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Solutions that Matter

Key HCBS Provisions in the Medicaid Access Rule

Notable Changes from the Notice of Proposed Rulemaking

On April 22, 2024, The Centers for Medicare and Medicaid Services (CMS) published the Ensuring Access to Medicaid Services (Access Rule) final rule, which incorporates feedback CMS received in response to the initial notice of proposed rulemaking (NPRM) published in May 2023. While the Access Rule becomes effective on July 9, 2024, states have several years to seek guidance and build the necessary systems and processes to comply with its provisions. Below, we highlight key Access Rule requirements for Medicaid home- and community-based services (HCBS)—including those provided through Medicaid fee-for-service (FFS) and managed care delivery systems—and emphasize notable changes to the rule since the initial version was proposed. For a more detailed summary of the final Access Rule and its implications for states, click here.

HCBS Payment Adequacy

Implementation deadline: July 9, 2030

States must ensure that at least 80 percent of their Medicaid payments for direct care workers (DCWs)—such as homeworkers, home health aides, and personal care service providers—go toward their compensation, including salaries and wages, benefits, and payroll taxes. While the payment adequacy requirement becomes applicable in 2030, starting July 9, 2028, states must submit an annual report indicating the percentage of payments directed toward the compensation of DCWs. Beginning July 9, 2027, states must report on their readiness to comply with payment adequacy reporting.

Notable changes from the NPRM

- For DCWs under a self-directed model, payments are excluded from the state's compliance calculations.
- States may develop hardship and/or size exemptions through a transparent process involving public notice and comments.
- The deadline is extended to six years from the effective date of the rule.

HCBS Quality Measure Set Reporting

Implementation deadline: July 9, 2028

States are required to report every other year on the HCBS Quality Measure Set. For each measure, states must establish performance targets and describe their quality improvement strategies.

- Some measures will be focused on specific populations defined by age, delivery system, or disability.
- Some measures will be stratified by age, disability, ethnicity, language, race, rural/urban status, sex, or other specified factors. The stratification requirement builds over an eight-year period, but by 2032, 100 percent of the selected measures must be stratified.

Notable change from the NPRM

The Quality Measure Set should be updated and reported every other year (rather than annually).

Access Reporting

Implementation deadline: July 9, 2027

States that cap the number of individuals served in their waiver programs must disclose annually how they maintain the waiting list for those programs, the total size of the waiting lists, and the average amount of time individuals enrolled in the past year spent on the waiting list. States must also report on access to homemakers, home health aides, and personal care and habilitation services, including the average time from approval to initiation and the percentage of authorized service hours provided.

Notable change from the NPRM
The requirement now includes habilitation services. The final rule also clarifies that reporting the time between approval and use of services is not for those recently approved for services but those who have received services over the past year.

Incident Management System

Implementation deadline: July 9, 2029 for incident management system; July 9, 2027 for other provisions

States must have an electronic system to track critical incidents—including investigation status and resolution— and must incorporate data from claims, Medicaid fraud units, and other state agencies to identify critical incidents. States must also trend data on critical incidents.

Notable change from the NPRM
The compliance deadline is more nuanced, requiring states to start collecting and tracking critical incidents by 2027 and then do so within a digital system by 2029.

Person-Centered Service Plans

Implementation deadline: July 9, 2027

Annually, states must demonstrate that a reassessment of functional needs—including changes in their circumstances—was conducted for at least 90 percent of beneficiaries enrolled in an HCBS program for at least one year. States must report the following to CMS annually:

- The percentage of beneficiaries for whom a reassessment was completed in the past 12 months
- The percentage of beneficiaries who had a service plan updated as a result of the reassessment

States may report on these using a statistically valid random sample of beneficiaries.

Notable change from the NPRM
No major modifications.

Payment Rate Transparency

Implementation deadline: July 1, 2026

States are required to publish all Medicaid FFS fee schedules on a publicly accessible website. States must also publish bundled payment rates and identify the portion allocated to each constituent service included in the rate. Every two years, states must publish a comparative payment rate analysis and disclosure for specific categories of services. The analysis must

- Compare Medicaid FFS fee schedule payment rates to the most recently published Medicare rates
- Include the average hourly FFS rate paid to providers

Notable change from the NPRM
The requirement now includes habilitation services.

Website Transparency

Implementation deadline: July 9, 2027

States must compile and post required reporting data to a public web page to promote public transparency of the administration of Medicaid-covered HCBS. Site functionality and information must be reviewed at least quarterly, and the site should report data on critical incidents, incident management, payment adequacy, person-centered planning, and quality management.

Notable change from the NPRM
No major modifications.

Grievance Systems

Implementation deadline: July 9, 2026

States must establish procedures for processing grievances reported by Medicaid beneficiaries receiving HCBS through an FFS delivery system. Such grievances can address the performance of the state or providers carrying out waiver services. States must develop a written policy for grievance processes and

- Maintain certain standards and beneficiary rights (e.g., the ability to provide grievances in writing or orally with translation support and other assistance as needed)
- Review the records and resolve grievances within state-specified timeframes not exceeding 90 days
- Maintain and be able to share the records with CMS

Notable change from the NPRM
These activities can be completed by a contractor.

Medicaid Advisory Committee and Beneficiary Advisory Council

Implementation deadline: July 9, 2025

State Medicaid agencies must establish both a Medicaid Advisory Committee and a Beneficiary Advisory Council, selecting members, meeting regularly, developing bylaws for governance, drafting meeting minutes, and posting everything publicly. States must also draft an annual report summarizing the activities of both councils.

Notable change from the NPRM
The final rule updated member terms, elaborated on meeting format, and clarified that states can use existing committees and administrative FMAP.

How Can PCG Help?

Navigating the challenges of delivering HCBS that foster community inclusion and promote self-determination for growing service populations requires careful planning and cross-agency collaborations. With more than 37 years of experience providing guidance and implementation support to state agencies administering Medicaid programs, Public Consulting Group (PCG) can help your organization navigate the complexities of the Access Rule.

We offer:

Services

- Guide HCBS rate modifications, including collecting cost data from providers, benchmarking wages, and researching peer states
- Establish definitions and processes, including ones that facilitate public comments and stakeholder forums
- Draft annual reports
- Develop websites that meet accessibility and availability requirements

Systems

- Establish performance targets and develop reporting systems
- Develop incident management systems and analyze incident data
- Develop grievance systems

Research & Analysis

- Perform data analyses, develop data tracking systems, and establish processes for reassessments
- Conduct comparative analyses
- Conduct provider oversight, including investigation of critical incidents
- Analyze bundled rates to comply with reporting requirements
- Analyze waiting lists and help address waiting list challenges

To learn more about how PCG can assist your agency with Access Rule compliance and implementation, contact us today!

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