JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

The New Medicaid Access Rule: Primer and Advocacy Strategies

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Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ+ individuals, and people with limited English proficiency.

About CLPC

The Community Living Policy Center (CLPC) at the Lurie Institute for Disability Policy at Brandeis University, conducts research on the provision and quality of home- and community-based service (HCBS) programs for people with disabilities in the United States.

Their research seeks to answer questions regarding the state of HCBS services for people with disabilities in the U.S., the policies that help people with disabilities live and participate in the community or prevent them from being fully integrated, and what policies are most effective to ensure that people with disabilities can live and participate in their communities.

Justice in Aging's Commitment to Advancing Equity

To achieve Justice in Aging, we must:

- Advance equity for low-income older adults in economic security, health care, housing, and elder justice initiatives.
- Address the enduring harms and inequities caused by systemic racism and other forms of discrimination that uniquely impact low-income older adults in marginalized communities.
- Recruit, support, and retain a diverse staff and board, including race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, and economic class.

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Implementing Access Rule

Compare to Implementation of Home and Community Based Services Settings Rule

- Despite nearly decade-long implementation process, many states remain out of compliance with Settings Rule although Centers for Medicare and Medicaid Services (CMS) has signed off.
  - Result: HCBS participants may lack basic protections.
- The Lesson: Get Involved Early!

Access Rule: Grievance System

Background on Grievance Systems

- To implement the Settings Rule, CMS has required states to document:
  - How beneficiary files complaint, and
  - How State responds.
    - *See* CMS, Themes Identified During CMS' Heightened Scrutiny Site Visits Slides 29 & 31, November 2022.
- But states' descriptions of complaint processes often lacked specifics and failed to provide basic protections.

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Grievance System in Access Rule

- Requires procedure for beneficiary to file grievance against
  - State or
  - Provider.
    - 42 C.F.R. § 441.301(c)(7).
- Note: Applies only to fee-for-service HCBS, because Medicaid managed care has preexisting grievance requirements.

Grievance Must Relate to Violation of Federal HCBS Regulation

- Violation of specific federal HCBS regulation regarding State's or provider's performance of:
  - Person-centered planning process;
  - Person-centered plan; or
  - HCBS Settings Rule.
    - Including eviction protections, prohibition of restraint use, guaranteeing privacy, etc.
  - Important to advocate broad interpretation of plans and planning, so that quality of care concerns are covered by grievance procedures.
    - For example, worker missing shifts or frequently arriving late.

Grievance Process

- File orally or in writing.
- Grievance decision-makers
  - Independent of prior reviews and
  - Relevant expertise.
- Beneficiary with meaningful opportunity to submit evidence, face-to-face (including video or audio) and in writing.
- Provide beneficiary with case file.
- Provide language services to support use of grievance system.

Timeframes

- Beneficiary can file grievance at any time.
- State must resolve the grievance "as expeditiously as the beneficiary's health condition requires."
  - Within State – established timelines not to exceed 90 days.

“Resolving” Grievance

- State must establish method to notify beneficiary of grievance resolution.
- In regulation, only listed requirements for format are accessibility for:
  - Beneficiaries with limited English proficiency (LEP), and
  - Beneficiaries with disabilities.
- State must maintain grievance records and review as part of ongoing monitoring.

Additional Requirements

- "Provide beneficiaries with reasonable assistance in ensuring grievances are appropriately filed."
  - Language assistance as necessary, including auxiliary aids and interpreter services.
- Notify beneficiaries and providers of grievance system and beneficiary rights.
- "Review" resolution when "beneficiary is dissatisfied."

Grievance Requirements Implementation Timeline

- Grievance requirements must be implemented by July 9, 2026.

Implementation Opportunities (1 of 4)

- Timeline: hold State accountable to addressing grievance as "expeditiously as possible"
  - Establish prompt response timelines based on grievance type
  - For grievance process to work as intended, needs to "prevent" more critical issues
- Ensure grievance system can address quality of care issues.

