Maryland
DEPARTMENT OF HEALTH

*Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary*

December 17, 2024

The Honorable Guy Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

**RE: 2024 Joint Chairmen's Report (p. 129-130) - Report on Federal Rule on Long-Term Care Data Reporting**

Dear Chairs Guzzone and Barnes:

Pursuant to the 2024 Joint Chairmen's Report (p. 129-130), enclosed is the Maryland Department of Health (MDH) report on the federal rule on long-term care data reporting that was published in the spring of 2023 that would create new home-and community-based services data reporting requirements, among other changes. MDH submits this report detailing the provisions in the final rule and plans to operationalize the rule in Maryland.

If further information on this subject is needed, please contact Sarah Case-Herron, Director, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, MD MPH
Secretary

Enclosure

cc: Ryan Moran, DrPH, Deputy Secretary, Health Care Financing and Medicaid
Tricia Roddy, Deputy Director, Office of Health Care Financing
Jamie Smith, Director, Office of Long-Term Services and Supports
Sarah Case-Herron, JD, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)


# Proposed Federal Rule on Medicaid Long-Term Care Data Reporting

**Joint Chairmen's Report (p. 129 - 130)**

**October 2024**

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## I. Introduction

In spring 2023, the federal Centers for Medicare and Medicaid Services (CMS) published a proposed rule referred to as Ensuring Access to Medicaid Services, which would create new home and community-based services (HCBS) data reporting requirements among other changes. The committees request that the Maryland Department of Health (MDH) submit a report detailing the provisions in the final rule and plans to operationalize the rule in Maryland. In addition, the report should include the process that MDH will take to collect and report the following information from long-term care providers generally (nursing home and HCBS providers):

- revenues allocated to salaries and wages of all direct care workforce non administrative staff, including registered nurses (RN), licensed practical nurses (LPN), certified nurse aides, non certified or resident care aides, directors of nurses, and in-house clerical staff who regularly interact with residents, program participants, and caregivers; and
- revenues allocated to contracted nursing care services.

The report should also include a review of the average hourly wage rate for private duty nursing services, including RNs and LPNs, in nearby states and the labor market overall. Finally, the report should discuss licensure requirements for residential service agencies to provide RN oversight, outlining the scope of work, associated costs, and coverage of these costs in provider reimbursement rates.

## II. Provisions of the *Ensuring Access to Medicaid Services Final Rule* (CMS-2442-F)

The Centers for Medicare and Medicaid Services (CMS) released the *Ensuring Access to Medicaid Services Final Rule* ("Access Rule"), which advances access to care and quality of care and improves health outcomes for Medicaid participants across fee-for-service (FFS) and managed care delivery systems, including home and community-based services (HCBS). The Access Rule was published in the Federal Register on May 10, 2024, and became effective on July 9, 2024. The key elements of the Access Rule that impact HCBS will be operationalized by the Maryland Department of Health's (MDH) Office of Long Term Services and Supports (OLTSS).

The Access Rule provisions and applicability dates are outlined in Table 1 below:

Table 1: Ensuring Access to Medicaid Services (CMS-2442-F) Provisions and Relevant Timing Information and Dates

| Regulation Section(s) in Title 42 of the CFR | Applicability Dates |
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| **Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC)**<br>§ 431.12 | § 431.12 MAC & BAC: Except as noted in paragraphs (d)(l) and (i)(3), the requirements in paragraphs (a) through (j) are applicable 1 year after the effective date of the final rule.<br><br>§ 431.12 (d)(l) BAC crossover on MAC: For |

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| | the period from 1 year after the effective date of the final rule through 2 years after the effective date of the final rule, 10 percent; for the period from 2 years plus one day after the effective date of the final rule through 3 years after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.<br><br>§ 431.12 (i)(3) Annual report: States have 2 years from the effective date of the final rule to finalize the first annual report. After the report has been finalized, States will have 30 days to post the annual report. |
| **Person-Centered Service Plans**<br>§§ 441.301(c)(1) and (3), 441.450(c), 441.540(c), and 441.725(c) | Beginning 3 years after the effective date of the final rule*** |
| **Grievance Systems**<br>§§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii) | Beginning 2 years after the effective date of the final rule |
| **Incident Management System**<br>§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), and (b)(1)(i) | Beginning 3 years after the effective date of the final rule***; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins 5 years after the effective date of the final rule*** |
| **HCBS Payment Adequacy**<br>§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi) | Beginning 6 years after the effective date of the final rule*** |
| **Reporting Requirements**<br>§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii) | Beginning 3 years after the effective date of the final rule*** for § 441.311(b) (compliance reporting) and § 441.311(d) (access reporting)<br><br>Beginning 4 years after the effective date of the final rule*** for § 441.311(c) (reporting on the HCBS Quality Measure Set) and (e) (HCBS payment adequacy reporting) |
| **HCBS Quality Measure Set**<br>§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v) | HHS Secretary begins identifying quality measures no later than December 31, 2026, and no more frequently than every other year.<br><br>HHS Secretary shall make technical updates |

