CLIENT ALERT: HOME AND COMMUNITY-BASED SERVICES PATIENT-CENTERED CARE PLANNING GRIEVANCE SYSTEM INCIDENT REPORTING

CMS Final Rule: Ensuring Access to Medicaid Services (CMS 2442-F)

PERSON-CENTERED PLANNING, GRIEVANCE SYSTEM, AND INCIDENT REPORTING

CMS identifies several home and community-based services (HCBS) program initiatives as part of the Ensuring Access to Medicaid final rule (Access Rule), released on May 10, 2024. The Access Rule is intended to improve access to care, quality of care, and health and quality-of-life outcomes for HCBS beneficiaries while increasing transparency and accountability. The Access Rule's requirements affect services provided under:

- 1915(c) waiver programs.
- State plan services under 1915(i), (j), and (k) authorities.
- 1115 demonstration project services, unless specifically waived.

The following is a summary of the new HCBS policy and program administration requirements as included in the Access Rule.

Person-Centered Service Planning (§ 441.301(c)(3))

An integral part of waiver services is the person-centered planning process. Within three years after the effective date of the Access Rule, states will be required to:

- Perform a reassessment of waiver-enrolled individual's functional needs and reassess annually thereafter.
- Conduct a reassessment when an individual requests one, or if their circumstances change.
- Review the person-centered plan for all waiver-enrolled individuals, and revise if necessary.

For services provided under managed care, reporting starts with the first rating period beginning on or after the date that is three years after the Access Rule's effective date.

Grievance System (§ 441.301(c)(7))

Effective beginning two years after the Access Rule's finalization, states are required to have a system in place to allow beneficiaries, or their representative, to file grievances related to state or provider performance under federal regulations. States will maintain responsibility for ensuring the performance and compliance of grievance system activities, but they may contract with external entities for assistance in maintaining compliance.

Incident Management System & Critical Incidents (§ 441.302(a)(6))

The Access Rule requires states to operate and maintain an incident management system to report any critical incident occurring during the delivery of 1915(c) HCBS within three years of the Access Rule's effective date. States must investigate no fewer than 90 percent of critical incidents within specified time-frames, under the Access Rule. These investigations require resolution and ensure that any corrective action is completed within state-established timelines.

Incident management systems must comply with 45 CFR 164 beginning five years after the Access Rule's effective date and must at minimum:

- Enable electronic collection of critical incident data.
- Track investigation statuses and critical incident resolution.
- Allow for data trending.

For any states that have a managed care delivery system, operation and maintenance of the incident management system begins in the first managed care plan contract rating period beginning following the specified deadlines above for incident management operation, maintenance and compliance, respectively.

Reporting Requirements (§ 441.311)

The Access Rule establishes new HCBS compliance reporting requirements and metrics beginning three years after the Rule's effective date. These requirements include those listed below.

REQUIREMENT	METRIC	COMPLIANCE TIME-FRAME
States will report on the results of the incident management system	Must demonstrate compliance with require-ments as listed above.	Initially every two years. Frequency may be reduced at the discretion of DHHS.
Critical incidents	▪ Number and percent of initiated critical incident investigations. ▪ Number and percent of investigated critical incidents with a resolution. ▪ Number and percent of critical incidents requiring a corrective action plan and that the plan is complete.	Annually.
Person-Centered Planning	▪ For individuals continuously enrolled in benefits for 365 days (a statistical sample is acceptable): – 90 percent of reassessments for functional needs were completed. – 90 percent of individual person-centered plans were reviewed and revised, if necessary, at least every 12 months.	At least every 12 months.
Access Reporting	▪ Waiver waiting list information, including, but not limited to, eligibility screenings and frequency, number of individuals on the waiting list, and average wait times. ▪ Access to specific services including homemaker, home health aide, personal care, and habilitation.	Annually, starting three years after the effective date of the Access Rule.

How Myers and Stauffer Can Support Your Programs

Myers and Stauffer has long-demonstrated success in developing policies and procedures supporting state HCBS programs. We are looking forward to leveraging our team's experience to assist states in initial and ongoing Access Rule compliance. Our team specializes in:

- Standardized functional needs assessment implementation.
- Training on person-centered practices.
- Policy development.
- Competency-based evaluations.
- Quality measurements.

Myers and Stauffer excels in HCBS-related programming and proudly relies on staff with extensive clinical, policy, and state-level experience. Our team's dynamic and diverse skill sets are used every day to ensure our clients are providing HCBS in a manner that is consistent with quality reporting requirements around health, safety, and welfare.

We look forward to working with your State to support the implementation of the new Access Rule requirements.

FOR MORE INFORMATION

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