Milliman

WHITE PAPER

Home and community-based services payment adequacy considerations under the CMS Proposed Access Rule

By Gwyn Volk, Dennis Finnegan, Katherine Wentworth, Jeremy Cunningham, and Alyssa Tolbert

06 June 2023

On May 3, 2023, the Centers for Medicare and Medicaid Services (CMS) released a notice of proposed rulemaking titled "Medicaid Program; Ensuring Access to Medicaid Services"[1] (Proposed Access Rule).

This rule is part of a series of CMS proposals[2] seeking to improve access to Medicaid services across three key dimensions: knowledge of and ease of enrollment for services; ability to maintain coverage; and access to services and supports. The Proposed Access Rule's provisions are specific to the third dimension and—as described in the Summary of Proposed Strategies sidebar—include a range of strategies to improve access to home and community-based services (HCBS).

This paper focuses on the Proposed Access Rule's HCBS payment adequacy provisions, with the goal of supporting states' strategic planning and submissions of comments to CMS by July 3, 2023.[3] We highlight high-level considerations related to the proposed requirement that direct care worker (DCW) compensation represent at least 80% of the Medicaid payment for homemaker, home health aide, and personal care services, noting that CMS is considering applying a similar requirement to other HCBS services.

SUMMARY

Proposed strategies to support access to HCBS

HCBS Payment Adequacy *Sections II.B.5 and II.B.7.d*

- Annually demonstrate that direct care worker compensation represents at least 80% of the Medicaid payment for homemaker, home health aide, and personal care services

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG) *Sections II.A. and II.C.2*

- Replace the current Medical Care Advisory Committee (MCAC) with a MAC and establish a BAG
- Establish an advisory group to advise on provider rates for personal care, home health aide, and homemaker services (MAC could be used for this purpose)

HCBS Person-Centered Service Plans *Sections II.B.1. and II.B.7.a.(3)*

- Annual demonstration that reassessment of functional need was conducted at least annually for 90% of individuals continuously enrolled in 1915(c) waivers

HCBS Incident Management System *Sections II.B.3. and II.B.7.a.(1) and II.B.7.a.(2)*

- Implement electronic system to collect and track HCBS critical incidents
- Demonstrate through annual report that at least 90% of critical incidents were investigated

Access Reporting Requirements *Sections II.B.6. and II.B.7.c*

- Annually report on how the state maintains any waiting lists for 1915(c) waivers
- Report annually to CMS the average time from service approval to delivery for specific HCBS

HCBS Quality Measure Set *Sections II.B.7.b and II.B.8*

- Biannual reporting to CMS on measures with state-specific CMS-approved goals
- Multiyear phase-in to stratify reporting measures

Website Transparency *Section II.B.9*

- Operate public website that meets availability and accessibility requirements and provides results of new reporting requirements

HCBS Payment Transparency *Section II.C.2*

- Publish fee-for-service (FFS) rates and provide a payment rate disclosure for certain HCBS that would permit CMS to develop and publish HCBS payment benchmark data

HCBS Grievance System – FFS *Section II.B.2*

- Implement a beneficiary grievance system for FFS HCBS

Background

The Proposed Access Rule includes a broad set of new state Medicaid requirements intended to improve access to high-quality HCBS, consistent with the preferences of many beneficiaries to receive care in the community rather than institutions. CMS states that "these proposed improvements seek to increase transparency and accountability, standardize data and monitoring, and create opportunities for States to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care."[4] CMS's commentary places these requirements in the context of states' ongoing HCBS direct care workforce challenges, which are attributed to high turnover and staff shortages that have been exacerbated by the COVID-19 pandemic and have the potential to negatively impact quality and access to HCBS.[5] As such, the Proposed Access Rule requires that state Medicaid agencies demonstrate that payment rates for homemaker, home health aide, and personal care services are able to support a sufficient direct care workforce to meet beneficiaries' needs and to provide access to quality services. Specifically, states would need to demonstrate, via annual retrospective reporting, that DCW compensation represents at least 80% of the Medicaid payment for homemaker, home health aide, and personal care services.

