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Agenda

- Background
- Access Rule
- Managed Care Rule
- Next Steps
- Questions

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Background

- Two major proposed regulations released on April 27th:
  - Access Rule
  - Managed Care Rule
- Immediately followed April 18th Biden Executive Order on Supporting Caregivers
- Most recent of many CMS actions to address "Access"
- Proposed rules → Not final
  - Comment period open until July 3rd

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Medicaid Catalysts Regarding "Access"

March 2015: Armstrong vs Exceptional Child Center

Removed Private Right of Action for State Payment Rates

October 2015: Original "Access" regulation

Required State Medicaid "Access Monitoring Plans"

July 2019: Proposed Rule

Would rescind original Access regulation

February 2022: Access Request for Information

Broad request covering Access issues including payment, wages, eligibility, Managed Care

April 2023: New Access Proposed Rule

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ACCESS RULE: Key Components

- HCBS Payment Adequacy
- Payment Rate Transparency
- Justification Required for Certain Rate Restructures
- Requirement to Create an Interested Party Advisory Council
- Waiver Waiting List Reporting
- Reporting on Delays or Gaps in Accessing HCBS
- HCBS Quality Reporting
- HCBS Grievance System
- HCBS Incident Management System

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HCBS Payment Adequacy

- Would require states to "assure" that at least 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers
- Limited scope of services:
  - Homemaker;
  - Home Health Aide; and
  - Personal Care.
- Applied to following parts of Medicaid:
  - 1915(c)
  - 1915(i)
  - 1915(j)
  - 1915(k)
  - 1115
- NOT applied to 1905(a) [State plan].
- Would be effective 4 years after the publication of the final rule.

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Worker Definition

- Workers who:
  - Provide nursing services
  - Assist with ADLs and IADLs
  - Provide behavioral supports, employment supports, or other services to promote community integration.
- Specifically includes:
  - Nurses (RNs, LPNs, NPs, Clinical Nurse Specialists)
  - Licensed or certified nursing assistants
  - Direct support professionals
  - Personal care attendants
  - Home health aides
  - "Other individuals" paid to directly provide Medicaid services that address ADLs/IADLs, behavioral supports, employment supports, or other services to promote community integration.

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Compensation Definition

- Salary;
- Wages;
- Other remuneration as defined by the Fair Labor Standards Act;
- Benefits:
  - Health and dental Insurance;
  - Sick leave;
  - Tuition reimbursement; and
- The employer share of payroll taxes for direct care workers.

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Reporting/Monitoring

- States would report annually on the percent of payments for homemaker, home health aide, and personal care spent on compensation for direct care workers
  - Separate reports for each service category
  - Separate report on self-directed services for each category
- Effective 4 years after issuance of final rule

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Areas Where CMS Specifically Requests Comment

- 80% threshold
- Timeline for implementation
- If additional services should be included
- Authorities included
- Other items to include in the definition of compensation

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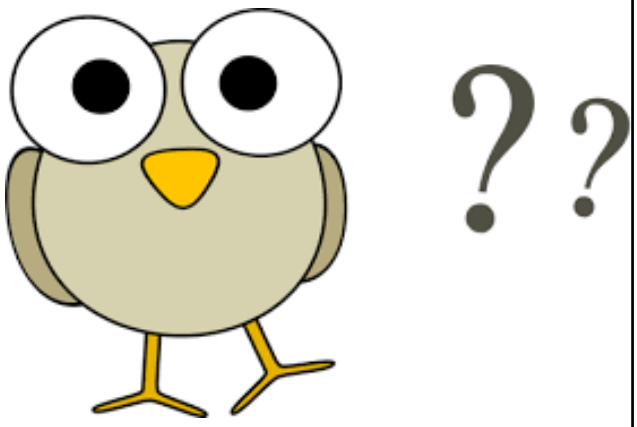
Outstanding Questions

- Is there statutory authority?
- Where did the 80% threshold come from?
- Why choose the services in the rule?
- What about state and federal quality, IT, and health/safety requirements?