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| | and corrections to the HCBS Quality Measure Set annually as appropriate. |
| **Website Transparency**<br>§§ 441.313, 441.486, 441.595, and 441.750 | Beginning 3 years after the effective date of the final rule*** |
| **Payment Rate Transparency Publication**<br>§ 447.203(b)(1) | July 1, 2026, then updated within 30 days of a payment rate change |
| **Comparative Payment Rate Analysis Publication**<br>§ 447.203(b)(2) to (4) | July 1, 2026, then every 2 years |
| **Payment Rate Disclosure**<br>§ 447.203(b)(2) to (4) | July 1, 2026, then every 2 years |
| **Interested Parties Advisory Group**<br>§ 447.203(b)(6) | The first meeting must be held within 2 years after the effective date of the final rule (then at least every 2 years). |
| **Rate Reduction and Restructuring SPA Procedures**<br>§ 447.203(c)(1) and (2) | Effective date of the final rule |

** In this final rule, including the regulations being finalized herein, we use the term "applicability date" to indicate when a new regulatory requirement will be applicable and when States must be in compliance with the requirements as specified in that regulation.

*** In the case of the State that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes HCBS in the managed care organization's (MCO), prepaid inpatient health plan's (PIHP), or prepaid ambulatory health plan's (PAHP) contract, the applicability date is the first rating period for contracts with the MCO, PIHP or PAHP beginning on or after the applicability date specified in the chart.

## III. Maryland's Plan to Operationalize the Final Rule

The Access Rule is applicable to all Medicaid FFS HCBS programs operated under various federal authorities including the HealthChoice 1115 waiver, 1915(k) and 1915(j) State Plan options, as well as 1915(c) waivers. Maryland's HCBS 1915(c) waivers are operated by several State agencies including MDH's Office of Long Term Services and Supports (OLTSS), MDH's Behavioral Health Administration (BHA), MDH's Developmental Disabilities Administration (DDA), and the Maryland State Department of Education (MSDE). Table 2 below provides an overview of HCBS programs in Maryland.

Table 2: HCBS Programs in Maryland

| Program | Authority | Operating State Agency (OSA) | Program Description<br>**(Note: All requirements for medical, technical and financial eligibility are not listed but must be met for program participation.)** |
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| Model Waiver for Medically Fragile Children (Model Waiver) | 1915(c) | OLTSS | Provides medically necessary services including case management, medical day care, and private duty nursing in the community for children with complex medical needs.<br><br>Participants must be admitted before age 22, have complex medical needs that meet the definition of a disabled child (at time of application), and meet a hospital or nursing facility level of care. |
| Community Pathways Waiver | 1915(c) | DDA | Provides a variety of Meaningful Day, Support Services, and Residential Services that promote community living, and includes a self-directed service model and a traditional, agency-based service model.<br><br>Participants must be 18 years of age or older, in need of residential services, and meet an intermediate care facility for the intellectually disabled level of care. |
| Family Supports Waiver | 1915(c) | DDA | Provides a variety of Support Services that promote community living, and offers a self-directed service model and a traditional, agency-based service model.<br><br>Participants must be children from birth through age 21 and meet an intermediate care facility for the intellectually disabled level of care. |
| Community Supports Waiver | 1915(c) | DDA | Provides a variety of Meaningful Day and Support Services that promote community living, and offers a self-directed service model and a traditional, agency-based service model.<br><br>New participants must be 18 years of age or older and meet an |

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| | | | intermediate care facility for the intellectually disabled level of care. |
| Waiver for Children with Autism Spectrum Disorder (Autism Waiver) | 1915(c) | MSDE | Provides services and support in the home and community to eligible children with autism spectrum disorder including intensive individual support services, therapeutic integration, family consultation and residential habilitation.<br><br>Participants must be children with autism spectrum disorder between the ages of 1 through 21, have an Individual Family Service Plan or Individualized Education Program (IEP) with 15 hours of special education and related services, and meet an intermediate care facility for the intellectually disabled level of care. |
| Brain Injury Waiver | 1915(c) | BHA | Provides specialized community-based services including day and residential habilitation, individual support services, and medical day care to individuals with a brain injury.<br><br>Participants must be diagnosed with a brain injury after the age of 17, be aged 22 through 64 years of age at time of application, and require a hospital or nursing facility level of care. |
| Medical Day Care Services Waiver | 1915(c) | OLTSS | Provides community-based health, social, and related support services in a structured setting for eligible individuals.<br><br>Participants must be 16 years of age or older, reside in the community and meet a nursing facility level of care. Individuals may not be enrolled in any other HCBS waiver to participate in this program. |

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| Home and Community-Based Options Waiver (HCBOW or Community Options) | 1915(c) | OLTSS | Provides community-based services and supports that enable older adults and those with physical disabilities to continue living in their own homes or in assisted living facilities.<br><br>Participants must be 18 years of age or older and meet a nursing facility level of care. |
| Community First Choice (CFC) | 1915(k) | OLTSS | Provides HCBS to older adults and individuals with disabilities who meet an institutional level of care and qualify financially to receive Medicaid in the community. |
| Community Personal Assistance Services (CPAS) | State Plan | OLTSS | Provides in-home personal assistance to older adults and individuals with disabilities.<br><br>To qualify, an individual must meet the financial criteria to receive Medicaid in the community and require assistance to perform activities of daily living. |
| Increased Community Services (ICS) | 1115 | OLTSS | Provides Medicaid State Plan benefits and HCBS to residents ages 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. |
| Program of All Inclusive Care for the Elderly (PACE) | State Plan | OLTSS | Provides comprehensive medical and social services to eligible individuals who live in the community.<br><br>Individuals must be at least 55 years old, be certified to need a nursing facility level of care, agree to receive all health and long-term care services from the PACE provider, and have an income of no more than 300% of the Supplemental Security Income (SSI) benefit level for a household of one |