This provision includes base and supplemental payments and would apply to services provided under fee-for-service (FFS), managed care, self-directed care, 1115 waivers, and via 1915(c), (j), (k), and (i) services. (Note that 1905[a] state plan services are excluded from this requirement.) Payments would presumably include value-based payments (e.g., pay-for-performance), negotiated rates, and other non-claims-based payments made to HCBS providers, although this has not been confirmed by CMS.

CMS further indicates that still under consideration is the use of percentage thresholds for other HCBS services, specifically:

- Adult day health and habilitation
- Day treatment and other partial hospitalization services
- Other partial hospitalization services
- Psychosocial rehabilitation services
- Clinic services for individuals with chronic mental illness
- Services for individuals with intellectual/developmental disabilities (I/DD), such as residential habilitation services, day habilitation services, and home-based habilitation services

Transportation services that are billed separately from other HCBS and face-to-face case management services were not specifically mentioned by CMS as being considered for a percentage threshold.

As part of the feedback CMS is soliciting from stakeholders on the Proposed Access Rule,[6] comments are specifically requested on the use of a minimum threshold for DCW compensation for additional HCBS, and what that threshold might be, acknowledging the necessary variation across HCBS regarding the proportion of provider costs that are specific to DCW wages. In particular, CMS notes that higher indirect costs (nonwage and benefits-related costs) would be appropriate for nonresidential community-based facility services (e.g., costs of transporting clients into the community), and facility-based round-the-clock services (e.g., building and activity space costs) as compared to homemaker, home health aide, and personal care services.

Proposed definition of DCW compensation

The Proposed Access Rule outlines the types of workers and compensation that would be counted toward the 80% requirement. The proposed federal definition of a direct care worker includes a range of positions involved in face-to-face support of individuals receiving services (e.g., direct support professionals, nurses, home health aides, and other individuals who provide services to Medicaid beneficiaries to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration). The proposed definition further specifies that the term includes individuals employed by or contracted with a Medicaid provider, state agency, or third party, and individuals delivering services under a self-directed service model.

Notably excluded from the proposed DCW definition are nurses in supervisory or administrative roles who are not directly providing nursing services to people receiving HCBS. The Proposed Access Rule does not specifically exclude non-nurse DCW supervisors. Many non-nurse DCW supervisors provide direct care services in addition to their supervisory roles and have wages that are not substantially higher than DCWs.

Because states have considerable variation in the terminology the use to define DCWs (in some cases differing by waiver type as well), it will be important to cross-walk these terms to the federal definition to assure compliance with the proposed compensation tracking requirements. States may also have providers who deliver other services beyond those types defined in the Proposed Access Rule.

The proposed compensation definition includes salary, wages, benefits, the employer share of payroll taxes, and other remuneration as defined by the Fair Labor Standards Act. CMS structured the compensation definition to be specific to the financial benefits to workers, electing not to include training (e.g., training activities that result in a certification that is not required to deliver the service) and other "workforce activities."

Reporting requirements for 80% threshold

States would be required to report annually on the 80% payment threshold for DCWs, with separate reporting for each applicable service. Additionally:

- States would need to report separately on self-directed care for each service.
- Reporting would be done in the aggregate across all programs as opposed to separately reporting by service for each waiver, HCBS program, or covered population.

CMS noted that it considered but chose not to allow states to exclude very small providers, stating that this may "discourage providers from serving Medicaid beneficiaries or increasing the number of Medicaid beneficiaries or amount of Medicaid revenues."

States are asked to provide comments on the following:

- Expansion of reporting for additional services
- Annual versus biannual reporting
- Alternative use of a state assurance or attestation subject to audit for compliance purposes
- Whether states should be required to report at the delivery system, HCBS waiver program, or population level
- Whether states should be required to separately report by compensation category: salary, wages, benefits, and payroll taxes
- Whether providers of agency-directed services that have low Medicaid revenue or beneficiaries should be excluded from reporting requirements