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Implementation Opportunities (2 of 4)

- Ensure “resolution” is meaningful for beneficiary.
  - Establish enforcement mechanisms to ensure provider compliance and identify underreported instances.
    - Ongoing monitoring efforts: random audits, annual site visits/ licensing inspections, data collection efforts inclusive of ombudsman program data, staff training, corrective action plans, fines, and penalties.
  - Create and fund unit to operate grievance system.

Implementation Opportunities (3 of 4)

- Embed Consumer Protections
  - Describe right to "review" of unsatisfactory resolution.
  - Define "reasonable assistance" to ensure beneficiaries get needed support and accommodations.
  - Consider accessibility needs beyond LEP and disability.
- Visibility
  - Training needed for state officials and providers on grievance system requirements.

Implementation Opportunities (4 of 4)

- Accessibility
  - Ensure recipients know how to report complaint and can do so without fear of retribution
    - System cannot only rely on case manager as primary reporting method (at times, conflict of interest)
  - Best practices:
    - Complaints accepted via 24-hour hotline, email, physical mail, or in person
    - Complaints accepted through Ombudsman
    - No “magic” language is needed to initiate a grievance
- Ensure state systems (grievance, Critical Incident, Adult Protective Services) collaborate
  - “No wrong door” for accepting grievance.

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Critical Incidents

Incident Management System

- States must have “incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.”
- System must enable:
  - Electronic data collection;
  - Tracking of incident and investigation resolution; and
  - Trend analysis.
    - 42 C.F.R. § 441.302(a)(6).

What Is “Critical Incident”?

- At a minimum, must include
  - Verbal, physical, sexual, psychological, or emotional abuse;
  - Neglect;
  - Exploitation;
  - Misuse or unauthorized use of restrictive intervention or seclusion;
  - Medication error causing emergency; and
  - Unexplained or unanticipated death.

State and Provider Obligations

- Providers must report critical incidents within state-established timeframes.
- State Responsibilities:
  - Identify unreported incidents by analyzing claims data analysis and other strategies.
  - Enable information sharing between government agencies for investigations.
  - Separately investigate incidents if investigative agency misses deadline.

“Minimum Performance” Standards for State

- Focus on Timeframes
  - Specifically, State must achieve at least 90% compliance with State-specified timeframes in:
    - Initiating investigation;
    - Completing investigation;
    - Determining resolution; and
    - Ensuring that corrective action has been completed.

Implementation Timeline

- Generally July 9, 2027.
- But July 9, 2029, for information system.

Implementation Opportunities re: Sources of Information

- Beneficiaries can only file **grievances** on violations of federal HCBS regulations.
- Critical incident investigation has broader subject matter scope – e.g., including neglect, abuse, medication errors, etc. – but is based on
  - Providers' self-reported information, and
  - Data from other state agencies.
- Inclusive system would allow beneficiaries and others to report "critical incidents."

Implementation Opportunities re: Enforcing Law

- State needs mechanism to"[e]nsure that corrective action has been completed."

Implementation Opportunities re: Investigative Process

- Question: What's the point of specifying 90% compliance for initiating investigation, determining resolution, and ensuring corrective action?
  - System should be set up for 100% compliance.
    - For example, should not disregard 10% of incidents.

Person-Centered Planning

Person-Centered Planning: Background

- Pre-existing federal regulations require person-centered planning process aimed at developing plan that
  - Meets service needs, and
  - Reflects beneficiary's preferences.
- Most service plans fall far short of being truly "person-centered."

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Access Rule on Person-Centeredness

- Old language: "The individual will lead the person-centered planning process **where possible**."
- New language: "The individual, or if applicable, the individual and the individual's authorized representative, will lead the person-centered planning process."
    - 42 C.F.R. § 441.301(c)(1)-(3).

Access Rule re: Assessments & Service Plans

- Both before and after Access Rule, assessment and service plan must be addressed
  - Every 12 months,
  - When necessitated by change in condition, or
  - When requested by beneficiary.
- Access Rule adds standard that State must have at least 90% compliance for
  - Reassessing beneficiary every 12 months, and
  - Reviewing service plan every 12 months.

Implementation Opportunities re: Person-Centered Planning

- State must comply with 90% standards by July 9, 2027.
- Paper compliance probably is relatively easy – a better goal is to increase person-centeredness of process.