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| | | | person and assets no more than $2,000. |

The Maryland Medicaid Administration (MMA) is the Single State Agency responsible for the administration and oversight of Maryland's Medicaid Program. As such, MMA is charged with ensuring compliance with all provisions within the Access Rule on or before the required applicability dates. Given the complexity of the Access Rule, CMS continues to hold various open forum meetings, conference presentations, and training sessions. CMS also receives stakeholder questions and concerns through its delegated email, and the feedback will be used to draft subregulatory guidance that will be issued to States next year. Given the continued partnership with CMS on the interpretation of the provisions in the final rule and ongoing technical assistance, MMA will continue to develop and refine its plan to operationalize the provisions in the Access Rule as more information is known.

OLTSS, a directorate within MMA, has primary responsibility for the implementation and ongoing tasks associated with the Access Rule as an operational and administrative oversight entity for all but one (1) HCBS program. OLTSS conducted an assessment of human resource needs to support the tasks required by the Access Rule and projects there is a need for 15 positions.

The 15 positions will support the provision implementation and maintenance, including the preparation and submission of the new federal deliverables required by CMS. They will also cover provisions related to quality reporting measures, transparency, and payment and rate revisions in additional Final Rules finalized by CMS recently – the *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule* ("Minimum Staffing Rule"),[1] *Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F),*[2] and *Fiscal Year (FY) 2025 Hospice Payment Rate Update Final Rule (CMS-1810-F)*.[3] Existing positions in OLTSS or other directorates within MMA will support the implementation of the remaining Access Rule provisions.

In addition to evaluating human resource requirements, MMA has developed immediate actions to comply with the Access Rule provisions by the applicability date. The following sections provide MMA's initial strategies to implement the provisions.

[1] Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid . Payment Transparency Reporting Final Rule (CMS 3442-F). (2024). *Centers for Medicare & Medicaid Services (CMS)*.
https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0

[2] Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F). (2024). *CMS*.
https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f

[3] Fiscal Year (FY) 2025 Hospice Payment Rate Update Final Rule (CMS-1810-F). (2024). CMS.
ttps://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2025-hospice-payment-rate-update-final-rule-cms-1810-f

**Rate Reduction and Restructuring SPA Procedures**

This provision went into effect on July 9, 2024, with the promulgation of the federal regulations. It applies to the Medicaid programs that elect to reduce provider payment rates or restructure provider payments, which could influence providers delivering services and result in diminished service access for participants. To ensure continued access for participants, the Medicaid program considering reducing or restructuring provider payment rates must provide written assurance and relevant supporting documentation to CMS for approval before establishing the change. The analysis must indicate that the new rates are at least 80 percent of the most recently published Medicare rates and no more than an aggregated four (4) percent rate reduction per benefit category. Also, the public comment should demonstrate that no significant concerns about access to care were raised by participants, providers, or other interested parties. Understanding the requirements, MMA is prepared to work with the Hilltop Institute (Hilltop)[4] to conduct the required analysis if provider payment rates are ever reduced or restructured.

There have not been any rate reductions in previous years for Maryland's HCBS programs. MMA has applied several rate increases since 2017 through several funding authorities including the budget, HB295 Maryland Minimum Wage Act of 2014 (Ch. 262 of the 2014 Acts); HB 166/SB 280 Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen) (Chs 10 and 11 of 2019 Acts)[5], the Governor's Supplemental Budget, and the American Rescue Plan Act (ARPA). Percentage increases and funding authority for each increase are listed below:

*Long Term Services and Supports administered programs:*

- FY 2017: 1.1% rate increase effective July 1, 2016
- FY 2018: 2% rate increase effective July 1, 2017
- FY 2019: 3% rate increase effective July 1, 2018
- FY 2020: 3% rate increase effective July 1, 2019
- FY 2021: 4% rate increase effective July 1, 2020; 4% rate increase effective January 1, 2021 (HB 166/SB 280)[6]
- FY 2022: 5.2% rate increase effective November 1, 2021 (ARPA)[7]
- FY 2023: Effective July 1, 2022 – Temporary, one-time emergency 4% rate increase for FY 2023 only (ARPA); 4% rate increase (HB 166/SB 280); 4% rate increase allocated in Governor Hogan's Supplemental Budget No. 4[8] in amendment to the budget for FY 2023
- FY 2024: 4% rate increase effective July 1, 2023 (HB 166/SB 280); the temporary 4% rate increase authorized by ARPA terminates on July 1, 2023 and as such reimbursement rates remain unchanged; the 4% increase scheduled for FY 2025 and 4% scheduled for

