UNIVERSITY of SOUTH FLORIDA

FLORIDA POLICY EXCHANGE CENTER ON AGING

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ENSURING ACCESS TO MEDICAID SERVICES: THE MEDICAID ACCESS RULE

What is the Medicaid Access Rule? It is a comprehensive ruling intended to improve quality and delivery of Medicaid-funded home-and-community-based services (e.g., home health services and personal care) for older adults and people with disabilities.

MEDICAID ACCESS RULING BACKGROUND

In April 2024, the Centers for Medicare and Medicaid (CMS) released the final Ensuring Access to Medicaid Services rule (Medicaid Access Rule), which addresses several aspects of home-and-community-based services (HCBS) for older adults and people with disabilities.

It is a comprehensive ruling that includes six primary provisions intended to improve quality and delivery of Medicaid-funded HCBS: Provisions address 1) direct care worker payment, 2) access to services, 3) person-centered planning, 4) incident management, 5) beneficiary grievances, and 6) service quality.

The entirety of the rule will be phased in over eight years (see timeline), and the Administration for Community Living (ACL) and CMS have committed to providing education and implementation support at the state and provider levels. The ruling applies to both fee-for-service and managed care Medicaid-funded HCBS programs, including but not limited to multiple 1915 waivers and 1115 demonstration waivers. The intended outcomes include helping more older adults and people with disabilities remain in their homes and communities while receiving necessary support.

PROVISIONS

Each provision includes several state and provider requirements intended to address some of the primary issues in current HCBS delivery, as well as systemize data recording and reporting across states. Components of the provisions are required to be phased in at various times over the next eight years (see timeline).

PAYMENT ADEQUACY

Primary Issue Addressing: The nationwide direct care worker (DCW) crisis, including a shortage of DCWs and low retention rates.

Core Components:

- 80% of ***all Medicaid payments*** for homemaker, health aide, and personal care services must go directly to compensating DCWs (80/20 Rule). This rule has ***some exceptions***: it excludes costs of travel, training, and PPE, it includes compensation for clinical supervisors who directly interact with beneficiaries, and there are avenues to create a separate percentage for small providers, as well as establish hardship exemptions. States must report the percentage of Medicaid funds going toward compensation for DCWs by 2028, and the 80/20 Rule becomes ***fully effective*** in 2030.

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2024

The Ensuring Access to Medicaid Ruling passed on April 24, 2024.

2026

States are required to have active systems to record and review grievance records.

States must establish a provider rate advisory group.

By July, states are required to have a published rate schedule that makes Medicaid fee-for-service payment rates publicly available.

2027

States are required to report on Medicaid HCBS waitlists, including average time beneficiaries are on lists.

States are required to have 90% compliance on the person-centered care provision.

States must implement all required incident management provisions, except an electronic system.

2028

States must establish quality performance targets and report on strategies to reach those targets.

States are required to report the amount of Medicaid payments spent on direct care worker compensation.

2029

States are required to have an electronic incident management system for Medicaid-funded HCBS.

2030

Providers must spend at least 80% of all Medicaid payments on compensation for direct care workers (80/20 rule).

2032

States are required to report data on quality measures stratified by subpopulations and demographic characteristics.

- By 2026, states must establish an ***advisory group*** to provide input on payment rates. The group must include DCWs, beneficiaries, and authorized representatives.
- By 2028, states are ***required to report*** percentages of Medicaid funds spent on DCWs ***annually***. Habilitation services are included in reporting requirements, but not included in the 80% compensation rule.

ACCESS

Primary Issue Addressing: Long state waitlists of beneficiaries who have been approved for HCBS services.

Core Components:

- By 2027, states must ***report on HCBS waitlists*** annually. Reports must include how waitlists are maintained, how often waitlist beneficiaries are screened for eligibility, how many people are on waitlists, and how long, on average, beneficiaries remain on waitlists.
- CMS aims to ***better identify the gaps*** between approved HCBS services and received HCBS services. To support this effort, states must report how long beneficiaries wait for homemaker, home health aide, personal care, and habilitation services after approval. They must also report the percentage of authorized service hours these beneficiaries receive.

"CMS is using this metric for currently enrolled participants to understand missed shifts, mitigate service plan inflation, and support determination of underserved states." – Leading Age

PERSON-CENTERED PLANNING

Primary Issue Addressing: Care plans may not always reflect beneficiaries' individual goals and preferences.

