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The 80/20 Rule is Here: CMS Finalizes HCBS Care Worker Payment Requirements

In May 2023, the Centers for Medicare and Medicaid Services ("CMS") proposed a series of rule changes intended to help promote the availability of home and community-based services ("HCBS") for Medicaid beneficiaries. Chief among these proposals was a new rule that would require HCBS agencies to spend at least 80% of their Medicaid payments for homemaker, home health aide, and personal care services on direct care worker compensation (the "80/20 Rule"). Intended to help stabilize the HCBS workforce, the proposal faced immediate backlash from HCBS providers and Medicaid agencies, who expressed concern that the 80/20 rule would harm HCBS providers by mandating specific allocations to worker compensation and bogging down providers and Medicaid agencies with burdensome reporting requirements.

After reviewing thousands of comments, CMS released an advance copy of the final rule this week. Defying stakeholder anticipation that the 80/20 Rule would be relaxed, or updated to provide more flexibility for providers, CMS finalized the 80/20 Rule largely as originally proposed, including the following key requirements:

- HCBS providers must spend at least 80% of Medicaid payments on direct care worker compensation;
- HCBS providers will have six years (increased from four) from the effective date of the final rule to demonstrate compliance with the 80/20 Rule;
- States must begin collecting and tracking data on direct care worker compensation within four years of the effective date of the final rule; and
- States are permitted to establish different standards for smaller HCBS providers and to establish hardship exemptions – in both cases based on objective and transparent criteria.

Under the broad mandate of the 80/20 Rule, there are a number of key definitions that HCBS providers must consider as they evaluate these new requirements:

Direct Care Workers

Because the 80/20 Rule was adopted largely to stabilize the HCBS workforce, a key component is *whose* compensation qualifies for inclusion. CMS's proposed definition encompassed almost any person with a role in providing direct care to patients (e.g., RNs, LPNs, individuals practicing under their supervision, home health aides, etc.). Under the final 80/20 Rule, CMS clarified that

"direct care workers" also include those whose role is specifically tied to clinical supervision (e.g., nurse supervisors).

Compensation

Compensation of direct care workers means: "[s]alary, wages, and other remunerations as defined by the Fair Labor Standards Act and implementing regulations; [b]enefits (*such as* health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and [t]he employer share of payroll taxes for direct care workers delivering services authorized under section 1915(c) of the Act." CMS clarified that "compensation" also includes:

1. Overtime pay;
2. All forms of paid leave (e.g., sick leave, holidays, and vacations);
3. Different types of retirement plans and employer contributions; and
4. All types of benefits: CMS intentionally used the phrase "such as" to indicate the list of benefits was non-exhaustive, and indicated technical guidance to states on this subject is forthcoming.

Excluded Costs

CMS expressed concern that HCBS providers would include training costs for direct care workers as "compensation," and that calculating compensation in this way could result in negative outcomes, such as diminished training opportunities. To address these concerns, CMS created the concept of "excluded costs," which are excluded from the percentage calculations under the 80/20 Rule. *See* § 441.302(k)(1)(iii) ("costs that are not included in the calculation of the percentage of Medicaid payments to providers that are spent on compensation for direct care workers."). Excluded costs are limited to:

1. Costs of required direct care worker training;
2. Direct care worker travel costs (mileage, public transportation subsidy, etc.); and
3. Personal protective equipment costs.

Medicaid Payments

CMS largely adopted its expansive view of what qualifies as a "Medicaid Payment" for purposes of 80/20 Rule calculations. CMS clarified that the 80/20 Rule encompasses both standard and supplemental payments and applies regardless of whether HBCS services are delivered through fee-for-service or managed care delivery systems. CMS also declined to create a formal carve-out for value-based care or pay-for-performance arrangements, despite recognizing their value.

What Comes Next?

HCBS providers and state Medicaid agencies have six years to sort out their compliance with the 80/20 Rule (though data tracking and reporting begins after year three). On the provider side, this means carefully evaluating the business and economic impacts of compliance with the 80/20 Rule and monitoring CMS and state-level guidance on implementation as it develops over time. For multi-state providers, this process becomes even more complicated, as there is a high likelihood that states will choose to implement the 80/20 Rule in different, and potentially contradictory, ways.

Providers also need to work with the state agencies to address the adequacy of HCBS rates generally. CMS recognized the important role that the underlying rates play in HCBS sustainability but declined to mandate specific payment rates or methodologies. As a result, positive momentum on the rates themselves must come from state initiatives.

Here at Polsinelli, we are communicating with key associations, impacted providers, and other stakeholders regarding potential responses to the 80/20 Rule and will continue to provide updates as to the status of this rule and further CMS guidance as it becomes available.