[4] The Hilltop Institute is a nonpartisan research organization at the University of Maryland, Baltimore County (UMBC) dedicated to improving the health and wellbeing of people and communities.
[5] https://mgaleg.maryland.gov/2019RS/bills/sb/sb0280E.pdf
[6] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) would go into effect January 1, 2021, rather than July 1, 2021,
https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JANUARY%201%202021.pdf
[7] For more information regarding MDH's ARPA spending plan, see the quarterly updates posted here: https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx
[8] State of Maryland. Supplemental Budget No. 4. Office of the Governor.
https://dbm.maryland.gov/budget/Documents/operbudget/2023/proposed/FY2023-Supplemental-Budget-No4.pdf

FY 2026 will be accelerated to provide an additional 8% rate increase effective January 1, 2024.[9]

- FY 2025: 3% rate increase effective July 1, 2024

*DDA-operated programs:*

- FY 2016: 3.5% rate increase effective July 1, 2015 (HB 295)
- FY 2017: 3.5% rate increase effective July 1, 2016 (HB 295)
- FY 2018: 3.5% rate increase effective July 1, 2017 (HB 295)
- FY 2019: 3.5% rate increase effective July 1, 2018 (HB 295)
- FY2020: 4% rate increase effective July 1, 2019 (HB 295)
- FY 2021: 4% rate increase effective January 1, 2021 (HB 166/SB 280); additional 5.5 % rate increase beginning April 1, 2021, except for targeted case management (ARPA)[10]
- FY 2022: 4% rate increase effective July 1, 2021 (HB 166/SB 280); additional 5.5% increase for targeted case management providers effective November 1, 2021 (ARPA);
- FY 2023: 4% rate increase effective July 1, 2022 (HB 166/SB 280); additional 4% rate increase effective July 1, 2022 (Governor's Supplemental Budget); one-time temporary emergency 10% rate increase for all providers from October 1, 2022 through December 31, 2022 (ARPA)
- FY 2024: 4% rate increase effective July 1, 2023 (HB 166/SB 280); an additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will be effective January 1, 2024.
- FY 2025: 3% rate increase effective July 1, 2024

*BHA-operated programs:*

- FY 2019: 3.5% rate increase effective July 1, 2018 (HOPE Act)
- FY 2020: 3.5% rate increase effective July 1, 2019 (HOPE Act)
- FY 2021: 4% rate increase effective January 1, 2021 (HB 166/SB 280)[11]
- FY 2022: 3.5% rate increase effective July 1, 2021 (HB 166/SB 280); 5.4% rate increase effective November 1, 2021 (ARPA).
- FY 2023: 3.25% rate increase effective July 1, 2022 (HB 166/SB 280); 4% rate increase effective July 1, 2022, that was allocated in Governor Hogan's Supplemental Budget No. 4 in amendment to the budget for FY 2023; one-time temporary emergency 4% increase in rate from July 2022 through September 2022 for Brain Injury Waiver providers (ARPA)

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[9] State of Maryland. FY24 Provider Rate Increases Public Notice. Maryland Department of Health. https://health.maryland.gov/mmcp/Documents/Public%20Notice/FY24%20Provider%20Rate%20Increases%20Public%20Notice%20CLEAN.pdf

[10] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) will go into effect January 1, 2021, rather than July 1, 2021, https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JANUARY%201%202021.pdf.

[11] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) will go into effect January 1, 2021, rather than July 1, 2021, https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JA NUARY%201%202021.pdf

- FY 2024: 3% rate increase effective July 1, 2023 (HB 166/SB 280); an additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will also be effective January 1, 2024.
- FY 2025: 3% rate increase effective July 1, 2024

**Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC)**

The monthly Maryland Medicaid Advisory Committee (MAC) meeting hosted by MMA will continue to comply with federal regulations regarding the Medicaid Advisory Committee (MAC). The Innovation, Research, and Development Office within MMA is in the process of implementing a Beneficiary Advisory Council (BAC), in alignment with the requirements in the Access Rule. The Access Rule requires that Medicaid participants serving on the BAC are also members of the MAC, strengthening the involvement of Medicaid participants across stakeholder forums. MMA is identifying Medicaid participants who engage with MMA in other capacities to determine their interest in joining the MAC, and, once established, the BAC. MMA hopes that the BAC will be representative of MMA's diverse participant population. Many of those participants who engage with MMA in other capacities, including those who serve on waiver advisory councils, will be able to bring varied participant voices to the MAC and BAC. These community voices will ensure that distinct voices of participants are heard in one joint forum to inform MMA's program administration and policy development. MMA is prepared to meet the provision's requirements on or before the applicability date.

**Payment Rate Transparency Publication**

MMA communicates FFS Medicaid payment rates to Medicaid-enrolled providers and the general public through regulatory and sub-regulatory guidance. Payment rate updates are communicated through a transmittal, which is distributed to stakeholders and published on the Medicaid provider transmittal landing page.[12] Payment rates for each program are also updated in the Code of Maryland Regulations (COMAR).[13] Both web pages are accessible to the general public for viewing the Medicaid FFS payment rates. As such, MMA is in compliance with this provision.

**Comparative Payment Rate Analysis Publication and Payment Rate Disclosure**

MMA is required to conduct a comparative payment rate analysis for Medicaid FFS payment rates against the Medicare payment rates for the applicable service categories based on July 1, 2025 rates. The initial comparative rate analysis must be published on the MMA's website no later than July 1, 2026, and subsequent comparative analyses are due every two (2) years thereafter.