States vary widely in regard to required provider reporting of HCBS cost and wage information, which can also vary by type of service or HCBS program waiver within a single state. While there are states that have implemented annual reporting of provider costs and salary-related information that could be used to support the reporting requirements, many states only periodically collect this type of data when conducting rate studies, due to the administrative burden and expense involved for both the state agency and providers. In many cases, small providers are exempt from this reporting due to limitations in their accounting systems and ability to comply with technical definitions of costs. Some states have begun collecting hourly wage data on an ongoing basis, including participation in the National Core Indicators Intellectual and Developmental Disabilities (NCI/DD) Staff Stability Survey. It is possible that states could use hourly wage data to identify the estimated proportion of the Medicaid payments attributed to DCW compensation, but that approach would also require estimating employee-related expenses or capturing those costs through the same wage reporting process; additional guidance from CMS would be needed to determine whether such an approach would be acceptable.

States will need to consider what existing provider reporting processes could be leveraged or modified to collect the necessary data, and how those processes might be streamlined for smaller providers or for specific types of services. States will also need additional guidance from CMS to address how to handle reporting for providers that have DCWs delivering more than one service classified as HCBS, because those providers may experience specific challenges allocating DCW compensation to individual services.

States may also wish to consider whether there is value in requiring HCBS providers reporting more broadly than required by the federal definition, if this creates better consistency and less provider confusion given the state's chosen definitions. This approach may also help the state to evaluate equity in DCW compensation among all HCBS provider types. However, this would require the state to then split the reported data for purposes of federal compliance versus other state uses, which may prove difficult.

States should also be thoughtful about how collected data can provide an understanding of the variance in costs across HCBS and providers and inform related payment and funding decisions. For example, ongoing collection of provider costs by service type and program can help assess whether additional funding efforts have been successful in meeting their intended goals (e.g., increasing DCW wages to support staff retention), and determining where additional funding or changes in funding might be needed.

Payment rate development policy considerations

The development of HCBS payment rates (e.g., updating or restructuring current rates) provides an opportunity to clearly define expectations regarding the proportion of costs expected to be dedicated to DCW compensation. As states continue or begin investments in workforce development initiatives, this also enables program evaluation regarding the impacts to DCWs.

While various rate methodologies may be used, HCBS payment rate development typically involves identifying the anticipated service delivery cost by developing assumptions regarding DCW wages and benefits, transportation, program support, and administrative costs. Obtaining provider feedback regarding HCBS-specific costs—e.g., via

stakeholder workgroups and cost and wage data collection—allows for transparency regarding these assumptions and supports the development of a DCW compensation framework. Subsequent provider reporting of DCW compensation as a percentage of Medicaid payment rates or managed care encounter data can then be compared to the expectations set during the payment rate development process, allowing states to determine whether additional policies or other changes are needed to achieve the goals for a particular service.

Managed care considerations

The Proposed Access Rule applies the 80% threshold requirement across service delivery approaches: managed care, FFS, and self-directed care. States will need to determine whether they will collect information directly from providers that provide services under managed care or require the managed care organizations (MCOs) to take on all or part of that responsibility. While states with managed care programs typically delegate reporting requirements and provider interactions to the contracted MCOs, providers may struggle with the complexity of reporting proportions of their costs to numerous MCOs (and depending on the state's delivery system design, potentially to FFS as well). Moreover, the data elements that providers must capture (e.g., salary, wages, benefits, payroll taxes, etc.) likely do not easily break down on a payer basis, which may lead to confusion about what costs should be reported to which payer. At a time when states are pursuing efforts to increase the size of their direct care workforces, it may be important to consider the level of administrative burden imposed on providers to support compliance with this reporting requirement.

States will also want to consider what consequences will apply if providers fail to report (or fail to provide full reporting). One option may be to make the reports a condition of program participation or certification. But again, as workforce challenges persist, states may wish to consider more supportive options such as mechanisms for technical assistance and provider education about the reporting requirements.

If a state does opt for the MCOs being responsible for the 80% threshold reporting, a standardized process may help reduce the reporting burden for providers. States can help clarify provider expectations and assure common MCO data collection processes by publishing the payment rate methodology and reporting standards, creating standard reporting templates, and even developing standard HCBS provider contract language that the MCOs must use. All of these requirements should be documented in an amendment to the state's MCO contracts, including reference to the federal definition (as per the CMS Final Access Rule, once published) and potential penalties for MCO noncompliance. MCOs would then be incentivized to work with their contracted providers to assure full participation in the data collection process. Additionally, even if MCOs are tasked with data collection for their portion of the HCBS provider payments, states may still wish to create provider education materials about the new requirements through state-issued provider bulletins or other communication pathways, in order to promote fuller provider understanding and cooperation.