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Payment Rate Transparency

- Every state must maintain an easily accessible website that contains current fee-for-service rates, including:
  - Variations based on population
  - Geographic differences and must clearly delineate each distinct payment amount in such instances
- States must also clearly delineate the different components of a bundled rate and the amount of payment attributable to those components.
- For personal care, home health aide, and homemaker services, the state must clearly identify the average hourly payment rates
- Must also show any differences for:
  - Individual providers and providers employed by an agency;
  - Variations between pediatric and adult;
  - Different provider types;
  - Geographical locations.
- The state must also identify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services.

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Justification for Certain Rate Cuts/Restructures

Proposes a three criteria test:

1)Aggregate payment rates at or above 80% of the comparable Medicare rate;
2)Aggregate payment reduction ≤ 4%; and
3)Public input processes resulted in no concerns or concerns that the state can reasonably mitigate.

If all three are met, State must show that it meets these criteria and that it will monitor access and continue to meet the three criteria on an ongoing basis

If all three are not met, significant data reporting requirements to get approval

Services, including many HCBS, without corresponding Medicare services would always be subject to the higher reporting

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Requirement to Create an Interested Party Advisory Council

Required group to advise and consult on fee-for-service rates specifically targeted to HCBS.

Focus on rates paid to direct care workers providing self-directed and agency HCBS, at a minimum for personal care, home health aide, and homemaker services.

Meet at least every 2 years to evaluate and comment on current and suggested payment rates and the sufficiency of these rates to ensure access to HCBS.

The Medicaid agency would be required to publish the recommendations of the interested parties' advisory group and should consider, but not be required to adopt, those recommendations.

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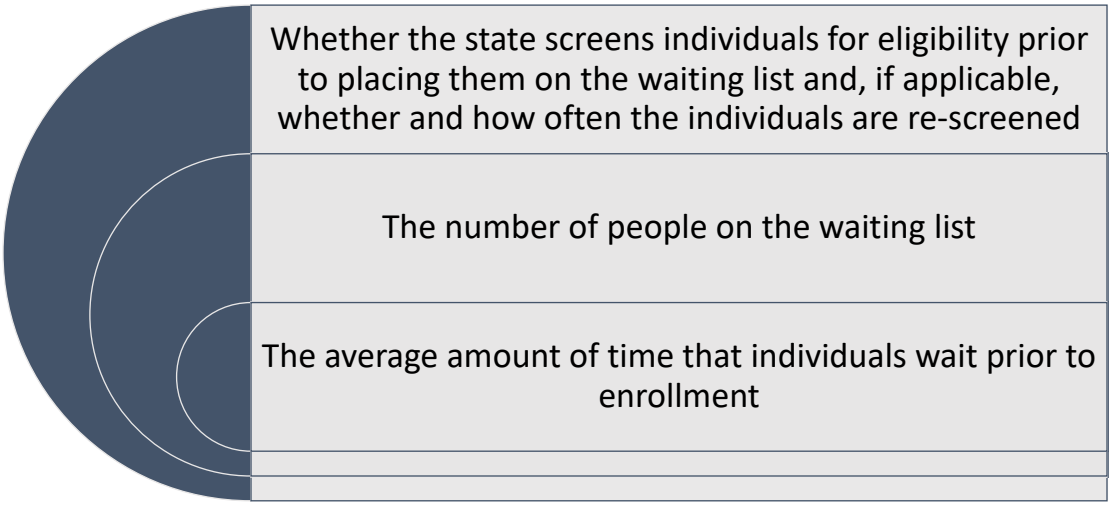
New Waiver Waiting List Reporting Requirements:



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Reports on Delays and Gaps in Care

- Report on the average amount of time that lapses between when certain HCBS are authorized and when services begin.
- Applies to:
  - Homemaker
  - Home health aide
  - Personal care services
- Delivered in sections
- 1915(c), (i), (j), (k) and 1115 of the Social Security Act, as well as under managed care delivery models.
- Additional reporting on the percentage of authorized hours that are delivered for those same three service categories.
- States allowed to use a statistically significant sample size of individuals

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New HCBS Quality Reporting System

Shift focus to the following five priority areas:	• Person-centered planning; • Participant health and welfare; • Access; • Beneficiary protections; and • Quality improvement.
As part of the new Quality requirements, states would have to report every alternating year on the HCBS Quality Measure Set	• Announced in July 2022 State Medicaid Director Letter • https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf

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HCBS Grievance Systems

States must establish a new system to collect and track "grievances"

- Grievance defined as "an expression of dissatisfaction or a complaint"
- Minimum requirement to deal with issues related to:
  - State's or a provider's compliance with person-centered planning and service plan requirements
  - The HCBS "settings" requirements that establish criteria for where HCBS may be provided

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HCBS Incident Management Systems

Requires States to operate and maintain an incident management system

- Core functions for system:
  - Identify
  - Report
  - Triage
  - Investigate
  - Resolve
  - Track
  - Trend
- 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.