Pursuant to Health-General Article §15-103.5, the Maryland Department of Health is required to submit an annual report that reviews the rates paid to providers under the federal Medicare fee schedule and compares the rates under the Medicare fee schedule to the FFS rates paid to similar

[12] Maryland Department of Health. Provider Transmittals.
https://health.maryland.gov/mmcp/provider/Pages/transmittals.aspx
[13] State of Maryland. COMAR Online. Division of State Documents.
https://dsd.maryland.gov/Pages/COMARHome.aspx

providers for the same services under the Maryland Medical Assistance Program and the rates paid to managed care organization providers for the same services under the Maryland Medical Assistance Program. Future iterations of this annual report will include the results of the comparative analysis. To comply with this federal requirement, MMA is communicating with Hilltop to map the Medicaid FFS procedure codes for each service to the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code level,[14] using the most current set of codes published by CMS. The mapping is expected to be completed prior to the July 1, 2025 rate release. MMA is confident in meeting the July 1, 2026 applicability date to publish the comparative analysis.

**Grievance System**

MMA must develop a grievance system that allows Medicaid participants to express dissatisfaction or file a complaint on the State's or a provider's performance whether remedial action is requested or not. The grievance system must establish a formal process to receive, investigate, and respond to grievances, as well as allow for tracking and trending of grievance data. OLTSS is responsible for receipt and triage of all grievances and will work with OSAs as applicable to remediate them. The Office will also track and trend grievances and report them to CMS. The grievance system must be operational by July 9, 2026, and MMA is currently evaluating its technology solutions to implement the system. MMA has also identified the human resource needs as previously mentioned to receive, triage, and remediate grievances for all HCBS programs.

**Interested Parties Advisory Committee**

MMA must facilitate an advisory group for interested parties to advise and consult on provider rates for service categories under the Medicaid State Plan, 1915(c) waiver, and demonstration programs where payments are made to the direct care workers. The purpose of the advisory committee is to ensure the relevant Medicaid payment rates are sufficient for direct care workers to provide personal care, home health aide, homemaker, and habilitation services to Medicaid participants at or above the level of access available to the general population and to ensure network adequacy. The committee must include direct care workers, participants and/or their authorized representatives, and other interested parties impacted by the service rates. The committee will advise MMA on current and proposed payment rates, HCBS payment adequacy data, and access to care metrics, and such recommendations will be published within one (1) month of receipt. The initial advisory group meetings must be held no later than July 9, 2026, and every two (2) years thereafter. To comply with the provision, MMA plans to establish a charter and begin soliciting members to participate in the advisory group in CY 2025.

**Quality Measure Set**

MMA participates in the Money Follows the Person (MFP) Demonstration which serves to strengthen its HCBS programs. As an MFP participant, MMA is required to implement and report on the quality measure set before the applicability date in the Access Rule. The quality measure set provision requires States to implement a customer experience survey and report on

[14] List of CPT/HCPCS Codes. CMS. https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt-hcpcs-codes

specific quality measures related to case management, comprehensive assessments, and claims/encounter data. MMA has procured the National Core Indicators (NCI) survey to conduct the required customer experience surveys for its aged and disabled participants. This is to align with DDA, which utilizes the NCI survey for adults with intellectual and developmental disabilities. MMA is required to report to CMS in September 2026 using data collected in CY 2025.

To prepare for collecting and reporting on the five (5) required quality measures and the outcome of the customer experience survey, MMA is working with Hilltop on data collection and conducting procurement activities to solicit a vendor to conduct the survey. Members of OLTSS have participated in several technical assistance sessions led by Advancing States to ensure that the Medicaid program is prepared to conduct its survey and report on the quality measures and survey outcomes within the required timeframe.

**Person-Centered Service Plans**

MMA's HCBS programs have a person-centered planning process, where a comprehensive assessment is completed to determine medical eligibility and functional needs to develop a person-centered care plan. Case managers work directly with each individual to understand their strengths, desired outcomes, preferences, goals, requested services and supports, risk factors, and backup plans in the absence of requested services and supports. MMA is reviewing the recent person-centered planning requirements in the Access Rule and completing a gap analysis for each program to identify necessary updates to the current process. The outcome of the gap analysis will drive system enhancements to ensure that the electronic plan of service in the State's data management system captures the required information for each program. MMA is confident in meeting the requirements in the Access Rule for the provision before the applicability date.

**Incident Management System**

MMA's HCBS programs leverage electronic methods of collecting incidents that adversely impact a participant's health and welfare. Currently, each Medicaid HCBS program has a procedure and technology solution for collecting, triaging, investigating, resolving, tracking, and trending critical incidents. In May 2024, MMA developed a workgroup comprised of relevant team members from each Medicaid HCBS program to develop a standardized procedure in alignment with the Access Rule provisions for incident management tasks. The workgroup is currently drafting a standardized incident management policy manual that will govern each HCBS program. The manual is expected to be complete by the end of CY 2024.

Upon completion of the policy manual, a redesigned standardized incident reporting form will be available in the State's data management system. MMA and its OSAs will train Medicaid-enrolled providers and relevant stakeholders on the standardized reporting process in CY 2025 ahead of the release of the redesigned reporting form. Additionally, OLTSS will create the incident management triage unit with the aforementioned positions. This unit will be responsible for receiving, triaging, and trending incident report data as well as sending the required incident management reporting to CMS. MMA will be in compliance on or before the applicability date.