Reporting and Website Transparency

Reporting to CMS (1 of 3)

- Critical incidents:
  - Number and percentage of timely initiated investigations.
  - Number and percentage of timely resolutions.
  - Number and percentage of corrective actions taken within specified timeframes.
- Person-Centered Planning:
  - Percentage of reassessments conducted within 12 months.
  - Percentage of service plans updated within 12 months.
    - 42 C.F.R. § 441.311.

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Reporting to CMS (2 of 3)

- Wait list
  - How State maintains wait list.
  - Number of people on wait list.
  - Average amount of time on wait list before approval for services.

Reporting to CMS (3 of 3)

- Access to Services (homemaker, home health aide, personal care, habilitation)
  - Time between approval and first provision of services.
  - Percentage of authorized services provided.
- Quality measure set (discussed separately).
- Payment adequacy.

Website Transparency

- Information reported to CMS must be posted on website.
- Deadline for compliance: July 9, 2027.
  - 42 C.F.R. § 441.313.

Implementation Opportunities re: Reporting and Website Transparency

- Need early and frequent input from stakeholders.
  - Public website will not fulfill purpose if public finds it difficult to access or understand.

HCBS Quality and Stakeholder Engagement

Focus on Two Provisions of Access Rule

- HCBS Quality Measure Set
- Interested Parties' Advisory Group
- Collaboration between states, plans, and advocates to meaningfully implement provisions

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HCBS Quality Measure Set Purpose

- Consistent reporting and comparability across states
- Drive quality improvement

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HCBS Quality Measure Set Timeline

- 2010-2014: Wild West
  - Managed Long-Term Services and Supports (MLTSS) and Duals Growth
- 2015-2016: National Quality Forum Committee HCBS Quality
  - Consensus Recommendations
- 2017-2019: Measure Development
  - Administrative HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - National Core Indicators – Intellectual and Developmental Disabilities (NCI-IDD)
  - National Core Indicators – Aging and Disabilities (NCI-AD)
- 2020-2024: CMS Guidance on HCBS Core Set
  - Request for Information
  - State Medicaid Director
  - Money Follows the Person (MFP) Reporting
- 2024-Forward: Final Access Rule

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Final Access Rule (1 of 2)

- Required Reporting
  - States begin reporting every other year on subset of required measures (July 2028)
  - CMS will report some measures on behalf of states
  - States must establish performance targets and describe quality improvement strategies
- Phase-In of Reporting
  - CMS will phase-in required reporting
  - Stratification of certain measures (race, ethnicity, sex, age, rural/urban status, disability, language)
    - 25% (4 years); 50% (6 years); 100% (8 years)

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Final Access Rule (2 of 2)

- Ongoing Process for Establishing and Updating HCBS Core Set (every other year)
  - Addition/deletion of measures, technical specifications, ensuring evidence-base
  - Populations for reporting
  - Selection of measures for stratification based on valid statistics and privacy
  - Consultation with wide range of stakeholders, including public input and comment

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How Can We Meaningfully Implement? (1 of 6)

- Maximize Use of HCBS Experience Surveys
  - Many states are already using
    - NCI-IDD
    - NCI-AD
    - HCBS CAHPS
  - If you are not using in your state START USING
    - Use MFP and American Rescue Plan Act (ARPA) funding
    - Use within MLTSS

