficiaries and other low-income people in the administration of the plan.

Every state will vary in the size and make-up of its committees and the topics that may benefit from interested parties' feedback. Members of the MAC and BAC will be selected by the state Medicaid director on a continuous rotating basis. The MAC and BAC must each meet at least once per quarter, with off-cycle meetings as needed, and at least two MAC meetings per year must be open to the public. CMS establishes an administrative framework for the MAC and BAC to ensure transparency and a meaningful feedback loop with the public and among MAC and BAC members.

CMS finalized that at least 25% of MAC members must be individuals from the BAC with lived Medicaid beneficiary experience (*e.g.*, they are currently or have been a Medicaid beneficiary or the family member/care giver of a Medicaid beneficiary). However, instead of the 25% minimum threshold coming into effect right away as proposed, through July 9, 2025, only 10% of the MAC members must come from the BAC. From July 10, 2025, through July 9, 2026, 20% of MAC members must come from the BAC. Thereafter, the full 25% threshold will be in effect.

The rest of the MAC membership should include representation from each of the following categories:

- Members of state or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service to, Medicaid beneficiaries.
- Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care.
- Representatives from participating Medicaid managed care plans or the state health plan association representing such plans, as applicable.
- Representatives from other state agencies serving Medicaid beneficiaries as *ex officio* members.

## Conclusion

As noted, the rule is effective 60 days after publication, but many provisions have an effective date that widely differs from the overarching effective date. Stakeholders should review the final rule to assess the changes and its implications for their business lines.

CMS clarifies that if any provision of this final rule is held to be invalid or unenforceable by its terms, or stayed pending further state action, it shall be severable from the final rule and not affect the other provisions.

Should you have any questions regarding the Medicaid Access final rule, please contact the McDermottPlus team.

For more information, please contact Katie Waldo, Jeffrey Davis, Kayla Holgash or Priya Rathakrishnan.

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