## Reporting Requirements

Under the Access Rule, MMA must provide reports on its incident management system every two (2) years as well as on critical incident management and the person-centered planning process annually to demonstrate compliance with the new requirements. Additionally, MMA must report every two (2) years on specific quality measures and performance targets and annually on access reporting requirements. The access reporting requirements include metrics on waiver waitlists and registries, processes and time to service, and authorized hours. The payment adequacy reporting is required annually and must indicate the portion of the Medicaid provider payment spent on compensation for direct care workers.

Each of the above reporting requirements has varying applicability dates. MMA continues to conduct its assessment of the reporting requirements to ensure compliance on or before the applicability date.

## Website Transparency

MDH currently has a website home page with a landing page that is specific to MMA. Specific information for Medicaid's programs is accessible through embedded links on MMA's landing page. MMA's communications team is actively updating Medicaid's webpages in alignment with the Access Rule requirements to ensure clear labels on documents and links. Additionally, MMA is preparing to publish the necessary reports according to the reporting requirement provision. MMA expects to meet this requirement on or before the applicability date.

## HCBS Payment Adequacy

The Access Rule contains several provisions related to payment rate transparency and adequacy. Maryland does not have a standardized cost report process across its HCBS programs to capture the costs of delivering services to ensure payment rate adequacy. DDA contracts with Hilltop to collect general ledger cost data annually from waiver providers to inform rates for DDA Medicaid waiver and targeted case management services. However, the cost data does not cover the full data set required for the Access Rule provisions.

The remaining Medicaid HCBS waiver and State Plan programs do not currently collect cost data from Medicaid-enrolled providers. The Access Rule aims to ensure adequate payment rates to secure a sufficient direct care workforce to meet the needs of Medicaid participants and provide access to services in the amount, duration, and scope specified in their person-centered service plans. States must ensure that each provider spends 80 percent of the total payments the provider receives for services it furnishes on total compensation for direct care workers (e.g.; minimum performance level). States are permitted to establish reasonable and objective criteria through a transparent process to exempt providers from the minimum performance requirement (e.g.; hardship exemption). For example, States may define small providers and set a reduced minimum performance level for those providers who meet the definition.

To ensure transparency and adequacy of payment rates and comply with the reporting requirements of the Access Rule across all Medicaid HCBS programs, MMA needs to collect provider cost data. MMA is working with MDH's procurement office to determine the best

method to expand the cost-reporting process to add HCBS providers. The contract that captures the HCBS providers will require Board of Public Works (BPW) approval.

MMA is required to demonstrate its readiness to begin reporting on the payment adequacy provision by July 9, 2027, and must submit the required data annually thereafter (42 CFR 441.311). Under the payment adequacy provision, MMA must report the percentage spent on compensating direct care workers from total payments (not including excluded costs) for furnishing homemaker services, home health aide services, personal care, and habilitation services. By July 9, 2030, MDH must ensure provider compliance with the minimum performance level unless the provider meets the definition of a small provider or has been approved for a hardship exemption (42 CFR 441.302). The HCBS cost reporting process will enable MMA to report the percentage of total payments spent on compensation for direct care workers and ensure provider compliance with the minimum performance level.

## IV. Data Reporting and Collection Process

MMA utilizes a cost-based reimbursement model to establish Medicaid rates for its nursing facility program. The annual cost reports received from nursing facilities capture expenditure data in cost center prices for administrative and routine costs, other patient care costs, capital costs, and nursing service costs. Cost center prices are revised (e.g.; "rebased") every two (2) and four (4) years to capture the current expenditures submitted by each facility.[15] MMA last rebased its cost center prices effective July 1, 2024, using the 2022 facility cost reports.

During the annual cost reporting process, nursing facilities complete the cost report template and supplemental schedules. The supplemental schedules capture relevant cost data for nursing services, including nursing salaries and wages, nursing benefit expenditures, and contracted nursing services. The nursing services expenditure data includes all direct care (e.g.; hands-on assistance or support) provisioned by registered nurses (RN), licensed practical nurses (LPN), certified nurse aides (CNA), and any other clinical staff.

Myers and Stauffer, LC conducted an analysis of the most recent cost reports to capture the nursing services costs as a percentage of revenue. Table 3 shows aggregated cost data for 205 Medicaid-enrolled nursing facilities across Maryland.

Table 3: Aggregated Nursing Services Cost - 2023 Nursing Facility Cost Reports[16]

| Nursing Salaries & Wages | Nursing Employee Benefits | Nursing Contracted Services | Total Revenue | Salaries, Wages, & Benefits as a percent of revenue | Contracted Services as a percent of revenue |
|---|---|---|---|---|---|
| $672,909,609 | $150,897,920 | $412,835,269 | $3,051,402,147 | 27% | 14% |

[15] State of Maryland. .09 Rate Calculation — Administrative and Routine Costs. Division of State Documents. https://dsd.maryland.gov/regulations/Pages/10.09.10.09.aspx
[16] Source: Unaudited 2023 Nursing Facility Cost Reports

The Minimum Staffing Rule requires States to report the percentage of Medicaid service payments spent on compensating direct care workers (e.g.; nursing and therapy staff) and support staff (e.g.; housekeepers and drivers providing transportation for residents) in nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).[17] The compensation for direct care workers excludes the costs of travel, training, and personal protective equipment (PPE). This exclusion encourages nursing facilities and ICFs/IID to continue to invest in these critical activities and provide necessary items. The Minimum Staffing Rule also requires States and CMS to make the institutional payment information available on public-facing websites. States must comply with this annual reporting requirement by June 21, 2028, as noted in 42 CFR 442.43.[18] MMA will work with Myers and Stauffer, LC to amend its future cost report template and supplemental schedules to collect the necessary information.