Core Components:

- Care plans must align with ***beneficiaries' preferences*** for care, and reflect each beneficiary's self-identified goals.
- Providers must demonstrate that they ***reassess*** beneficiary needs at least annually, and revise care plans accordingly.
- States must show ***90% compliance*** with the person-centered planning provision by 2027.

INCIDENT MANAGEMENT

Primary Issue Addressing: Nationally, there is minimal accountability to report, minimize, and prevent incidents, including neglect and abuse.

Core Components:

- All states must use a ***minimum definition*** of "critical incident" to establish national consistency (see below).

"The minimum definition of critical incident is comprehensive and 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 consultation with a poison control center (including telephone calls), an emergency department or urgent care visit, hospitalization, or death; an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect." - ACL

- States are required to adhere to ***minimum performance requirements*** for critical incident management, including investigation, resolution, and corrective action.
- By 2029, states must establish an ***electronic incident management system*** that helps them respond quickly and effectively when beneficiaries are harmed or at risk of harm.
- States must also use ***incident data*** to identify trends and patterns, and develop preventive policies.
- States are required to take a ***collaborative approach*** to incident identification and reporting when appropriate. This includes using outside information in incident investigations from agencies such as law enforcement and adult and child protective services, as allowed by law. It also includes sharing resolution information with these agencies when appropriate and allowable.
- States are required to ***assess*** their incident management systems every two years.

GRIEVANCES

Primary Issue Addressing: Many states lack a clear, transparent grievance processes for beneficiaries.

Core Components:

- By 2026, states are required to ***establish grievance processes*** for beneficiaries receiving fee-for-service Medicaid, similar to the requirements already in place for managed care.
- Grievance processes will ensure beneficiaries have clear avenues to ***express complaints*** about provider or state compliance with these provisions, among other quality standards.
- States must establish processes to ***investigate and respond*** to complaints.

They must also maintain complaint records, review them periodically, and supply records to CMS upon request.

QUALITY MEASURES

Primary Issue Addressing: Lack of nationally standardized quality measures for Medicaid-funded HCBS.

Core Components:

- The Centers for Medicare and Medicaid will establish ***national quality standards*** for Medicaid-funded HCBS with consideration of stakeholder input and public comment.
- By 2028, states must establish ***performance targets*** for each national quality measure, as well as report the strategies used to reach each target.
- States are required to ***report*** on quality measures every other year. In eight years, reports are required to include data stratified by demographic characteristics and subpopulations, such as race, ethnicity, sex, age, rural/urban status, disability, and language.

SUMMARY

The Medicaid Access Rule is a landmark policy initiative to improve delivery and quality of Medicaid-funded HCBS. The provisions of the ruling address critical issues in HCBS, including the DCW crisis, long waitlists, and lack of systemized reporting, to name a few.

While many stakeholders, including beneficiaries, believe the ruling will improve service delivery and quality, there is notable controversy over the payment adequacy provision, which is directed toward providers rather than states. Some providers are concerned they will have difficulty adhering to the provision, depending on how states choose to implement it.

At best, states will provide resources to help providers adequately compensate DCWs, as well as maintain strong operations. This may include states adapting hardship exemptions and more lenient payment provisions for small providers. At worst, this provision could deter providers from offering Medicaid-funded HCBS, or encourage them to cut administrative corners. Providers, beneficiaries, and other stakeholders should get involved at state levels as this provision develops.

HOW TO USE THIS INFORMATION:

National Agencies: Recognize that states and providers will need transparent, accessible support to implement this encompassing ruling well. Ensure that states, providers, and beneficiaries are involved in the development of educational materials and programs.

States: Utilize the educational resources available from national agencies, such as the Administration for Community Living. Also, look to states with well-developed HCBS programs, and even consider seeking mentorship from those state agencies. Use the eight-year timeline to begin building state infrastructure and personnel ahead of time.

Providers and Beneficiaries: Join state advisory boards to share ideas and concerns so that these provisions are implemented in an effective manner for all stakeholders.

RESOURCES:

ACL Blog: https://acl.gov/news-and-events/acl-blog/medicaid-access-rule-historic-regulation-strengthen-home-and-community

Leading Age: https://leadingage.org/final-medicaid-access-rule-includes-controversial-80-compensation-pass-through/

Final Rule: https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services

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