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MANAGED CARE RULE: Key Components

- Experience of Care Surveys
- Appointment Wait Time Standards
- "Secret Shopper" Surveys
- Managed Care Payment Analysis
- Access Remedy Plan
- State Directed Payments
- In Lieu of Services
- Managed Care Quality Rating System

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Managed Care Requirements

Appointment Wait Time Standards	"Secret Shopper" Surveys	Experience of Care Surveys

• Outpatient mental health and substance use disorder:
  • 10 business days;
• Primary care:
  • 15 days;
• Obstetrics and gynecology:
  • 15 days
• Additional state-defined service:
  • No Federal maximum.
  • Defined using an "evidence-based" approach
	• Require states to contract with an independent entity to verify compliance
	  • Would attempt to schedule as though it were a Medicaid participant
	• Applies to same 4 services as wait time requirements
	• Used to monitor wait time and provider directories
		• Require States to conduct an annual enrollee experience survey
		• Does not prescribe the tool – examples such as CAHPS surveys
		• Results used to monitor and improve managed care performance
		• Encourages but not requires provider surveys

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Managed Care Payment Analysis

The plan must compare aggregate payment amounts to what Medicare would have paid for the same services for:	Primary care
	OB/GYN
	Mental health
	Substance use disorder services
Health plan must compare aggregate payment amounts to what Medicaid fee-for-service would have paid:	Homemaker
	Home Health Aide
	Personal Care

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Access Remedy Plan

- State must develop and submit a plan to address any identified Access issues
- CMS does not prescribe any specific remedies and instead provides examples, such as:
  - Increasing payment rates to providers;
  - Improving outreach and problem resolution to providers;
  - Reducing barriers to provider credentialing and contracting;
  - Providing for improved or expanded use of telehealth; and
  - Improving the timeliness and accuracy of processes such as claim payment and prior authorization.

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State Directed Payments

- Eases limits to facilitate:
  - Value based purchasing agreements
  - Medicare fee-schedule requirements
- Limits payments to average commercial rate for:
  - Inpatient hospital services
  - Outpatient hospital services
  - Nursing facility services
  - Qualified practitioner services
- No limit for other services, including HCBS
  - Must be reasonable, appropriate, and attainable
- Considers, but does not, establish maximum amount of SDP

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In Lieu of Services

Limits services to a service available under the Medicaid state plan or a waiver, including sections 1905(a), 1915(i), 1915(k), and 1915(c)	• Exception: IMDs under current 15 day rule
Document the clinically defined target population(s) for in lieu of service	
Limits expenditures to 5% of program	• Exception: IMDs

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Managed Care Quality Rating System

- Three specific parts of the MCO quality strategy:
  - Mandatory measures
  - Rating methodology
  - Website display requirements
- Goal is help individuals make MCO choices by improving:
  - Availability
  - Understandability
  - Usability

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NAHC Next Steps

- Information Gathering
  - Current Medicaid payment rates
  - Existing pass-through requirements in states
  - Current cost-centers for NAHC members
- Partner Engagement
  - Identifying potential partners
  - Forming coalitions
- Developing Comments
  - Comment period closes July 3rd
  - Call for workgroup participants! Email dterzaghi@nahc.org by Friday, May 12th
- Capitol Hill Advocacy
  - Understanding positions of Congressional Offices
  - Explaining concerns and challenges with proposal

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Discussion

- Questions
- Feedback on rules
  - Concerns
  - Areas you support
  - Outstanding unknowns/unclear proposals
- Next steps
  - Other items NAHC should consider
  - Actions you are taking

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THANK YOU

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