PARTNERSHIP FOR MEDICAID HOME-BASED CARE

PROPOSED MEDICAID ACCESS RULE

On April 27, 2023 the Centers for Medicare & Medicaid Services (CMS) published the proposed rule, Medicaid Program: Ensuring Access to Medicaid Services. This proposed rule is intended to advance CMS's efforts to improve access to care, quality, and health outcomes, and better promote health equity for Medicaid beneficiaries including for home and community-based services.

The Social Security Act includes an "equal access provision" which requires that state Medicaid provider payments are "consistent with the efficiency, economy and quality of care… sufficient enough to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in a geographic area." This statutory provision was not regulated for decades until 2015, when the Obama Administration finalized regulations requiring states to report on certain Medicaid services and payment structures. The 2015 rule did not include Medicaid home and community-based services (HCBS) in the initial regulations. This latest proposed rule is the second attempt to regulate the equal access provision and now does cover HCBS services.

Proposal – Concerns and Positives

- **CONCERN:** While several recommendations below are in line with the equal access provision and are positive policy developments, PMHC is alarmed about a specific proposal for states to require that at least **80 percent of all Medicaid payments**, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers for homemaker, home health and personal care services.
    - This proposal is not accompanied by any data to justify a threshold and only cites two states who have done somewhat similar but lesser threshold requirements.
    - This proposal does not acknowledge the uniqueness of HCBS waivers - not one of over 300 HCBS waivers in the country are identical with regard to the population served, services provided, staff required to provide the service, and rate reimbursed.
    - This proposed mandate lacks acknowledgment of provider costs including transportation (particularly in rural areas), training, licensing, facility, and numerous other overhead costs.
    - This proposal appears to violate the purpose of the equal access provision by stressing the system and putting the network of providers in jeopardy, particularly those that serve rural and underserved populations.
    - CMS predicts that upwards of 12,000 HCBS providers will be impacted by this proposal.
- **POSITIVE:** In rescinding the 2015 final rule reporting requirements, CMS instead proposes new state reporting requirements and would for the first time include certain HCBS programs in those requirements for transparency, reporting, and advisement from stakeholders on reimbursement rates.
- **POSITIVE:** CMS proposes to create an HCBS grievance system and incident management system.
- **POSITIVE:** CMS proposes standard reporting requirements for waiting lists including PMHC recommendation of time between approval of service and actual start of service.

HCBS Primer: The Home and Community-Based waiver program was created in 1981 and incorporated into the Social Security Act at Section 1915(c). HCBS programs provide opportunities for Medicaid beneficiaries to "waive" services in institutions and instead receive services in their own home or community. These programs, often called 1915(c) HCBS waiver programs, serve a variety of targeted populations groups, such as seniors, people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. HCBS programs are managed by states, with federal approval and funding support. However, providers are ultimately reimbursed according to state determined reimbursement rates. These at home supports and services are now the essential foundation of our advancing home-based healthcare system.