## V. Private Duty Nursing Wage Analysis

Hilltop completed a scan of regional direct support occupations in the home health care industry, which would include private duty nursing (PDN) services. Hilltop also compared average hourly wages and Medicaid reimbursement rates from May 2023 in nearby states and the overall labor market to inform the required reporting requested in this Joint Chairmen's Report (JCR). Hilltop used publicly available State Occupational Employment and Wage Estimates from the United States Bureau of Labor Statistics (U.S. BLS) to identify compensation trends for registered nurses, licensed practical nurses and licensed vocational nurses, nursing assistants, and home health and personal care aides.[19] These occupations were selected because they provide direct care in HCBS programs. Hilltop's analysis focused on surrounding states including Delaware, Pennsylvania, Virginia, Washington, D.C., and West Virginia to report the average hourly wage rate.

Table 4 shows the average hourly wage rates for registered nurses, licensed practical nurses and licensed vocational nurses, nursing assistants, and home health and personal care aides in nearby States across all industries in May 2023. Registered nurses receive the highest pay in Washington, D.C. at $51.37, with Maryland ranking third at $44.27. For licensed practical and vocational nurses, Maryland's average hourly wage rate is $31.95, close behind Washington D.C., at $32.75. Washington D.C. also leads in nursing assistant wages at $23.01, and Maryland follows at an average hourly wage rate of $19.60. Home health and personal care aides earn the most in Washington, D.C. at $17.88 and Maryland places second at $16.89.

Table 4: Average Hourly Wage Rate for Registered Nurses, Licensed Practical Nurses and Licensed Vocational Nurses, Nursing Assistants, and Home Health and Personal Care Aides - All Industries - By State, May 2023[20]

[17] Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F). CMS. https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0

[18] § 442.43 Payment transparency reporting. Code of Federal Regulations. https://www.ecfr.gov/current/title-42/section-442.43

[19] Occupational Employment and Wage Statistics. U.S. Bureau of Labor Statistics. https://www.bls.gov/oes/current/oessrcst.htm

[20] Source: BLS State Occupational Employment and Wage Estimates

| | Registered Nurse | Licensed Practical and Vocational Nurse | Nursing Assistant | Home Health and Personal Care Aides |
|---|---|---|---|---|
| Delaware | $45.51 | $30.52 | $18.57 | $14.87 |
| **Maryland** | **$44.27** | **$31.95** | **$19.60** | **$16.90** |
| Pennsylvania | $42.08 | $28.27 | $19.12 | $14.70 |
| Virginia | $42.48 | $27.79 | $18.00 | $14.18 |
| Washington, D.C | $51.37 | $32.75 | $23.01 | $17.88 |
| West Virginia | $36.53 | $24.08 | $16.99 | $12.69 |
| **Regional Total or Average** | **$43.71** | **$29.23** | **$19.22** | **$15.20** |

Table 5 shows the national average hourly wage for the home health care industry across HCBS direct care occupations. The average hourly wage varies significantly across registered nurses, licensed practical nurses and licensed vocational nurses, nursing assistants, and home health and personal care aides. Registered nurses received the highest average hourly wage at $42.04, followed by licensed practical and vocational nurses at $29.35, nursing assistants at $17.13, and home health and personal care aides with the lowest at $15.44. This national trend aligns with the trends in Maryland and the regional average presented above, despite variations in industry scope.

Table 5: National Average Hourly Wage Rate for Direct Support Occupations in the Home Health Care Industry, By Occupation, May 2023[21]

| Occupation | Average Hourly Wage Rate |
|---|---|
| Registered Nurse (RN) | $42.04 |
| Licensed Practical Nurse (LPN) | $29.35 |
| Nurse Assistant (NA) | $17.13 |
| Home Health and Personal Care Aides (HHA) | $15.44 |

In addition to the regional analysis of the HCBS direct care workforce, Hilltop investigated Medicaid FFS rates for services equivalent to Maryland's home health and nursing services, offered through the state's Model Waiver program. When available and, if necessary, rates were converted from 15-minute units to hourly units to allow comparison across states. Although the data is limited, the available data noted in Table 6 below shows that registered nurses who provide services for a single participant receive the highest pay in Virginia at $84.07, with Maryland following at $79.50 per hour.