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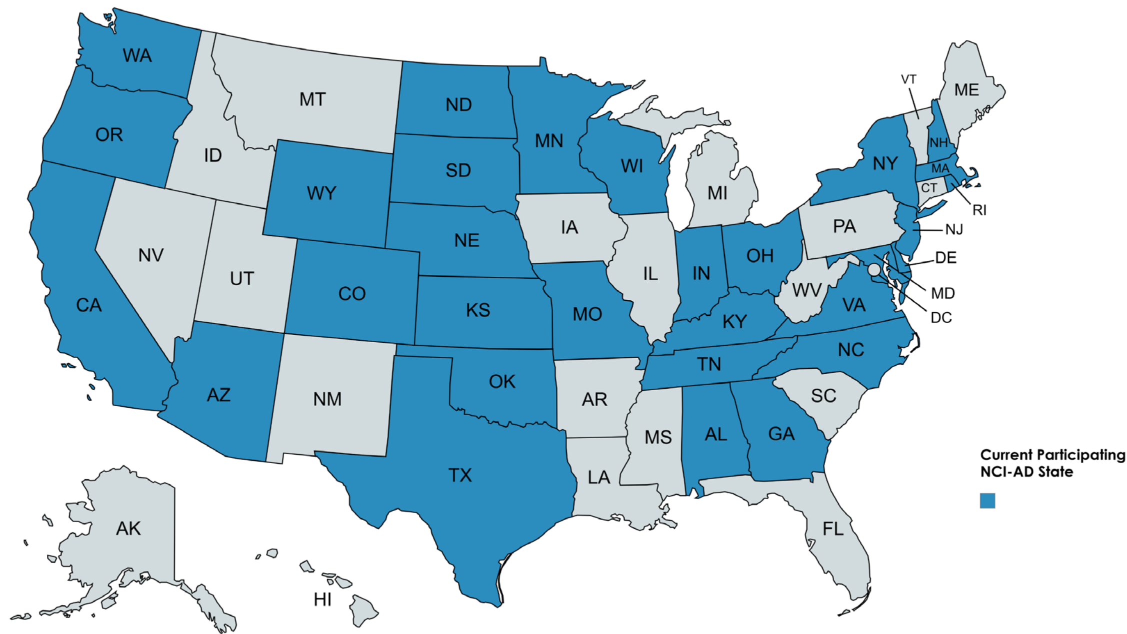
National Core Indicators – Aging and Disability Survey (NCI-AD)



HSRI and ADvancing States (2024)

How Can We Meaningfully Implement? (2 of 6)

- Improve Quality of State Medicaid Data within Transformed Medicaid Statistical Information System (T-MSIS)
  - Quality of HCBS Data
    - CMS and states need to monitor and improve to ensure reliable and valid administrative measures
  - Quality of Race/Ethnicity Data
    - Improving but many states still have high concerns or unusable data

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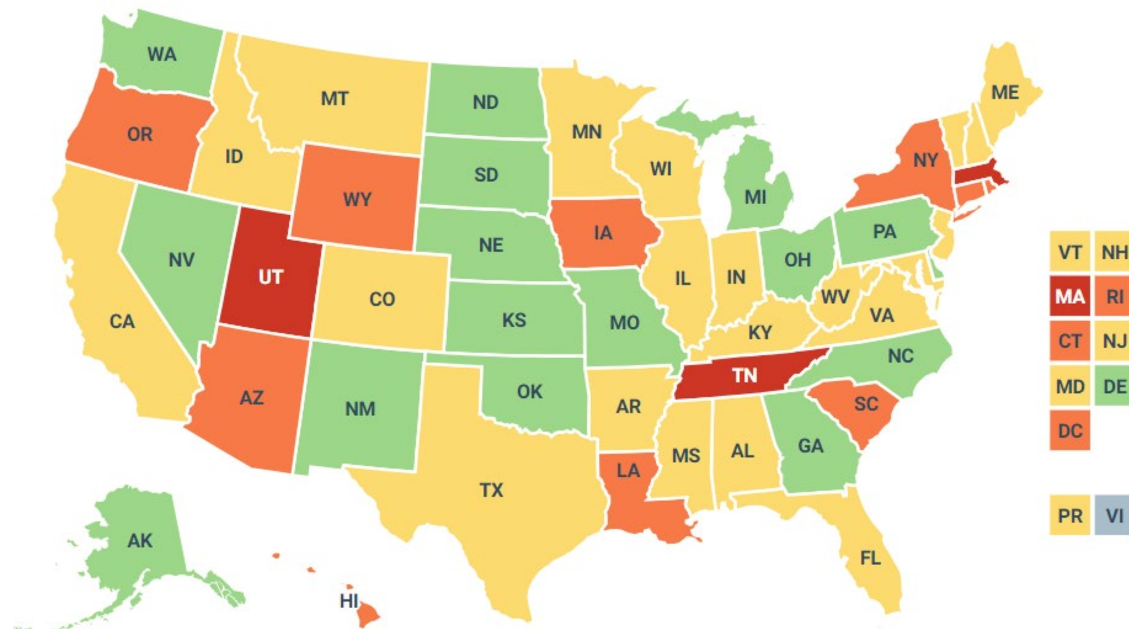
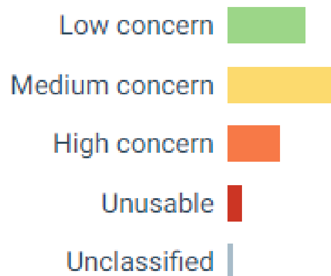
Quality of Medicaid Race/Ethnicity Data





