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 Pamela Beidle, Chair
Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Joseline A. Peña-Melnyk, Chair
Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

**RE: Report Required By HB 189/SB 371 (Ch. 865/864 of the Acts of 2024) – *Maryland Medical Assistance Program – Personal Care Aides – Wage Reports* – Report on the Final Ensuring Access to Medicaid Services Federal Rule and Plans or Steps that MDH will Take to Operationalize the Rule (MSAR #15140)**

Dear Chairs Beidle and Peña-Melnyk:

Pursuant to HB 189/SB371 (Ch. 865/864 of the Acts of 2024) – *Maryland Medical Assistance Program – Personal Care Aides – Wage Reports*, the Maryland Department of Health (MDH) submits this report to provide an overview of the final Ensuring Access to Medicaid Services federal rule and plans or steps that MDH will take to operationalize the rule. The report includes information on the process that MDH will use to review wage reports of personal care aides, and how the data will be used to review Medicaid reimbursement rates as outlined in the rule.

If further information 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

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)


# Maryland Medical Assistance Program - Personal Care Aides
# Report Required by HB189/SB371

**October 22, 2024**

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## I. Introduction

Pursuant to HB189/SB371 passed during the 2024 legislative session, residential service agencies (RSAs) must submit certain reports to the Maryland Department of Labor (DoL) regarding wage rates for personal care aides. Additionally, the Maryland Department of Health (MDH) must report to certain committees of the General Assembly within 180 days of the release of the final federal Ensuring Access to Medicaid Services rule on an overview of the final rule and plans or steps that MDH will take to operationalize the rule. MDH must also report on personal care services reimbursed by the Maryland Medical Assistance Program.

This requirement applies to personal assistance services provided exclusively through an RSA under Community First Choice (CFC), Home and Community-Based Options Waiver (HCBOW or "Community Options"), Community Personal Assistance Services (CPAS), and any other home and community-based services administered by MDH. This does not apply to personal care services provided through the Developmental Disabilities Administration (DDA).

On or before September 1st of each year, beginning in 2025, each RSA must submit an annual report to DoL that includes the following:

- average wage rate for personal care aides;
- highest and lowest wage rates for personal care aides; and
- any other information that DoL determines appropriate.

The annual report must be signed by an authorized representative of the RSA.

On or before the 180th day after the release of the final federal Ensuring Access to Medicaid Services rule, MDH shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on an overview of the final rule and plans or steps that MDH will take to operationalize the rule. The required report shall include:

- the process that MDH will use to review wage reports of personal care aides; and
- how the data will be used to review Medicaid reimbursement rates as outlined in the rule.

## 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[1]

| Regulation Section(s) in Title 42 of the CFR | Applicability Dates |
|---|---|
| **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 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** | Beginning 3 years after the effective date of |

[1]The Centers for Medicare and Medicaid Services. (2024, April 22). Ensuring Access to Medicaid Services (CMS-2442-F) Provisions and Relevant Timing Information and Dates. https://www.medicaid.gov/medicaid/access-care/downloads/applicability-date-chart-ac.pdf

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| §§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii) | 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 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 applies 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 (Note: All requirements for medical, technical and financial eligibility are not listed but must be met for program participation.) |
|---|---|---|---|
| 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 |

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| | | | 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 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 |

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| | | | 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. |
| 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 |

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| | | | 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 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 sub-regulatory 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 determined there is a need for 15 additional 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"),[2] *Contract Year 2025 Medicare Advantage and Part D*

[2] The Centers for Medicare and Medicaid Services. (2024, April 22). Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final

*Final Rule (CMS-4205-F),*[3] and *Fiscal Year (FY) 2025 Hospice Payment Rate Update Final Rule (CMS-1810-F)*.[4] 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.

**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)[5] 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)[6], 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

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Rule (CMS 3442-F).
https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0

[3] The Centers for Medicare and Medicaid Services. (2024, April 4). Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F).
https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f

[4] The Centers for Medicare and Medicaid Services. (2024, July 30). Fiscal Year (FY) 2025 Hospice Payment Rate Update Final Rule (CMS-1810-F).
https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2025-hospice-payment-rate-update-final-rule-cms-1810-f

[5] 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.

[6] Labor and Employment – Payment of Wages – Minimum Wage and Enforcement 2 (Fight for Fifteen), Senate Bill 280, (2019). https://mgaleg.maryland.gov/2019RS/bills/sb/sb0280E.pdf

- 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)[7]
- FY 2022: 5.2% rate increase effective November 1, 2021 (ARPA)[8]
- 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[9] 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 FY 2026 will be accelerated to provide an additional 8% rate increase effective January 1, 2024.[10]
- 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)[11]
- 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); additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will be effective January 1, 2024.