Timeframe for implementation

States will have four years after the Final Rule effective date to reach compliance with any new minimum threshold percentage requirements. For managed care, compliance must occur as of the first rating period on or after the four-year period. While the additional time for managed care may be useful in some cases given the cadence of MCO contracting terms, states may also wish to seek input from providers about whether a bifurcated approach (where FFS reporting precedes managed care reporting) is more disruptive to providers, who may need to implement new tracking mechanisms to comply with the data collection process. If so, the state may prefer to select a common date for implementation across delivery systems.

States will need to determine the timing for any necessary changes to state regulations, and work across agencies and with state legislatures (if needed) to make appropriate revisions to policies, operational processes, information systems, and contracts. These processes can often take one to two years to complete, so planning for these changes will be important. States may also want to consider a phase-in of any new data collection efforts within the four-year implementation time period, as data quality typically improves when data are collected on an ongoing basis. Some provider types may be more ready to begin reporting sooner, which may also impact a state's implementation plan. States should also note that a full year of data would likely be needed to assess compliance, which would need to be accounted for within the four-year period.

Conclusion

The implementation of the 80% minimum percentage threshold and reporting requirements for homemaker, home health aide, and personal care services would provide states an opportunity to provide transparency in the expected wages paid to DCWs and a mechanism for states to monitor that the expected compensation is reaching the DCWs. Many states have been developing policies to support ensuring that increased provider rates translate into increased DCW wages, and this Proposed Access Rule is supportive of those efforts. States should consider the potential impact on DCWs for other services and any opportunities for alignment with homemaker, home health aide, and personal care services.

While it is not clear to what extent the Final Rule will include a minimum percentage threshold beyond homemaker, home health aide, and personal care services, it is likely that CMS will continue down the path of establishing national requirements regarding the proportion of the payment rate attributable to DCWs. From this perspective, states should consider their overall strategies regarding HCBS payment rate development and provider cost and wage data collection and analysis across programs, Medicaid authorities, and service delivery systems. In particular, using a rate model buildup approach for payment rate development allows for transparency regarding the amount of DCW compensation that is assumed for a service, and to what extent that compensation is salary, wages, or employee-related benefits. Applying such an approach would promote a common understanding of expectations by providers and the state.

CMS has provided the proposed rule changes as well as posed a number of other potential changes for comment. Stakeholders have until July 3, 2023, to submit comments for consideration.

---

[1] Ensuring Access to Medicaid Services. 88 Fed. Reg. 27960 (May 3, 2023), to be codified at 42 CFR 431, 438, 441, and 447. See https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf.

[2] Other currently proposed CMS access-related regulations: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54760 (September 7, 2022), to be codified at 42 CFR 431, 435, and 457; and Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (May 3, 2023), to be codified at 42 CFR Parts 430, 438, and 457.

[3] Ensuring Access to Medicaid Services. 88 Fed. Reg. 27960 (May 3, 2023), to be codified at 42 CFR 431, 438, 441, and 447. See https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf. Request for comment is described on page 27960.

[4] Ibid., p. 27960.

[5] Ibid., p. 27965.

[6] Ibid., p. 27960.

About the Author(s)

Gwyn Volk

Indianapolis | Tel: 1 262 2302489

Dennis Finnegan

Seattle | Tel: 1 206 3428951

Katherine Wentworth

Indianapolis | Tel: 1 317 524 3552

Jeremy Cunningham

Indianapolis | Tel: 1 317 5243579

Alyssa Tolbert

Seattle

For 75 years, we have combined technical expertise with business acumen to create elegant solutions for our clients. Today, we are helping organizations take on some of the world's most critical and complex issues, including retirement funding and healthcare financing, risk management and regulatory compliance, data analytics and business transformation.