[21] Source: BLS State Occupational Employment and Wage Estimates

Table 6: Medicaid Hourly Rates for Home Health and Nursing Services, By State[22]

| Occupation | Service | Procedure Code | DE[23] | MD[24] | PA[25] | VA[26] | D.C.[27] | WVA[28] |
|---|---|---|---|---|---|---|---|---|
| | | | HR | HR | HR | HR | HR | HR |
| Registered Nurse | 1 participant | T1002 | $76.00 | **$79.50** | $77.00 | $84.07 | $70.84 | |
| | 2 or more participants | T1030 | | **$54.84** | | $48.36 | | |
| Licensed Practical Nurse | 1 participant | T1003 | | **$51.53** | $50.00 | $65.33 | $59.00 | |
| | 2 or more participants | T1031 | | **$35.54** | | $38.04 | | |
| Certified Nursing Assistant Or Home Health Aide | 1 participant | W1000 | | **$27.24** | | | | |
| | 2 or more participants | T1021 | | **$18.79** | | | | |
| | 1 participant | T1004 | | **$22.61** | | | $25.48 | |
| | 2 or more participants | T1004 | | **$15.59** | | | | |

## VI. Licensure Requirements for Residential Services Agencies

Residential Service Agencies (RSAs) must be licensed by the Office of Health Care Quality (OHCQ), an agency within MDH. The licensure procedure includes submitting a no-cost application and various documents to demonstrate provider integrity and qualification. Pursuant to SB108 passed during the 2018 legislative session, RSAs are no longer required to pay a $1,000 fee when submitting an application to request licensure.[29] With the license, RSAs can hire skilled nurses such as registered nurses and licensed practical nurses to deliver complex care to

[22] Note: Gray cells indicate the rate was not publicly available at the time of this analysis. The rates shown are the most up-to-date for each state. Fifteen-minute unit rates have been converted to hourly rates (HR). Virginia rates represent those for the north of the state.
[23] Physician Fee Schedule Effective January 1, 2024. Medicaid Publications. Delaware Department of Health and Human Services. https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1725&language=en-US&PortalId=0&TabId=94
[24] Maryland Medical Assistance Program. Model Waiver Program Transmittal No. 62; EPSDT: Nursing Services Transmittal No. 57. Maryland Department of Health. https://health.maryland.gov/mmcp/provider/Documents/Transmittals_FY2025/PT%2007-25%20Fiscal%20Year%202025%20Rates%20for%20Nursing%20Services.pdf
[25] https://www.humanservices.state.pa.us/OUTPATIENTFEESCHEDULE/Search/Submit
[26] Department of Medical Assistance Services. Commonwealth Coordinated Care Plus Waiver. Commonwealth of Virginia. https://www.dmas.virginia.gov/media/cpkjirw3/cccplus-waiver-web-file-6-4-2024.pdf
[27] Department of Health Care Finance. Skilled Nursing Rate Changes. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2023-42%20-%20Skilled%20Nursing%20Rate%20Changes%20Effective%20October%201%2C%202023.pdf
[28] Not available
[29] State of Maryland. 2018 General Assembly. Senate Bill 108 Regulation of Health Care Programs, Medical Laboratories, Tissue Banks, and Health Care Facilities. https://mgaleg.maryland.gov/2018RS/Chapters_noln/CH_661_sb0108t.pdf

clients.

The licensure process requires the RSA applicant or corporate representative to be at least 21 years of age and submit identification of individuals or parties who have a 25 percent or greater interest in the agency. The RSA applicant must present other licenses or certifications held under the Health Occupations or Health-General Articles if applicable, and report on any previous or current operation of a similar health care program. To demonstrate the ability to operate an agency in compliance with COMAR 10.07.05.04, the RSA applicants must submit a business plan with at least one (1) year of an operating budget, a marketing plan that identifies the target population, and a detailed description of services that will be provided. As required by the Maryland Workers' Compensation Commission, RSA applicants must also provide proof of Workers' Compensation for all employees and present copies of their policies and procedures as specified in COMAR 10.07.05.08B.

RSA applicants must disclose any prior denial, suspension, or revocation of a license to provide care, any criminal charges or convictions by the applicant, owner, or party with 25 percent or greater interest, and any violations of laws and regulations for Medicare, Medicaid, or the Health Occupations or Health-General Articles of the Annotated Code of Maryland. RSAs face increased scrutiny and restrictions if the applicant, owner, or party with a 25 percent or greater interest had a license suspended or revoked by MDH, had sanctions imposed for being non-compliant, or had a history of regulatory violations or criminal history that may harm service recipients.

OHCQ provides a new RSA with a license to operate upon the successful completion of the licensure application. While RSA licenses do not expire, the agency must continue to adhere to applicable federal, state, and local laws and regulations, including the provisions described in COMAR 10.07.05.04.[30] Medicaid's reimbursement rates do not consider the cost of the licensure requirements. However, as noted, there is no cost associated with the application for licensure.

## VII. Conclusion

The unprecedented Access Rule establishes historic national standards for access to care and health equity across Medicaid programs. Maryland is already in compliance with some of the provisions outlined in the Access Rule and is well-positioned to comply with the remaining provisions on or before the applicability dates. Additionally, Maryland's wage rates for nursing services are competitive with surrounding states and exceed the national average. MMA will continue to evaluate Medicaid rates and rate-setting methodologies as it implements its plan to address the various rate and payment provisions embedded in the Access Rule. MMA is committed to improving the access to care, quality of care, and health outcomes for Medicaid participants through the implementation of the rule.

[30] State of Maryland. .04 Licensing Procedures. Division of State Documents. https://dsd.maryland.gov/regulations/Pages/10.07.05.04.aspx