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[7] 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

[8] For more information regarding MDH's ARPA spending plan, see the quarterly updates posted here: https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx

[9] For more information on the 2023 Supplemental Budget Bill, see https://dbm.maryland.gov/budget/Documents/operbudget/2023/proposed/FY2023-Supplemental-Budget-No4.pdf

[10] For more information on the public notice, see https://health.maryland.gov/mmcp/Documents/Public%20Notice/FY24%20Provider%20Rate%20Increases%20Public%20Notice%20CLEAN.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%20JANUARY%201%202021.pdf.

- 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)[12]
- 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)
- FY 2024: 3% rate increase effective July 1, 2023 (HB 166/SB 280); 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 (MMAC) 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 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 subregulatory guidance. Payment rate updates are communicated through a transmittal, which is distributed to stakeholders and published on the

[12] 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

Medicaid provider transmittal landing page.[13] Payment rates for each program are also updated in the Code of Maryland Regulations (COMAR).[14] 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 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,[15] 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.

[13] Maryland.gov. Provider Transmittals. Maryland Department of Health Provider Services. Retrieved November 19, 2024 from https://health.maryland.gov/mmcp/provider/Pages/transmittals.aspx
[14] Maryland.gov. COMAR Online. Maryland Division of State Documents. Retrieved November 19, 2024 from https://dsd.maryland.gov/Pages/COMARHome.aspx
[15] The Centers for Medicare and Medicaid Services. (2024, September 10). List of CPT/HCPCS Codes. https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt-hcpcs-codes

## 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 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. All other reporting requirements will be managed by each team within OLTSS responsible for the provision implementation (e.g.; the incident management triage team will be responsible for its reporting requirement). 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. Review Process for Wage Reports of Personal Care Aides

As noted in Table 2 above, MMA offers a broad range of HCBS programs that provide services and supports to older adults, individuals with physical, intellectual, or developmental disabilities, and children with complex medical needs. While various services and supports are available in HCBS programs, personal assistance services (PAS) are specifically offered under CFC and CPAS. PAS are provided through RSAs that assist participants with activities of daily living

(ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing.

RSAs are licensed by MDH's Office of Health Care Quality (OHCQ) to provide a broad array of services including home care services, durable medical equipment (DME), DME with oxygen, speech therapy, occupational therapy, physical therapy, medical social services, nutritional services, intravenous therapy, and/or ventilator services. To provide these services, the agency may employ a diverse workforce that includes registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medication technicians (CMTs), direct service professionals (i.e.; personal care aides), therapists, and administrative staff. For PAS specifically, the services are provisioned by personal care aides with oversight from a nurse. The oversight from the RSA nurse includes completing nursing assessments and care plans, providing nursing services, delegating nursing tasks to personal care aides, and training, supervising, and evaluating personal care aides.

Pursuant to HB189/SB371,[16] RSAs are required to submit data to DoL regarding wage rates for personal care aides beginning in CY 2025. Specifically, RSAs must submit average wage rates for personal care aides, the highest and lowest wage rates for personal care aides, and any other information that DoL determines appropriate. In order to collect data on wage rates for personal care aides, DoL will distribute a survey to RSAs. In June 2024, OLTSS staff met with representatives from DoL to discuss the survey, and DoL agreed to collaborate with OLTSS to determine what additional data should be captured to align the survey with Access Rule requirements. OLTSS will continue collaborating with DoL throughout the survey development process, along with reviewing survey responses once data is collected. The survey is expected to be released by June 30, 2025.

## V. Medicaid Reimbursement Rates for Personal Care Aides

OLTSS is committed to using data from DOL's survey to review personal care aide reimbursement rates; however, it also plans to implement HCBS cost reports to collect detailed financial information such as staffing and other relevant costs. The HCBS cost reports will be used to assess the adequacy of Medicaid's reimbursement rates and confirm each provider's compliance with the minimum performance level (e.g.; 80 percent of the total Medicaid payments spent on compensation for direct care workers) required in the payment adequacy provision of the Access Rule, which is referenced in section three of this report.

## VI. 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. MMA will continue to evaluate Medicaid rates

[16] Maryland Medical Assistance Program – Personal Care Aides – Wage Reports. House Bill 189, (2024). https://mgaleg.maryland.gov/2024RS/Chapters_noln/CH_865_hb0189e.pdf

and rate-setting methodologies as it implements its plan to address the various rate and payment provisions embedded in the Access Rule. Additionally, MMA will continue to partner with other State agencies, such as DoL, to collect relevant wage data as it conducts its rate/rate-setting evaluation. MMA is committed to improving the access to care, quality of care, and health outcomes for Medicaid participants through the implementation of the rule.