CMS DQ Atlas (2022)

How Can We Meaningfully Implement? (3 of 6)

- Engage Stakeholders
  - Establish ongoing processes to engage beneficiaries, workers, advocates, providers and plans on HCBS quality
  - Share HCBS quality measures (aligned with CMS HCBS core set) and work together to set performance improvement targets
  - Collaborate with universities

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Interested Parties' Advisory Group (IPAG)

- Purpose
  - Stakeholder advisory group to "advise and consult" on adequacy of payment rates of direct care workers.

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Final Access Rule: IPAG Membership

- Minimum Requirements:
  - Direct care workers, beneficiaries and their authorized representatives, and other interested parties.
  - "Authorized representatives" refers to individuals authorized to act on the behalf of the beneficiary, and other interested parties may include beneficiary family members and advocacy organizations.
  - States can use MAC if all IPAG requirements met
  - States must publish IPAG selection and convening process

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Final Access Rule – Purpose & Reporting Requirements

- IPAG Formation & Meet Deadline – July 9, 2026 (§ 447.203(b)(6))
  - Meet at least every 2 years;
  - Recommendations to state Medicaid agency on sufficiency of direct care worker payment rates under all HCBS authorities including 1905(a) state plan services;
  - Medicaid agency required to publish IPAG recommendations within 1 month of recommendation to agency;
  - States required to consider, analyze, and respond to recommendations & share analysis with CMS, in connection with any SPA submission that proposes to reduce or restructure Medicaid service payment rates.
- Access Data Reporting Deadline – July 9, 2027 (§ 441.311(d)(2))
- Payment Adequacy Data Deadline – July 9, 2028 (§ 441.311(e))

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Final Access Rule: IPAG Reminders

- States have flexibility to rely on this group in ways that will best help to enhance HCBS or Medicaid more broadly. States can have, for example:
  - IPAG review broader HCBS issues or rates;
  - IPAG advise on provider payment rates in managed care delivery systems;
  - Focus on dually eligible beneficiaries – the majority of HCBS recipients are dually eligible;
  - Provide as much relevant and reasonably available data to support IPAG work:
    - Bureau of Labor Statistics wage data is publicly available and can be used by the group
- *States receive 50% federal match for expenses related to advisory groups.

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How Can We Meaningfully Implement? (4 of 6)

- Establish Right Group and Process
  - Ensure diverse perspectives
    - Beneficiaries, family caregivers, workers, advocates, providers, plans
    - Disability populations, agency/self-direction, race/ethnicity, geography
  - Support meaningful engagement
  - Mechanisms for broader community input
  - Ongoing process (versus 2-year minimum)
    - Group might also develop workforce recruitment and retention strategies

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How Can We Meaningfully Implement? (5 of 6)

- Provide Right Data and Information to Allow the Group to Make Informed Decisions
  - Payment rates and adequacy reporting required in the regulation (i.e. gaps in care)
  - HCBS experience surveys related to workforce (NCI-IDD, NCI-AD, HCBS CAHPS)
  - NCI-IDD and NCI-AD State of the Workforce Surveys (i.e. turnover and retention)
  - Qualitative – comments, testimonies, stories

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How Can We Meaningfully Implement? (6 of 6)

- Use the Analysis and Report
  - Must be publicly reported on website
  - Do a plain language version
  - Advocates can use the report to inform legislature about adequacy of payment rates and access

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Questions?

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